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# *migration letters*

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# MIGRATION LETTERS

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# Mental Health Workforce Collaboration and Partnership: Towards a response to World Health Assembly Resolution WHA 57.19

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## Abstract

Using Australia as the main example, the aim of this paper is to consider selective aspects of the forthcoming World Health Report 2006 as it sets an agenda to create a responsive and dynamic health workforce. At the core of a culturally competent mental health workforce will be clinicians prepared to question and respond to particular health experiences and what they, managers and policy makers of all persuasions see as different perceived causes of concern, optimal care and culturally appropriate support and treatment. The enlargement of focus contained in this paper is intended to stimulate more informed and compassionate awareness and respect for alternative points of view held between health and human service workers and communities from culturally and linguistically diverse backgrounds.

**Keywords:** culture, cultural competence; mental health, refugee.

## World Health Assembly resolution WHA57.19

The World Health Assembly through resolution WHA57.19 has directed the World Health Organisation (WHO) Director-General to declare the 'health workforce' to be the theme of the World Health Report 2006 (WHO 2005). The Report will offer scientific and policy support for health promotion for the "Day and the Decade". The Day will energize relevant constituencies to celebrate health workers around the world. The follow-up activities of the Decade will focus on implementing and evaluating policies and strate-

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gies for workforce development. Both the Day and the Decade will emphasise collaboration, partnership and global responsibility for health workforce issues. The core messages of the World Health Report 2006 include:

1. Health workers are crucially important for producing good health through the performance of health systems; they constitute a significant share of the labour force and perform key social roles in all societies;

2. Health for all is not achievable without an appropriately prepared, deployed and supported health workforce;

3. Good health depends also on good governance and stewardship of the health labour market, and country leadership is the key to sustainable health workforce development.

The timing of the WHO initiative has significant implications for refugees and asylum seekers. Article 1 of the 1951 UN Refugee convention defines a refugee as: “a person who is outside his/her country of nationality or habitual residence; has a well-founded fear of persecution because of his/her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail himself/herself of the protection of that country, or to return there, for fear of persecution” (UNHCR 2003). The Convention distinguishes refugees from migrants who leave their countries voluntarily. Though these two groups share commonalities, such as changes in identity caused by moving to a foreign culture with attendant losses, refugees have usually endured trauma and stress secondary to war, persecution, and forced exile.

### **Refugees and Mental Health**

In January 2003, 20.6 million people were registered globally with the United Nations High Commission for Refugees (UNHCR 2003) as ‘Persons of Concern’, approximately one in every 300 people on the planet.

The global response to the refugee crisis has been relocation schemes in cities and rural and regional settings in developed countries (ABC News 10/08/05). The acceptance of

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newly arrived refugees by regional communities is an extremely important component of any settlement program. Social connectedness, like housing, infrastructure and employment must be seen as practical elements of a mental health promotion and suicide prevention strategy for newly arrived refugee people and families.

Social connectedness is, in this sense, an external 'protective factor' (Seifer et al 1992) promoting resilience, sense of belonging and purposeful being with others. With children and young people (for example) there is increasing evidence that connections with family, school or a significant adult can reduce the risk of suicide. Feelings of connectedness to a partner or a parent or responsibility for care of children appear to be protective factors, and 'connectedness' within a community has been linked to positive health and wellbeing (Commonwealth Department of Health and Aged Care 2000).

If community health agencies and regional governments are to provide culturally relevant, integrated and sustained mental health supports, they should be applied in nature, properly funded, and not imposed by a predetermined set of monologic or monocultural beliefs and values. Being so applied they are in partnership with the needs of local and regional communities. For those who do experience mental health problems emphasis must be given to the provision of recovery and relapse prevention services and the cultural competence of these concepts should guide partnerships in service delivery.

### **Cultural Competence as Integrated Response**

Cultural competence is, in this sense a set of behaviours, attributes and policy infrastructure that come together in a system, organisation or among professionals and enable that system, organisation or those professions to work effectively in cross cultural situations (adapted from Eisenbruch 2004). Also important will be assessment and mobilisation of strengths inherent in systems to improve health and wellbeing by valuing cultural perspectives.

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Such factors go a long way to promote positive mental health and reduce emotional suffering. At the same time family supports through regional infrastructure, meaningful employment, child support, language tuition, affordable housing, improved nutrition and physical activity also provide substantial insight into the role of risk and protective factors in the developmental pathways to mental health problems and mental illness (WHO 2004). The period of flight to settlement can be injurious to mental health and the people who endure this process will express their injury in ways that are in keeping with their culture (Procter, 2005). High co-morbidity among mental ill health and its interrelatedness with physical illness and social struggle stress the need for integrated public health activity which will target groups of related problems and issues, common determinants, early stages of multi-problem trajectories, and people at multiple risk of injury.

At the core of an integrated response will be the need to actively engage and understand the significance of the family unit and a willingness to understand individuals' lived experience of flight, settlement and relocation. This will go a long way in forming a trusting and therapeutic partnership – a relationship of sorts – that promotes trust as a fundamental requirement for growth and mental stability (Procter, 2004). This will be particularly helpful when working with survivors of torture and trauma who may feel that they have no will or reason to continue living because the need for therapy and treatment can remain long after the violence has stopped (Witterholt and Jaranson, 1998).

These considerations are particularly important when we consider the mental health of our community. Neuropsychiatric conditions account for 13 per cent of the total Disability Adjusted Life Years lost due to all diseases and injuries in the world, and this is estimated to increase to 15 per cent by the year 2020. Mental disorders represent not only an immense psychological, social and economic burden to society, but also increase the risk of physical illnesses (WHO 2004).

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Practical emphasis on trust and the therapeutic relationship (defined broadly and in a culturally appropriate way) is consistent with a recent extensive and critical review of literature about treating suicide and life threatening behaviour (Rudd et al 2001). The reviewers concluded that it is the trust inherent in the therapeutic relationship that allows the person to take the necessary risks, do things differently, reach out during periods of acute and excruciating vulnerability, and experiment with new skills, all essential for progress and recovery.

Responding to individual and community need is the focus of Standard 3 of the National Mental Health Standards in Australia. The Standard makes the point that mental health professionals will practise in an appropriate manner through actively responding to the social, cultural, linguistic, spiritual and gender diversity of consumers and carers, incorporating those differences in their practice. And, as we have already seen many migrants and refugees who settle in Australia are from culturally and linguistically diverse backgrounds.

### **Coordination and Advocacy**

Given the likely adverse effects surrounding the impact of migration and settlement, the harshness of immigration detention environments, the current limitations in reaching and advocating for vulnerable and stateless populations alienated by cultural and linguistic barriers - and the ineffectiveness of treatment modalities for decreasing disability due to mental disorders, the only sustainable method for reducing mental suffering are advocacy based models of intervention and prevention.

Such analysis has significant implications for mental health and social care. Mental health literature for traumatised people the world over emphasises coordination of services, safe and predictable environments and the stability of client-provider relationships over time (Burnett and Peel, 2001; Jones and Gill, 1998).

And for coordination of services to be ensured requires at the very minimum getting to know and trust the people who need treatment that meets the national standards in mental

health care. And before this is possible it will require a health workforce prepared to look beyond taken for granted assumptions related to mental health and expressions of human suffering. This means accepting that different cultures have different views of what constitutes mental health and mental illness. As both the WHO Day and the Decade emphasise collaboration, partnership and global responsibility for health workforce issues the clinical task begins by looking at the 'cognitive distance' (Weiss, 2001) between particular health experiences and what practitioners, managers and policy makers of all persuasions see as different perceived causes of concern, optimal care and culturally appropriate support and treatment.

### **Explanatory Models of Mental Health**

Interdisciplinary activity also requires a health workforce to free its vision in health and social services, demonstrating an understanding of the role of culture, and of the explanatory models of illness of other cultures. Such knowledge is integral to the accurate diagnosis and treatment of mental illness, the development of effective strategies for rehabilitation and recovery, and for mental health promotion and illness prevention.

Cultural competency for assessment and treatment of mental health problems across cultures requires a service provider to understand the concept of culture, its impact on human behaviour, and the interpretation and evaluation of behaviour. Cultural competency also implies recognition of other issues often associated with dealing with individuals from different cultures. These include stigma, isolation, communication and language difficulties, and sensitivity to the specific problems experienced by people of diverse cultural backgrounds, clinicians, and service providers when working with interpreters in the health setting. Cultural competency in health service delivery also includes the practitioner's ability to understand the emphasis many cultures place on the involvement of family in the patient's care and an understanding of the role of family and its implications, particularly in relation to confidentiality and gaining trust.

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Based upon the work of Kleinman and Seemen (2000) this means examination of the way in which symptoms of mental distress are understood and presented, the way help is sought, and the way care is evaluated by those who receive it. This process links the mental health experiences of relocation and settlement as they are held by new arrivals, their leaders, healers, and other concerned individuals with health professionals' interpretation of them. The clinical work of any health professional - no matter how willing or keen to help - will be compromised if it does not take account the persons' understanding of health difficulties and what practitioners themselves see as different perceived causes of illness, optimal care and culturally appropriate support and treatment.

### **Managing Inter-agency Conflict**

Under any initiative for health services for newly arrived refugees, it is essential to ensure that the mainstream health workforce has the skills and knowledge to allow it to develop and enhance the way it provides services to people from culturally and linguistically diverse backgrounds. And this will involve effective means of resolving conflict between services and agencies, and between health care provider and patient.

Clinical service managers and public servants for example can begin to prevent conflict by building and modelling effective communication practices between agencies and where possible create formal policy for resolving interagency conflict. The aim of such policy - to be formally agreed upon - is to avoid deadlock, improve trust networks, and ensure fairness and equity of points of view with regard to individual roles and responsibilities.

Service provision to newly arrived migrants and refugees can be hindered due to a fundamental clash of beliefs surrounding cross-cultural assessment, treatment and social care. This makes breakdown of communication and deadlock between people and organisations a very real possibility. The implications of this can be catastrophic - especially when the issue (e.g. admission to hospital) is time-sensitive.

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But resolving the problem early on is ultimately more desirable in a health service where many issues have significant implications for numerous parts of the service.

When people collaborate more freely they are more likely to trust each other. When people trust their organisations, they are more likely to give of themselves now in anticipation of future change and reward (Weiss and Hughes 2005).

### **Conclusion**

As the World Health Assembly sets forth to meet its agenda building a responsive and dynamic health workforce, deeper meaning questions must underpin the theme of the World Health Report 2006. Government policies have the ability to promote or undermine professional and community trust and confidence in a health workforce. If the WHO direction of an appropriately prepared, deployed and supported health workforce (WHO 2005) is to become a reality, it must be applied in nature and specifically linked to ways to improve health service delivery. The analysis contained in this paper has sought to promote more informed and compassionate awareness and respect for the deeper meaning structures and alternative points of view held by people from culturally and linguistically diverse backgrounds.

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