



**The 'Can Do' Initiative:  
Managing Mental Health and Substance Use in General Practice**

***'Can Do' for Culturally and Linguistically Diverse People  
Facilitator's Notes***

**Presentation and facilitator's notes,  
case studies and facilitator's trigger questions**

Joint learning module for general practitioners, allied health practitioners and other service providers involved in the provision of care for rural men at risk of or experiencing mental health and substance use issues.

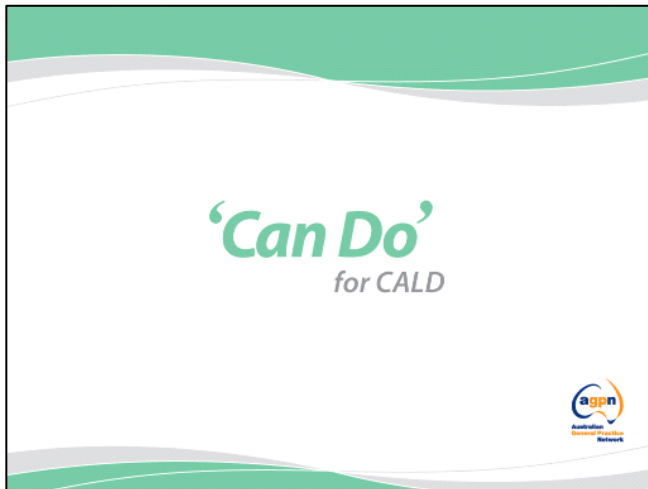
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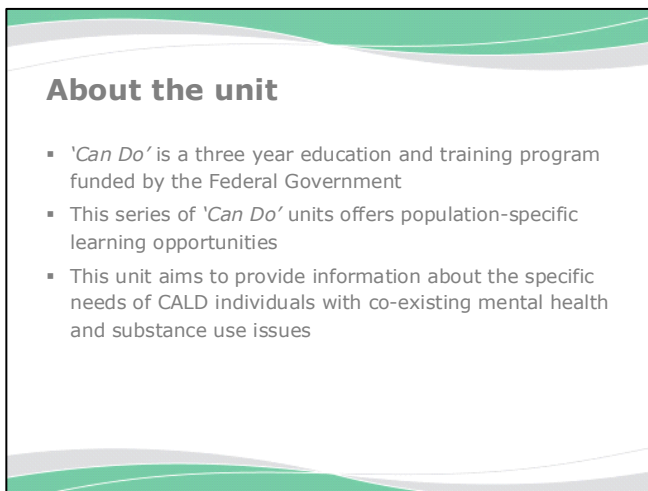
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## Slide 1: Title page



This is the title slide. You may use this slide as participants arrive and during the welcome. As the facilitator it is important that you familiarise yourselves with the slides and notes.

## Slide 2: About the unit

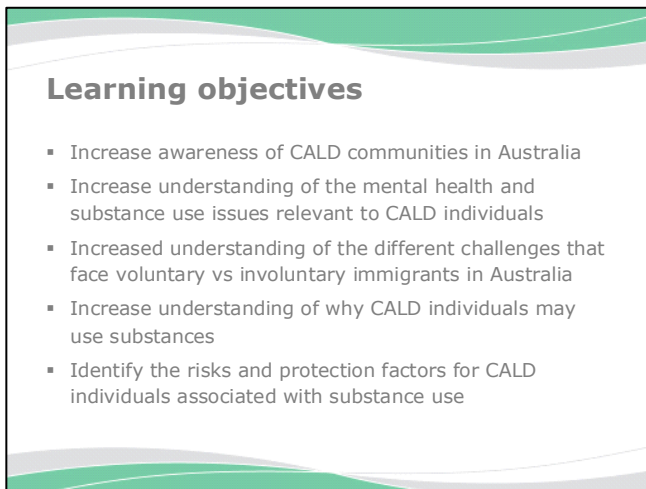


This slide provides an overview of how this unit fits into the 'Can Do' initiative.

### Key points

- The 'Can Do' initiative is a three year education and training program, funded by the Australian Government Departments of Health and Ageing and Veterans' Affairs. This unit has been developed to provide information about the specific needs of CALD People who experience co-morbid mental health and substance use issues. A multidisciplinary team focus has been taken, with the aim of involving a range of health and community service providers.
- The unit aims to provide key information related to the topic area, and encourages interactive learning via discussion of the 'stories' of two CALD People and the opportunity to network and 'map' local service providers
- It has been developed for a range of professionals and provides the opportunity to increase awareness of local networks and referral pathways
- The unit is intended to be used alongside other 'Can Do' Network Training units (*Teams of Two* and other population specific units)

### Slide 3: Learning objectives



**Learning objectives**

- Increase awareness of CALD communities in Australia
- Increase understanding of the mental health and substance use issues relevant to CALD individuals
- Increased understanding of the different challenges that face voluntary vs involuntary immigrants in Australia
- Increase understanding of why CALD individuals may use substances
- Identify the risks and protection factors for CALD individuals associated with substance use

The overarching goal of the unit is to inform participants about the specific needs of CALD communities, with reference to co-occurring mental health and substance use problems. Specific information related to particular cultural backgrounds is provided in the slide notes as relevant. The intended audience for this unit is general practitioners, allied health professionals and other service providers.

#### **Key points**

The unit aims to:

- demonstrate an increased awareness of cald communities in australia – including the physical, psychological, social, spiritual and cultural needs of cald people
- demonstrate an increased understanding of the mental health & substance use issues relevant to cald individuals, such as alcohol use, smoking, depression and anxiety (including post-traumatic stress disorder)
- demonstrate an increased understanding of the different challenges that face voluntary vs. involuntary immigrants in australia
- identify why cald individuals may use substances eg. to relax, to socialise or to manage symptoms of anxiety or depression
- identify the physical, psychological and social risks as well as protection factors associated with substance use by cald individuals
- demonstrate improved knowledge of strategies to prevent and address substance use issues in cald communities
- identify health and community services at the local level, particularly those that engage with and provide support to cald people
- demonstrate an increase in ability and confidence in developing appropriate pathways of referral and care for CALD people with mental health and substance use issues.

## Slide 4: Learning objectives (cont.)

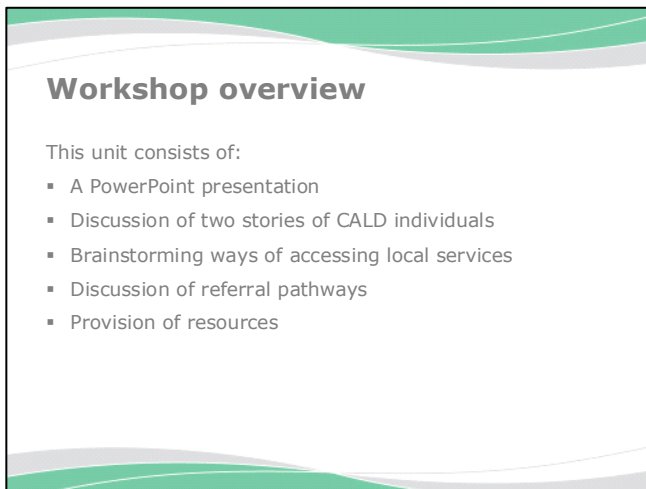
### Learning objectives (cont.)

- Improve knowledge of strategies to prevent and address substance use issues in CALD communities
- Identify health and community services at the local level, particularly those that engage with and provide support to CALD people
- Increase confidence in developing appropriate pathways of referral and care for CALD people with mental health and substance use issues

The learning objectives will be achieved by:

- Encouraging multidisciplinary and solution-focused approaches
- Facilitating interactive learning and peer discussion
- Fostering networking and mapping of local services and referral pathways
- Improving knowledge about local services
- Ensuring skills gained are transferable to clinical practice

## Slide 5: Workshop overview



**Workshop overview**

This unit consists of:

- A PowerPoint presentation
- Discussion of two stories of CALD individuals
- Brainstorming ways of accessing local services
- Discussion of referral pathways
- Provision of resources

This slide provides an overview of the format of this unit. The unit is intended as an overview of the main issues when working with this population. However, it is important to note that this subject is an extensive and complex one.

### Key points

This unit consists of:

- A brief PowerPoint presentation to provide participants with an overview of relevant background information about CALD populations and substance and mental health issues.
- Discussion of two CALD individuals' stories to provide an opportunity to share knowledge, skills and practical advice on working with this population group.
- Brainstorming ways of identifying and accessing local services during the discussion of the CALD person's stories and a service mapping exercise – service providers will be given an opportunity to introduce their service in the service mapping exercise.
- Discussion of referral pathways - details of local agencies and the process of appropriate referral; who is able to refer, what details to include in the referral letter/form.
- A number of handouts will be provided and a comprehensive list of resources can be found at the end of the unit.

### References

Australian Government Department of Immigration and Citizenship. (2008). Immigration Update (2006-7). Belconnen, ACT; National Communications Branch of the Department of Immigration and Citizenship.

DrugInfo Clearinghouse. (2007). Issues paper: culturally and linguistically diverse communities and drug prevention. *Prevention Research Quarterly: Current Evidence Evaluated, June 2007*. Retrieved 22 January 2008, from [http://www.druginfo.adf.org.au/downloads/Prevention\\_Research\\_Quarterly/IP\\_07Jun\\_CLD\\_prev.pdf](http://www.druginfo.adf.org.au/downloads/Prevention_Research_Quarterly/IP_07Jun_CLD_prev.pdf)

Holmes, D., Hughes, K., Julian, R. (2003). *Australian Sociology; A Changing Society*. New South Wales; Pearson Education.

Silove, D. (2004). Mental health problems in migrants and refugees. *Australian Doctor*, 16 July, 31-38

## Slide 6: CALD populations

**CALD populations**

- In 2005-2006, 119,564 immigrants from non-English speaking countries settled in Australia
- Such immigrants are referred to as being "Culturally and Linguistically Diverse" (CALD)
- CALD refers to those born overseas in a non-English speaking country, and those born in Australia who have one or both parents or grandparents born overseas in a non-English speaking country
- The immigrant experience can lead to improved quality of life or be viewed as a negative experience

This slide is the first of two slides outlining the definitions and statistics related to CALD communities in Australia. Australia is an ethnically diverse country. A person's cultural background (i.e. country of birth, language spoken at home, religion, and ethnic background) may have an impact on drug use and/or associated problems and their resolution.

Culture is defined as 'the learned ideas, values, knowledge, rules and customs shared by members of a collectivity (such as those based on ethnicity, gender, sexuality, indigeneity, age, disability)' (Holmes, Hughes, & Julian, 2003).

### Key points

- Australia's immigrant population has grown enormously in recent decades. Millions of people from more than 150 different countries, and from diverse backgrounds, have settled with much success: in the year 2005-06, 119,564 immigrants from non-English speaking countries settled permanently in Australia (Australian Government Department of Immigration and Citizenship, 2008).
- The population group, 'Culturally and Linguistically Diverse', encompasses those born overseas in a non-English speaking country as well as those born in Australia, but with one or both parents or grandparents born overseas in a non-English speaking country. However, this group can be further divided into voluntary migrants, people who have been drawn to Australia for their own personal reasons, and involuntary migrants (refugees and asylum seekers, who have felt 'pushed' out of their country of origin). It is important to highlight differences between these two subgroups during the discussion, in terms of prevalence of mental health issues and likely risks and challenges.
- While for the majority of arrivals immigration means a significant improvement in quality of life, the immigrant experience is a very complex one. There may be very high expectations of the new country, and later disappointment that not all aspects are positive. Migrants may encounter various stressors that have an impact on their general wellbeing, and therefore the experience of immigrating has the capacity to negatively influence all parts of their lives.

From a drug prevention perspective, it is desirable to prevent stressors related to the immigrant experience from leading to the development of drug and/or alcohol problems

### References

Australian Government Department of Immigration and Citizenship. (2008). Immigration Update (2006-7). Belconnen, ACT; National Communications Branch of the Department of Immigration and Citizenship  
 DrugInfo Clearinghouse. (2007). Issues paper: culturally and linguistically diverse communities and drug prevention. *Prevention Research Quarterly: Current Evidence Evaluated, June 2007*. Retrieved 22 January 2008, from [http://www.druginfo.adf.org.au/downloads/Prevention\\_Research\\_Quarterly/IP\\_07Jun\\_CLD\\_prev.pdf](http://www.druginfo.adf.org.au/downloads/Prevention_Research_Quarterly/IP_07Jun_CLD_prev.pdf)  
 Holmes, D., Hughes, K., Julian, R. (2003). *Australian Sociology; A Changing Society*. New South Wales; Pearson Education.  
 Silove, D. (2004). Mental health problems in migrants and refugees. *Australian Doctor*, 16 July, 31-38

## Slide 7: CALD populations (cont.)

### CALD populations

- Comprised of both voluntary and involuntary immigrants to Australia
- Voluntary: 147,850 in 2004-7
- Involuntary: 14,158 in the same years (8.7% of immigrants)
- 20% of Australian residents speak a language other than English at home, and this figure approaches 50% in some areas of major cities

### Key Points

- The CALD population can be divided into voluntary migrants, people who have been drawn to Australia for their own personal reasons, and involuntary migrants (refugees and asylum seekers, who have felt 'pushed' out of their country of origin).
- In the financial years 2004-5 and 2006-7, there were 147,850 voluntary immigrants.
- There were a further 14, 158 involuntary immigrants, accounting for 8.7% of the total (Australian Government Department of Immigration and Citizenship, 2008).
- 20% of Australian residents speak a language other than English at home, and this figure approaches 50% in some areas of major cities (Silove, 2004).

### References

- Australian Government Department of Health and Ageing. (2005). Culturally and linguistically diverse (CALD) groups. Retrieved 17 January 2008, from <http://www.aodgp.gov.au/internet/aodgp/publishing.nsf/Content/cald>
- Australian Government Department of Immigration and Citizenship. (2008). Immigration update (2006-7). ACT: National Communications Branch of the Department of Immigration and Citizenship.
- DrugInfo Clearinghouse. (2007). Issues paper: culturally and linguistically diverse communities and drug prevention. *Prevention Research Quarterly: Current Evidence Evaluated, June 2007*. Retrieved 22 January 2008, from [http://www.druginfo.adf.org.au/downloads/Prevention\\_Research\\_Quarterly/IP\\_07Jun\\_CLD\\_prev.pdf](http://www.druginfo.adf.org.au/downloads/Prevention_Research_Quarterly/IP_07Jun_CLD_prev.pdf)
- Silove, D. (2004). Mental health problems in migrants and refugees. *Australian Doctor*, 16 July, 31-38

## Slide 8: Culture and substance use issues

### Culture and substance use issues

- Alcohol consumption varies greatly between countries
- Some cultures favour the use of drugs, some little known in Australia eg. kava, khat, betel nut
- In many Asian countries, the traditional use of opioids was by smoking, but injecting them is becoming more common
- Drug use is not condoned in some cultures

### Key points

Different cultures vary in their attitudes to and use of alcohol and other drugs.

- Alcohol consumption varies greatly within and between countries, for example:
  1. In Italy, wine is commonly consumed with meals, but intoxication is not accepted
  2. Alcohol is less widely used in countries of the Middle East and Asia
  3. In many Asian groups, alcohol is viewed as leading to loss of control of behaviour, and this conflicts with the Taoist belief of moderation
  4. Alcohol consumption tends to be higher in Eastern European countries
- Some cultures favour the use of drugs that aren't well known in Australia i.e. kava, khat, betel nut
- in many Asian countries, the traditional use of opioids was by smoking -- this is rapidly changing, with injecting becoming increasingly common among Asian populations
- Drug use is not condoned in Islam, acting as a strong deterrent to use in Muslim communities

### References

DrugInfo Clearinghouse. (2007). Issues paper: culturally and linguistically diverse communities and drug prevention. *Prevention Research Quarterly: Current Evidence Evaluated, June 2007*. Retrieved 22 January 2008, from [http://www.druginfo.adf.org.au/downloads/Prevention\\_Research\\_Quarterly/IP\\_07Jun\\_CLD\\_prev.pdf](http://www.druginfo.adf.org.au/downloads/Prevention_Research_Quarterly/IP_07Jun_CLD_prev.pdf)

Silove, D. (2004). Mental health problems in migrants and refugees. *Australian Doctor*, 16 July, 31-38

Sowey, H. (2005). Are Refugees at Increased Risk of Substance Misuse? Accessed 2 February 2008, from [www.damec.org.au/publications.aspx](http://www.damec.org.au/publications.aspx)

## Slide 9: CALD populations and substance use

### CALD populations and substance use

- Statistics suggest CALD communities have lower rates of alcohol and drug use
- Practitioners tend to dispute this due to:
  - Narrow definitions of who is 'CALD'
  - Under-reporting in some communities
  - Practitioners tending to see a narrower group of this diverse population

This slide outlines a study which explored the discrepancies between actual drug use by CALD communities and practitioner perceptions. Practitioners' perspectives of the extent of drug and/or alcohol use in CALD communities were explored in a 2007 focus group. Having an understanding of practitioners' ideas of the extent of the problem is important, as their opinions possibly influence their opinions about the sector as a whole (DrugInfo Clearinghouse, 2007).

### Key points

- Statistics from systematic data collection indicate that CALD communities have lower rates of alcohol and drug use than the general population (Australian Institute of Health and Welfare, 2003) - see the following two slides for data.
- The majority of practitioners in the focus group were dubious about this finding - some practitioners believed that certain drug use in certain cultures would be equal to, if not higher than, usage rates in the general population.
- Previous prevalence studies may have employed a narrow interpretation of CALD status, only considering first generation immigrants to have of CALD status; therefore, the results of some studies may reflect only a small portion of the drug and/or alcohol use that occurs in CALD communities.
- Some practitioners suggested that CALD communities may under-report their drug and/or alcohol use - reasons for this may include stigma attached to drug use, or reporting problems may go against religion or beliefs in some cultures. Further, some CALD communities believe in sorting out issues within families, rather than through services offered externally. Others feel discriminated against and want to prevent further such experiences.
- A further reason for the observed discrepancy could be attributed to the "clinician's illusion" where practitioners tend to overestimate prevalence because they interact with people experiencing problems at a higher rate due to the nature of their job - this can also work in reverse if practitioners have a preconceived notion of prevalence based on prior research (in some cases, people with genuine problems could be overlooked inadvertently); therefore, it is important not to base prevalence information on experience alone.

Because most studies have been qualitative, much is still unknown about actual prevalence. Available data is provided in the following two slides.

### References

Australian Institute of Health and Welfare. (2003). Statistics on drug use in Australia 2002. AIHW cat. no. PHE 43. Canberra: AIHW.  
 DrugInfo Clearinghouse. (2007). Issues paper: culturally and linguistically diverse communities and drug prevention. *Prevention Research Quarterly: Current Evidence Evaluated, June 2007*. Retrieved 22 January 2008, from [http://www.druginfo.adf.org.au/downloads/Prevention\\_Research\\_Quarterly/IP\\_07Jun\\_CLD\\_prev.pdf](http://www.druginfo.adf.org.au/downloads/Prevention_Research_Quarterly/IP_07Jun_CLD_prev.pdf)  
 Silove, D. (2004). Mental health problems in migrants and refugees. *Australian Doctor*, 16 July, 31-38

## Slide 10: CALD populations and substance use 2

**CALD populations and substance use**

<i>Substances ever used</i>	<i>English speaking</i>	<i>Non-English speaking</i>
Alcohol	92%	68%
Tobacco/cigarettes	51%	32%
Marijuana	35%	12%
Any illicit drug	39%	20%
Any illicit drug other than marijuana	19%	14%

### Key points

This table provides the most recent data available on drug and alcohol use by persons of a non-English speaking background. It describes substances ever used by English speaking and non-English speaking populations in Australia in 2002. Note that the rate of use is consistently lower amongst non-English speaking groups.

### Reference

Australian Institute of Health and Welfare (AIHW). (2003). Statistics on Drug Use in Australia 2002. AIHW cat. no. PHE 43. Canberra; AIHW (Drug Statistics Series no. 12).

## Slide 11: CALD populations and substance use 3

**CALD populations and substance use**

<i>Substances used in last 12 months</i>	<i>English Speaking</i>	<i>Non-English speaking</i>
Alcohol	84%	58%
Tobacco/cigarettes	24%	18%
Marijuana	13%	5%
Any illicit drug	17%	11%
Any illicit drug other than marijuana	8%	7%

### Key points

This table provides the most recent data available on drug and alcohol use by persons of a non-English speaking background. It describes substances used in the last 12 months by English speaking and non-English speaking populations in Australia in 2002. Note that the rate of use is consistently lower amongst non-English speaking groups.

### References

Australian Institute of Health and Welfare (AIHW). (2003). Statistics on Drug Use in Australia 2002. AIHW cat. no. PHE 43. Canberra; AIHW (Drug Statistics Series no. 12).

**Slide 12: Substance use: risk factors**

**Substance use: risk factors**

- Family problems
- Social isolation
- Low socio-economic status; unemployment
- Difficulties at school
- Loss and grief
- Adjustment issues
- Lack of information about drugs
- Assimilation; marginalisation

This slide outlines a number the risk factors amongst CALD communities that contribute to the development of drug and alcohol problems.

**Key points**

- Some specific family problems are discussed later in this presentation; in particular, issues associated with parenting.
- Social isolation and lack of community connection; community support is often a source of problem-solving for individuals.
- Low socio-economic status and difficulty with employment and housing can be co-related. Further, given that certain types of visas do not permit employment in Australia, the CALD individual may have little opportunity to improve their situation.
- Difficulties at school due to language and cultural differences e.g. they may not be used to sitting still or using pens. Also, children with mental health issues such as PTSD may experience difficulties with concentration (note that individuals with temporary protection visas or asylum visas are also not supported with English language tuition and neither are their children, whereas holders of permanent protection visas are).
- Loss and grief issues, such as loss of social status or identity, family members through death or separation, occupational position (particularly for men); 'cultural bereavement' is a term used to describe the sense of loss of culture experience by refugees.
- Adjustment issues including dramatic changes in language, food, culture.
- Lack of information about drugs. One practitioner in the 2007 focus group told a story of a CALD parent whose child (15 y.o.) came home from a party not behaving normally. Both parent and child decided to go to sleep and see how things were going in the morning, but by morning the child had died. Incidents such as this could be prevented if parents and young people from CALD backgrounds had access to better information about the risks associated with substance use.
- A desire to gain acceptance, and assimilation into the Australian culture, in which drinking is acceptable and often encouraged.
- Marginalisation and discrimination, particularly if large numbers of a particular cultural group have settled in one place.

**References**

DrugInfo Clearinghouse. (2007). Issues paper: culturally and linguistically diverse communities and drug prevention. *Prevention Research Quarterly: Current Evidence Evaluated, June 2007*. Retrieved 22 January 2008, from [http://www.druginfoclearinghouse.org.au/downloads/Prevention\\_Research\\_Quarterly/IP\\_07Jun\\_CLD\\_prev.pdf](http://www.druginfoclearinghouse.org.au/downloads/Prevention_Research_Quarterly/IP_07Jun_CLD_prev.pdf)

Silove, D. (2004). Mental health problems in migrants and refugees. *Australian Doctor*, 16 July, 31-38.

Sowey, H. (2005). Are Refugees at Increased Risk of Substance Misuse? Accessed 2 February 2008, from [www.damec.org.au/publications.aspx](http://www.damec.org.au/publications.aspx)

**Slide 13: Substance use: protective factors**

**Substance use: protective factors**

- Family connectedness and satisfaction with parental relationships
- Opportunities for further education
- Being involved in social or recreational activities on a regular basis (especially clubs)
- Being well informed about substance use risks
- Feeling connected to society; employment

This slide provides information on factors known to protect persons from CALD communities from developing drug and alcohol problems. Knowing the protection factors is important, as is understanding how to create a context in which it is easy for such protection factors to be present.

**Key points**

- Family connectedness and satisfaction with parental relationships can be improved with the assistance of counselling, psychotherapy, and/or parenting skills training.
- Opportunities for further education: attending educational facilities also provides opportunities for social connectedness and support.
- Strategies to facilitate CALD individuals joining sporting or recreational clubs may be considered. It is worth taking the time to understand what some of the barriers may be eg. an individual may wish to join the local tennis club but may not have the means to purchase a racquet (note that sporting clubs can often design strategies to facilitate access to such resources).
- Being well informed about risks of substance use: it is important that CALD groups are able to access accurate information about drugs and alcohol, including translated information.
- Feeling isolated from society can lead people to drug and/or alcohol use, and the initiatives that improve peoples' sense of connectedness to society can be effective means of preventing and reducing such use eg. improving access to recreational facilities is thought to be an effective way to achieve such connectedness (these can become places where homework is done, where parents can connect and where jobs are offered), or improving employment opportunities.

**References**

Ashfield, J. (2007) Taking Care of Yourself and Your Family: A resource book for good mental health. Adelaide, SA: Peacock Publications.  
 DrugInfo Clearinghouse. (2007). Issues paper: culturally and linguistically diverse communities and drug prevention. *Prevention Research Quarterly: Current Evidence Evaluated, June 2007*. Retrieved 22 January 2008, from [http://www.druginfo.adf.org.au/downloads/Prevention\\_Research\\_Quarterly/IP\\_07Jun\\_CLD\\_prev.pdf](http://www.druginfo.adf.org.au/downloads/Prevention_Research_Quarterly/IP_07Jun_CLD_prev.pdf)  
 Silove, D. (2004). Mental health problems in migrants and refugees. *Australian Doctor*, 16 July, 31-38.

## Slide 14: Reasons for substance use in CALD populations

### Reasons for substance use in CALD populations

- To relax, to decrease boredom, to become intoxicated
- To enjoy company, to increase confidence, to assimilate
- To manage mental health issues
- To "block-out" painful memories or to buffer grief and loss issues

This slide outlines some reasons for alcohol and drug use in CALD groups. There is overlap with the non-CALD population, such as relaxation and intoxication. However, there are additional issues to be aware of. It is useful to know whether drug and alcohol problems predated the individual's relocation or whether they have emerged since arrival.

### Key points

Reasons CALD people uses substances:

- To relax, to decrease boredom, to become intoxicated.
- To enjoy company, to increase confidence, to assimilate ie. cultural pressure to drink.
- To manage mental health issues eg. self-medication by alcohol in depressed persons. Note that there is an increased risk of psychiatric symptoms displayed by involuntary immigrants compared with that of voluntary immigrants.
- Additional issues, especially for involuntary immigrants, such as drug and alcohol use to 'block-out' painful memories or to buffer grief and loss issues (it can be useful to familiarise yourself with the context from which the person has fled).

### Additional information

- From a drug prevention perspective, it is desirable to prevent stressors related to the immigrant experience from leading to of drug and/or alcohol problems developing.

### References

- Boys, A., Marsden, J., & Strang, J. (2001). Understanding reasons for drug use amongst young people: a functional perspective. *Health Education Research: Theory & Practice*, 16(4), 457-469.
- Procter, N. G., (2005). They first killed his heart (then) he took his own life". Part 1: A review of the context and literature on mental health issues for refugees and asylum seekers. *International Journal of Nursing Practice*. 11: 286-291.
- Silove, D. (2004). Mental health problems in migrants and refugees. *Australian Doctor*, 16 July, 31-38.

## Slide 15: Substance use and mental health co-morbidity hypotheses

### Substance use and mental health co-morbidity hypotheses

The current literature outlines four hypotheses:

1. Drug use as a way of coping with mental health problems
2. Drugs potentially lead to mental health problems
3. Combination of genetic and environmental factors
4. Berkson's paradox: high rates of co-morbidity are reflective of the treatment setting being studied

This slide introduces theories on co-morbidity between mental health and drug and alcohol issues. There is no consensus in the literature about the reasons for the frequent co-morbidity of substance use and mental health problems. However, there are a number of theories as to why co-morbidity may occur. This slide details four hypotheses for the co-occurrence of substance use and mental health issues. It is possible that a combination is responsible.

### Key points

Four possible explanations for co-morbidity of mental health issues and substance use:

- A way of coping: mental health problems lead to drug use or abuse.
- Drugs as 'causal' - influential/exacerbating: substance use and or abuse directly or indirectly leads to mental health problems (Meyer, 1986).
- Context is key: a combination of genetic and environmental factors (socio-economic disadvantage, emotional deprivation, social disorganisation, childhood abuse, genetic loading and childhood trauma) interplay to increase the likelihood of co-morbidity.
- Berkson's paradox: high rates of co-morbidity are reflective of the treatment setting being studied i.e. hospital and treatment service settings have a greater than average proportion of attendees who experience co-morbid mental health and substance use problems.

### References

Meyer, R.E. (1986). How to understand the relationship between psychopathology and addictive disorders: another example of the chicken and the egg. In R.E. Meyer (Ed.), *Psychopathology and addictive disorders* (pp.3-16). New York: Guilford.

## Slide 16: CALD and mental health: general issues

**CALD and mental health: general issues**

- Western Society is individualistic, while many other cultures are collectivistic
- There may be distinct roles for men and women, and conflicts related to changes in roles in a new society
- Attitude to authority varies between cultural groups
- Religion may have a large role in everyday life
- How the person conceptualises mental health problems may be different to Western ideas
- There is prejudice and racism in the community

This slide outlines general issues related to CALD populations which may impact on the experience of mental health issues and management.

### Key points

- Western society tends to be individualistic, whereas many other cultures operate as a collective society.
- There may be distinct roles for men and women e.g. the woman as homemaker and the man as breadwinner; moving into a different society can cause conflicts related to changes in roles.
- Attitude to authority varies between different cultural groups e.g. doctors may be expected to take control, elders may be highly respected, immigrants from countries with military regimes may fear police.
- Religion may have a large role in a person's everyday life .
- How the person conceptualises mental health problems may be different to Western ideas; it is important to understand a person's 'explanatory model' or conceptualisation of mental health problems e.g. the continuum of mental health issues may not be appreciated, instead emotional problems are seen as either mild or 'mad'.
- Individuals may experience significant prejudice and racism, which may have a significant impact on individuals or groups (such as trauma, isolation).

### References

- Adib, S. M. (2004). From the biomedical model to the Islamic alternative: a brief overview of medical practices in the contemporary Arab world. *Social Science & Medicine*, 58(4), 697-702.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (DSM-IV) 4th ed.* Washington, DC: APA.
- Armato, P. R. (1985). An exploratory study of people's reasons for delaying or avoiding helpseeking. *Australian Psychologist*, 20(1), 21-31.
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## Slide 17: CALD and mental health: voluntary immigrants

### **CALD and mental health: voluntary immigrants**

- Australian immigration policies contribute to lower rates of overt mental health problems in voluntary migrant groups
- The mental health problems of recent immigrants reflect the patterns in country of origin
- Later patterns reflect those present in their new country

### **Key points**

- In Australia, the immigration policy favours successful, highly skilled immigrants and reduces the chances of those with overt mental illnesses from entering the country. Recent data show that immigrants from English-speaking countries are at lower risk of common mental health problems such as anxiety and depression.
- In the early phase of migration, the pattern of mental illness among immigrant groups is similar to that of their country of origin; the profile slowly changes to that of the host country over time.
- It is important to be aware of broad patterns eg. there tends to be higher rates of alcohol use and suicidal ideation and behaviour among immigrants from Eastern European countries, and lower rates for these problems among people from Middle Eastern-backgrounds.

### **Additional information**

- Immigrants are in a dynamic state of transition, in which certain aspects of their cultural beliefs are retained while they adapt to their new environment. It is useful to be sensitive to such issues eg. it is not uncommon to hear someone from a Chinese or Vietnamese background talk about afflictions to kidneys, liver or other organs in relation to emotional disturbances. Taken out of cultural context, the practitioner could make an inappropriate assessment of the person's mental health status.
- There are many stresses associated with relocating, including those that are practical, social, financial and cultural. For many, coming to grips with such challenges can be empowering, yet for others it can present difficulties in adjustment. It is important to remember that even for immigrants who have lived in Australia for a long time, an arising mental health issue may still have issues related to the person's migration. For example, a job-loss could cause someone to doubt their reasons for choosing to migrate in the first place and they may experience serious regret.
- People on student visas would be expected to experience mental health issues similarly to their home country counterparts.

## Slide 18: CALD and mental health: involuntary immigrants

### CALD and mental health: involuntary immigrants

- Time of arrival and country of origin can give important clues to practitioners
- Refugees are at greater risk of common mental disorders such as depression and PTSD
- Clients may or may not reveal episodes of torture
- Involuntary child migrants are at increased risk of mental health problems

This slide outlines some of the key issues for involuntary immigrants.

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### Key points

- The time of arrival and country of origin can give important clues to practitioners as to the background and experience of immigrants.
  - One of the robust findings in trans-cultural psychiatry is the close association between trauma exposure and risk of psychiatric disturbance in refugees. Hence, involuntary immigrants are at greater risk of common mental disorders such as depression and post-traumatic stress disorder (PTSD).
  - Clients may or may not reveal episodes of torture to their health practitioner.
  - Children are particularly at risk of mental health problems: even years after resettlement, they have higher rates of mental health problems.
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## Slide 19: Stressors faced by asylum seekers/people on temporary visas

**Stressors faced by asylum seekers/people on temporary visas**

- Residency determination
- Health, welfare and asylum problems
- Separation from family; worry about family
- Communication and adaptation difficulties
- Loss of culture and support
- Limited access to supports
- Uncertainty about future

*These stressors can predispose an individual to turn to drugs or alcohol, or to develop anxiety and depression*

This slide expands on some of the specific stressors facing asylum seekers or individuals on temporary visas.

### Key points

- Residency determination.
- Health, welfare and asylum problems.
- Separation from family; worries about family still at home; threat to family and friends.
- Communication and adaptation difficulties.
- Loss of culture and support.
- Limited welfare support; limited access to medical, dental or psychological care.
- Uncertainty of future, including fears related to being sent home.

The existence of such stressors can predispose a person to turn to drugs or alcohol as a coping strategy, and predispose the person to anxiety or depression.

### Additional information

The following can be related stressors:

- Interviews by immigration.
- Conflict with immigration officials.
- Delays in processing applications.
- Detention experiences.
- Insecurity of not having a permanent visa.
- Discrimination.
- Difficulties in obtaining a work permit.
- Unemployment.
- Poverty.
- Loneliness and boredom.
- Isolation.
- Poor access to traditional foods.

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## Slide 20: CALD populations and mental health: depression and anxiety

**CALD populations and mental health: depression and anxiety**

- Depression and anxiety are common mental health problems in the CALD communities
- It is important to understand a person's 'explanatory model' of mental health problems
- CALD individuals may describe mental health issues in somatic terms e.g. having something wrong with the heart or head
- 'Mood' may not be a term that is understood
- Some may self-medicate with alcohol or analgesics

Depression and anxiety are common mental health problems worldwide. This slide outlines issues related to anxiety and depression in CALD communities

### Key points

- Depression and anxiety occur commonly in CALD communities because of the stressors involved; involuntary immigrants are at greater risk of common mental disorders such as depression and post-traumatic stress disorder (PTSD).
- It is important to understand a person's 'explanatory model'/conceptualisation of mental health problems e.g. depression may be labelled as 'thinking too much, while psychosis may be understood as being caused by a 'jin' (spirit).
- CALD individuals may describe mental health issues in somatic terms e.g. having something wrong with the heart or head e.g. having a worm in the head or the heart, or the brain is not working, or 'I am dizzy'.
- Mood may not be a term that is understood.
- Self-medication with alcohol or analgesics occurs, particularly as there is often shame and stigma associated with experiencing mental health issues.
- Smoking is acceptable in many CALD communities and rates may increase significantly in relation to having depression or anxiety.

### Additional information

- Men's responses to grief:
  - Not as self-caring or help-seeking
  - Men tend to need more time and have to make a more conscious effort to connect with grief emotions
  - Men often need privacy, or a 'safe' ritual place (like a cemetery) before facing and experiencing emotional pain
  - Men tend to exhibit more anger than women (can pose a problem as people tend to be unsympathetic to men whose dominant emotional expression is anger)
  - Men usually achieve through activities, action, small rituals, and 'mulling things over'
  - Men benefit from the company of other men – not necessarily by any verbal exchange but just by another man being 'present' who cares but doesn't intrude (Ashfield, 2007)

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## Slide 21: CALD populations and mental health: PTSD

**CALD populations and mental health: PTSD**

- Assessment for PTSD should be routine
- Symptoms can be exacerbated by temporary visa status
- Many additional issues can impact on symptoms e.g. racism, delays in processing refugee applications
- There is a link between PTSD and alcohol and drug problems
- Children are particularly at risk for PTSD

This slide addresses the issue of PTSD in CALD groups. PTSD is common amongst involuntary immigrants, and research indicates a link between PTSD and alcohol and drug dependence.

### Key points

- Assessment for PTSD should be routine in refugee populations – assessment includes the history of traumatic events, questions re-experiencing the event such as flashbacks, nightmares (inquire into whether the content of dreams reflect real or imagined experiences), anniversary reactions, persistent anxiety.
- Symptoms can be exacerbated by temporary visa status i.e. insecurity about the future and continuing to feel unsafe; also, those on temporary protection visas are not allowed to leave Australia and their families are not permitted to join them, this can result in anxieties about what is happening to those left behind.
- Many additional issues can impact on symptoms e.g. racism, unemployment, delays in processing refugee applications, trauma experiences in the home country, not having a work permit, loneliness, boredom, conflict with immigration officials.
- Research indicates a link between PTSD, alcohol and drug dependence. There is also a higher rate of relapse into substance abuse compared with people without PTSD. There can be a vicious cycle with alcohol increasing the anxiety symptoms and worsening PTSD.

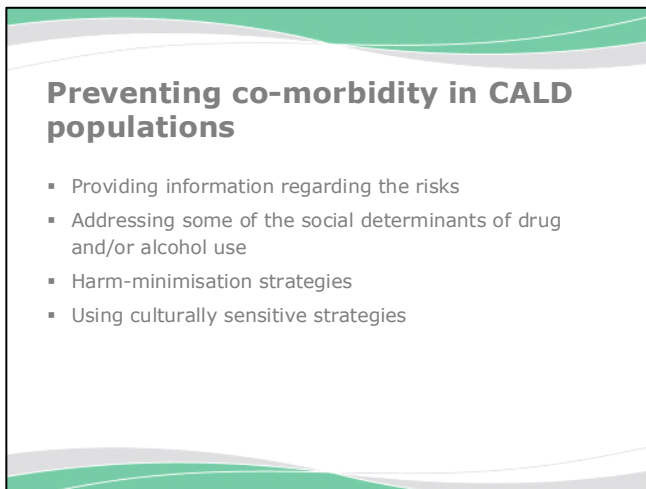
### Additional information

- The most debilitating stressor is the fear of being involuntarily repatriated at some time in the future.
- Depending on the type of visa they are granted, there can be considerable barriers to the person moving forward in their 'new' life. For example, people on a temporary protection visa or asylum visa are ineligible for certain medical, educational or employment opportunities.
- Practitioners can expect clients to experience relatively constant levels of anxiety, punctuated by acute crises as applications are processed with varying outcomes.
- Any treatment can be undermined by the ongoing stressors that the person is experiencing.
- Children are particularly at risk of mental health problems; even years after resettlement, they have higher rates of mental health problems such as PTSD.

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## Slide 22: Preventing co-morbidity in CALD populations



**Preventing co-morbidity in CALD populations**

- Providing information regarding the risks
- Addressing some of the social determinants of drug and/or alcohol use
- Harm-minimisation strategies
- Using culturally sensitive strategies

This slide outlines general strategies for preventing drug and alcohol and mental health co-morbidities in CALD populations.

### Key points

- Providing information about the risks that can be associated with drug and/or alcohol use: it is important that younger and older individuals, and particularly parents of adolescents, are educated specifically about drug and alcohol issues (education about both legal and illicit drugs is equally important).
- Addressing some of the social determinants of drug and/or alcohol use: two significant risk factors are the lack of connectedness to the community and strained family relationships. Therefore, initiatives to improve people's sense of connectedness can be effective eg. improved access to recreational facilities where friendships are formed and homework is done. Supporting people to find employment is also vital.
- Harm minimisation strategies are advised, although information may need to be provided as to its use, as some cultures may believe this is condoning behaviours.
- It is important to consult with specific cultures, and to have ethno-specific workers where possible.
- These strategies will also assist in preventing mental health problems.

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## Slide 23: Preventing mental health issues in CALD populations

### Preventing mental health issues in CALD populations

- Improve the health literacy of the community
- Being informed about cultural needs
- Prevention of stressors in immigration process
- Working with the group to design appropriate therapy
- Viewing the situation holistically to uncover reasons for mental health issues
- Focussing on improving the overall family dynamic
- Employing ethno-specific workers

### Key points

- Improve the health literacy of the community.
- Being informed of the needs and social norms of various cultures.
- Prevention of stressors in immigration process e.g. reduce conflict with officials, or delays in processing applications; improve access to welfare and care.
- Working with the CALD community/group to design appropriate forms of therapy e.g. utilising a Narrative Therapy approach if most appropriate.
- Viewing situation holistically (bio-psycho-social-spiritual) to uncover reasons for mental health issues eg. traumatic experiences, or drugs and alcohol.
- Focusing on improving the family dynamic as whole e.g. practical assistance with employment, housing, education; family therapy.
- Employing ethno-specific workers.

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## Slide 24: Issues faced by CALD parents

**Issues faced by CALD parents**

- Some parents get very overwhelmed about what is happening in their families
- Many parents' anxiety levels are very high because of their children's behaviour
- These issues can cause significant intergenerational conflict
- Further, some adolescents may turn to drugs and/or alcohol as a means of dealing with this stress in the home

This slide specifically addresses issues for CALD parents related to managing their children/adolescents in Australia.

Adjusting to life in Australia can be difficult for some CALD families. Some CALD parents struggle when their children behave in a manner that would have been inappropriate in their own home country, but which is acceptable and normal in Australia. Parents can find it difficult if their children expect greater freedom than they would have been allowed in their home country, and if they feel they have lost some authority over them. They can be over protective and anxious about their children's safety, and moreover place unrealistic expectations on their children to succeed at school. Furthermore, in a single parent family the mother may be the head of a large household. In some CALD families, this causes difficulties for adolescent sons. Issues such as these can cause significant stress in CALD families.

### Key points

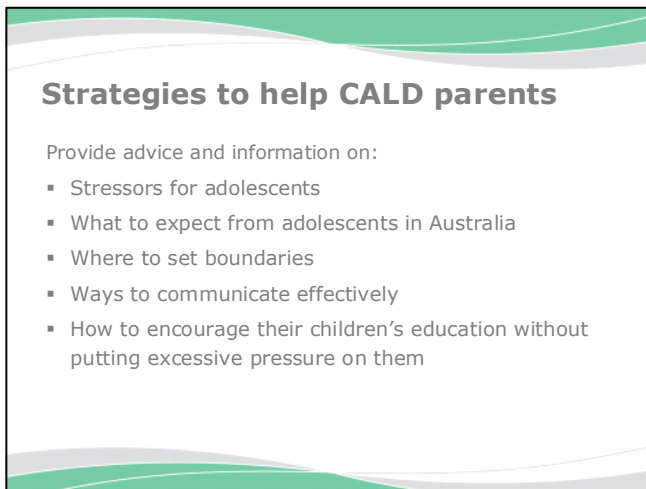
- Some parents get very overwhelmed about what is going on in their families.
- Many parents' high anxiety levels are related to their child/children's behaviour. If the CALD parent's children are spending a lot of time outside the home, especially in social situations or going into the city, parents may feel that they are losing control. Also, difficulties can arise if children start to become more outspoken at home. The pressures mount and many are at a loss to know how to handle the situation.
- These issues can cause significant intergenerational conflict.
- Further, some adolescents may turn to drug and/or alcohol use as a means of dealing with the stress they are experiencing within in the home.

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## Slide 25: Strategies to help CALD parents



**Strategies to help CALD parents**

Provide advice and information on:

- Stressors for adolescents
- What to expect from adolescents in Australia
- Where to set boundaries
- Ways to communicate effectively
- How to encourage their children's education without putting excessive pressure on them

This slide specifically addresses strategies to assist CALD parents.

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### Key points

Provide advice and information to parents on:

- Stressors for adolescents - specific to the Australian context, e.g. peer pressure, body image, binge-drinking.
- What to expect from adolescents in Australia – acceptable vs. unacceptable behaviour, social norms, legal issues.
- Where to set boundaries.
- Ways to communicate effectively with children and adolescents – allowing time, asking practical questions about school, friends and interests, asking about worries or concerns.
- How to support and encourage children's education – strategies for dealing with homework and extracurricular activities, and avoiding putting excessive pressure on the young person to perform academically.

Parenting skills training programs can be particularly valuable for such families.

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Ater, R., (1998) Mental health issues of resettled refugees. Ethnomed. Retrived on 22 January 2008 from. [http://www.ethnomed.org/ethnomed/clin\\_topics/mental\\_health.html](http://www.ethnomed.org/ethnomed/clin_topics/mental_health.html).

Minas, I. H., Sawyer, S. M., (2002). The mental health of immigrant and refugee children and adolescents. *The Medical Journal of Australia*. 177 (8) 404-405.

## Slide 26: Mental health and suicide (risk)

### Mental health and suicide (risk)

- Risk factors include mental health issues (e.g. PTSD), drug and alcohol use
- Assess the risk:
  - Current plan
  - Past history/previous attempts
  - Use of drugs or alcohol
  - Means to carry out the plan
  - Social and/or other protective factors
- Ensure the person is safe, or arrange care if you cannot ensure safety

This slide outlines some of the factors contributing to suicide risk in CALD individuals with co-morbid drug/alcohol and mental health issues, and strategies to ensure safety.

### Key points

- Risk factors include mental health issues (e.g. PTSD), drug and alcohol use, social isolation, unemployment, relationship loss or breakdown, loss and grief issues, depression, previous suicide attempts, high levels of stress e.g. financial.
- Assess the risk - including current plan, past history of mental health disorders, previous attempts, access to means to carry out the plan, use of drugs and alcohol, protective resources e.g. social support; also be aware of the risk of impulsive suicidal behaviour
- Ensure they are safe (call the crisis line, or organise for review at a hospital if you cannot ensure the person's safety)

### Additional information

Alcohol and drug use and suicidal behaviour (SQUARE):

- The hazardous use of alcohol/other drugs may lead people to see suicide as a viable option. It may do this by:
  - destabilising a person's sense of hope or social value
  - promoting depression, leading to impulsive behaviour
  - exacerbating other problems, such as mental illness or domestic violence issues
  - interacting with each other, thus causing non-intentional but potentially lethal overdoses.
- The use of illicit drugs such as cannabis and amphetamines has been shown to be associated with mental illness, suicidal ideation and suicide, especially among young people.

It is therefore essential that primary care professionals include assessments for drug and alcohol use in their suicide risk assessment.

### References

Commonwealth of Australia. (2006). SQUARE: Suicide Questions Answers Resources Desk Top Guide. Commonwealth Department of Health and Aged Care. (2007). *LIFE Living is For Everyone: a framework for prevention of suicide and self-harm in Australia*. Canberra, Australia: Commonwealth of Australia.  
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## Slide 27: Assessment and treatment approaches

**Assessment and treatment approaches**

- Cultural sensitivity - what is the person's background and explanatory model for mental health?
- Seek advice from health care providers who have specific cultural knowledge
- Be aware of the role of loss and trauma
- Be sensitive to the desire to use traditional healing
- Counselling may be foreign
- Check literacy skills
- Assess the need for an interpreter
- Be aware of services and resources

This slide outlines assessment and treatment approaches with CALD communities. Overall, the approach to CALD people should be very much the same as for other population groups. Establishing a trusting relationship is vital.

One of the main issues for practitioners to address is their own hesitancy in stepping in to assist, for fear of now knowing enough about individual cultures. In reality, however, most clients will forgive mistakes if they know the practitioner is trying his or her best to understand and help.

### Key points

- Cultural sensitivity - practitioners need to be aware of their own ethnocentricity (seeing the world from their own viewpoint); inquire into the country of origin, reasons for migrating, and visa status; be aware of the person's cultural background, religion and belief system – what is the explanatory model for mental health? Is there shame or stigma attached to the diagnosis of a mental health problem?
- Seek advice from people who have specific cultural knowledge.
- Be aware of the role of loss and trauma.
- Be sensitive to a person's desire to utilise traditional healing methods - the practitioner and client may agree to use both the traditional and western approaches simultaneously.
- Remember that the concept of counselling may be foreign; psychological assessment tools will need careful explanation.
- Check literacy skills, even if the material is in the individual's own language.
- Assess need for an interpreter.
- Be aware of services, supports and resources – see the resource list provided.

### Additional information

Be prepared to go slowly to build a trusting relationship. Helpful questions include:

- What is the main problem you would like me to help you with today?
- How is this problem affecting you?
- Why do you think it started when it did?
- What do you most fear about this problem?
- What solutions have you tried or have you thought of?
- What were you hoping that I would do for you today?
- How might your family and community be able help you with your problem?
- How will we know when you are well again?
- When would you like to come back?

Note that traditional healers may have told the CALD individual what to do, and they may expect the same of Western practitioners.

In regard to medications:

- Take the time to explain that medications do not necessarily work immediately.
- Explain side effects simply by referring to the "likelihood" that something may occur rather than using percentages. Often people are concerned about whether side-effects are permanent or irreversible, and it is important to take the time to explain.

Treatment may be best managed with a team care approach. Team-based care provides a comprehensive multidisciplinary approach. Potential team members may be based at Migrant Health or Resource Services or in other community agencies and include:

- Family members and carers may be involved in development and implementation of care plans.
- GPs, psychiatrists, clinical psychologists/psychologists.
- Social workers, mental health nurses, occupational therapists.
- Drug & alcohol specialists/counsellors.
- Youth Workers, school counsellors, teachers.

Assistance may be available via the following programs

- Access to Allied Psychological Services through Divisions of General Practice.
- Medicare Better Access to Mental Health Care (clinical psychologists, psychologists, social workers, occupational therapists).
- Federal (Medicare) and State funded Mental Health Nursing Programs

It is important that the physical health of the individual be taken into account, and a health check be undertaken for problems such as Hepatitis B and Schistosomiasis. There is a Medicare Benefits Scheme Item Number for a Health Check for refugees, to encourage GPs to provide comprehensive health assessments to refugees and other humanitarian entrants within six months of their arrival in Australia, aiming to help identify refugees' physical and mental health needs and initiate preventative action and treatment.

Other services/agencies that may become involved in care:

- Services for Survivors of Trauma and Torture.
- Centrelink.
- Interpreter services.
- Housing services.
- Public and private mental health services.
- Domestic violence services and shelters.
- Community based psychiatry services.
- Drug and alcohol services.
- Family and community agencies.
- The justice system.

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## Slide 28: CALD populations: key issues for services

### CALD populations: key issues for services

- Less access to services
- Cultural issues e.g. stigma or shame
- Financial or language barriers
- Language barriers
- Lack of knowledge of the availability of services
- Fewer professionals located in the areas in large cities where newly arrived migrants tend to settle

This slide covers other issues related to treatment, including difficulties accessing services and reasons for this.

### Key points

- Relative to their Australian-born counterparts, migrants have less access to psychological and counselling services.
- Seeking assistance may go against cultural or religious beliefs and in many cultures there may be a strong stigma or shame attached to mental health issues or drug dependency. In some CALD populations it is common for families to prefer to care for loved ones with mental health issues within the family unit, believing that mental health services are for the "mad" (such issues can cause a delay for the CALD individual receiving appropriate professional care); the harm minimization approach often used in substance use may not be acceptable due to the stigma of alcohol or drug use.
- Financial barriers, sometimes caused by visa limitations on employment can cause difficulties.
- Language can be an issue and care needs to be taken with the use of interpreters.
- There may be lack of knowledge of the availability of services or fear of discrimination.
- There are often fewer professionals located in lower socio-economic areas in large cities where newly arrived migrants tend to settle.

### Additional Information

Interpreter issues:

- Use of professional interpreters is encouraged.
- Be concise in your questions and language, and check out the understanding of the client regularly as well as summarising information regularly.
- There may be privacy issues: finding interpreters who are unknown to the CALD individual may be difficult in small CALD communities.
- Take care about using relatives as interpreters; sometimes people are not comfortable in discussing mental health or drug and/or alcohol related issues in front of loved ones.
- Also, using young relatives to interpret can put undue pressure and excessive responsibility on these young people, and expose them to issues beyond years.
- Interpreters may be hearing and interpreting traumatic information which can impact on them.

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## Slide 29: Barriers to accessing services

**Barriers to accessing services**

- Seeking assistance may go against cultural or religious beliefs
- Strong stigma or shame attached to mental health or drug use issues
- Fears of discrimination
- Poor past experiences with health professionals
- Lack of access to services under Medicare, or confusion as to how to use medical services and/or lack of awareness of services available
- Inability to meet medical expenses
- Mistrust of drug and/or alcohol services

This slide highlights some of the barriers to care experienced by CALD individuals.

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### Key points

- Seeking assistance may go against cultural or religious beliefs.
  - In some cultures there may be a strong stigma or shame attached to mental health or drug use issues.
  - There may be fears of discrimination.
  - There may have been poor experiences with health professionals in the past.
  - The involuntary immigrant may not have access to services under Medicare, or be confused as to how to use medical services and/or lack of awareness of the services that are available.
  - There may be inability to meet medical expenses.
  - There may be mistrust of drug and/or alcohol services.
- 

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## Slide 30: Story vignettes and case discussion – part A

### Story vignette A - Jafar

1. What are the important issues for Jafar?
2. How would you prioritise the risks to Jafar?
3. If Jafar was telling you this story, how would you engage with him?
4. What interventions may be useful?
5. What particular challenges might there be in managing Jafar?
6. What support could local health services offer?
7. How could Jafar be effectively managed using the services and resources in your local area?

*"I am so grateful to be in Australia and to be able to work. Before we arrived here from Sudan we had to stay in a refugee camp for two years. That was very hard, as we were still dealing with the killings and the disappearance of my father. As the oldest son it was my responsibility to take care of my mother, brother and four sisters.*

*It was hard not being able to speak English, and people did not understand what we were running away from. I had many nightmares in the early days and my mind would go back to the horrors. I couldn't sleep for a long time. It was better when we left the refugee camp because I found a few drinks at night helped me get to sleep. Now the problem is waking up in the morning. There have been some mornings when I have not woken up for work – it has caused problems because three other families rely on me to take them to the job.*

*We have worked picking fruit and pruning for growers. I have been very reliable getting other Sudanese people to the properties to work, but lately I am finding it harder and harder with the early morning starts as I am so tired all the time. The growers are grateful for our help as the work is hard and tedious. We have many smoking breaks to stop the monotony. My family try to stop me from smoking so much because they worry for my health. I just don't like how much the cigarettes are costing each week."*

### Points for discussion

1. What are the important issues for Jafar?
2. How would you prioritise the risks to Jafar?
3. If Jafar was telling you this story, how would you engage with him?
4. What interventions maybe useful?
5. What particular challenges might there be in managing Jafar?
6. What support could local health services offer?
7. How could Jafar be effectively managed using the services and resources in your local area?

### Story vignette - feedback session:

- The points for discussion are to trigger group discussion.
- Use the whiteboard to write up main ideas.
- The facilitator's notes below are to direct discussion and prompt further exploration of important issues.
- Ensure only one participant speaks at a time and is heard by the entire group. Be aware of who is speaking and who is not.
- Invite participation from everyone.

- Reflect, and if necessary, rephrase the participant's comment to link its relevance to the topic.

### Facilitator's notes

- How much do participants know about Sudan and the life this young man has left behind?
- Encourage participants to discuss Jafar's story. What other information would you want to obtain from him and how would you obtain this?
- Discuss the main health issues for Jafar. What other tests or assessments might it be useful to pursue? Make sure participants also look at Jafar's physical health – there may be other underlying health risks because of his background.
- Jafar will have had health checks on arrival in Australia – can other health practitioners access these records with Jafar's permission? How would participants find out? In discussion of mental health and substance use issues in this story, consider Post Traumatic Stress Disorder and its implications for Jafar.
- How would participants engage with Jafar and start setting some short term goals to assist his health.
- Ask participants to consider whether Jafar's family should be involved. If so, ask participants how they would access translation services, arrange transport, childcare if required.
- What is the range of services that are available to Jafar and that would assist his health problems?
- If Jafar is still on a temporary visa, how can participants check his health status and his entitlements under Medicare.
- Are the local services suitable for Jafar and does he understand the health system. Consider whether he needs a support person to accompany him on health service visits.
- What particular role can a GP play in assisting Jafar with his health? How would Jafar access a GP?

### Additional information

You may wish to ask participants to consider how they would obtain information about Sudanese refugees and resettlement. A website that provides community profiles for Sudanese refugees is the DIAC website which also contains community profiles at: <http://www.immi.gov.au/living-in-australia/delivering-assistance/government-programs/settlement-planning/community-profiles.htm>

To find out more about family structure in Southern Sudan read [Southern Sudanese Family Structure](#), a paper published in November 2004 by the Migrant Information Centre in Eastern Melbourne.

## Slide 31: Story vignettes and case discussion – part B

### Story vignette B - Poni

1. What are the important issues for Poni?
2. What issues would be of most concern to health professionals?
3. If Poni was telling you this story, how would you engage with her?
4. What interventions maybe useful at this stage?
5. What particular challenges might there in managing Poni?
6. What support could local health services offer?
7. How could Poni be effectively managed using the services and resources in your local area?

### Poni is Jafar's mother.

*"Poni means 'second born girl' in my language. It is all so different here, the food, the language, the cars, everything. For years we lived in the camps, the men were fighting and killed. But the women had each other.*

*I have five children – except for the two boys they have never known their fathers. The children seem to find it easier to settle than me. They pick up English better, make friends, play games. Jafar is working and bringing in some money which helps. But I can't settle. I feel afraid and alone.... The Church has found us a house now, but the people in the street have not welcomed us. They just look away and whisper.*

*The children need to go to school to learn and have a better life, but I don't know how to get them there. One of the children has a problem with her heart and I need help for her too. But it is all very hard and I don't have the energy.*

*Now I have bad headaches, and I feel dizzy all the time. There is something wrong with my head. The doctor gave me strong painkillers for the pain - they help me feel less afraid. Now I buy alcohol and that makes me feel better too."*

### Points for discussion

1. What issues are challenging Poni in Australia?
2. What issues would be of most concern to health professionals?
3. If Poni was telling you this story, how would you engage with her?
4. What interventions maybe useful at this stage?
5. What particular challenges might there be in managing Poni?
6. What support could local health services offer?
7. How could Poni be effectively managed using the services and resources in your local area?

### Story vignette - feedback session:

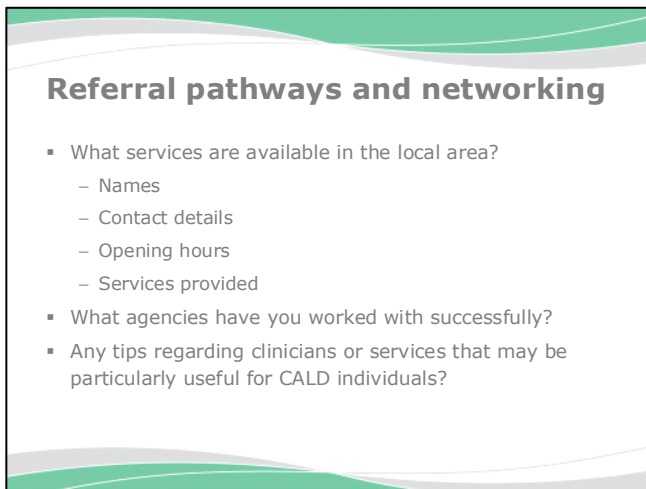
- The points for discussion are to trigger group discussion
- Use the whiteboard to write up main ideas
- The facilitator's notes below are to direct discussion and prompt further exploration of important issues.
- Ensure only one participant speaks at a time and is heard by the entire group. Be aware of who is speaking and who is not.

- Invite participation from everyone
- Reflect, and if necessary, rephrase the participant's comment to link its relevance to the topic

### **Facilitator's notes**

- Encourage participants to discuss Poni's situation.
  - Consider the burden of care Poni carries in looking after her five children.
  - Make sure participants recognise her limited English and her fear of this new environment. Encourage them to think of ways that will make Poni feel welcome and comfortable when talking with health professionals.
  - Identify ways that participants could become familiar with issues facing Sudanese refugees.
  - Given her background and her references to the killings back at home, consider whether she is comfortable speaking with or being treated by male health professionals.
  - Are there similarities with the story Jafar told?
  - Are there health or other issues it would be good to explore with them both together?
  - Make sure participants identify the key health issues for Poni and suggest strategies to resolve or alleviate these. Note her lack of energy, dizziness and headaches. Make sure participants discuss physical health and nutrition as well as mental health and substance use.
  - Ask the question – is it health care or social support that will make the greatest difference here?
  - How can Poni be put in touch with the right services? - Both for herself and for her sick daughter.
  - Does she have a case worker allocated to the family who could be included in care planning?
  - Ask participants to identify the refugee associations that work in the local area.
-

## Slide 32: Referral pathways and networking



**Referral pathways and networking**

- What services are available in the local area?
  - Names
  - Contact details
  - Opening hours
  - Services provided
- What agencies have you worked with successfully?
- Any tips regarding clinicians or services that may be particularly useful for CALD individuals?

### **Service mapping exercise:**

Participants are provided with a service mapping template which they should complete and bring with them to the training session. If they have not, ask them to spend a few minutes completing the template.

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### **Key points**

- Participants share information about their services based on the areas outlined in the slide.
  - Map key services on the white board or ask the coordinator to scribe information.
  - Be as precise as possible and include contact phone numbers and key information.
  - Where possible, include other agencies and services such as non Government Organisations and community or Council programs.
  - Ask participants for consent to circulate the information provided to all participants.
  - Following the workshop, ensure the coordinator circulates a copy of this information to all participants.
- 

### **Additional information**

- Revisit the two stories discussed and 'map' the services identified so that participants are aware of the service location, referral procedures, opening hours, contact numbers, and other relevant information.
  - Appoint someone to note the details of local service providers on the whiteboard. If possible, ensure all attendees receive a copy.
-

## Slide 33: In summary

**In summary**

- Meeting the needs of the patient and their families and carers
- Including families and carers
- Utilising other services
- Creating partnerships
- Identifying roles and responsibilities
- Maintaining defined boundaries
- Encouraging professional collaboration
- Establishing workable procedures for realistic and sensible referral

**What will you do differently now?**  
*(Please take a minute to complete your evaluations)*

An opportunity is now provided for the audience to address any questions to the facilitators and conclude the discussion of this topic.

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### Key points

- This unit aimed to:
    - increase participant awareness of the mental health and substance use issues relevant to CALD people
    - increase participant understanding of why CALD people may use substances
    - identify the physical, psychological and social risks to mother and child associated with substance use (both during and after pregnancy)
    - improve participant knowledge of strategies to address these risks, and resources available to assist.
  - Ask each participant to say one or two words on what they thought about the unit
  - Ask the question: What will you do differently? (as a result of knowledge and information received at the training sessions).
  - Ask participants to complete the post test evaluation.
  - Hand out information packs.
-