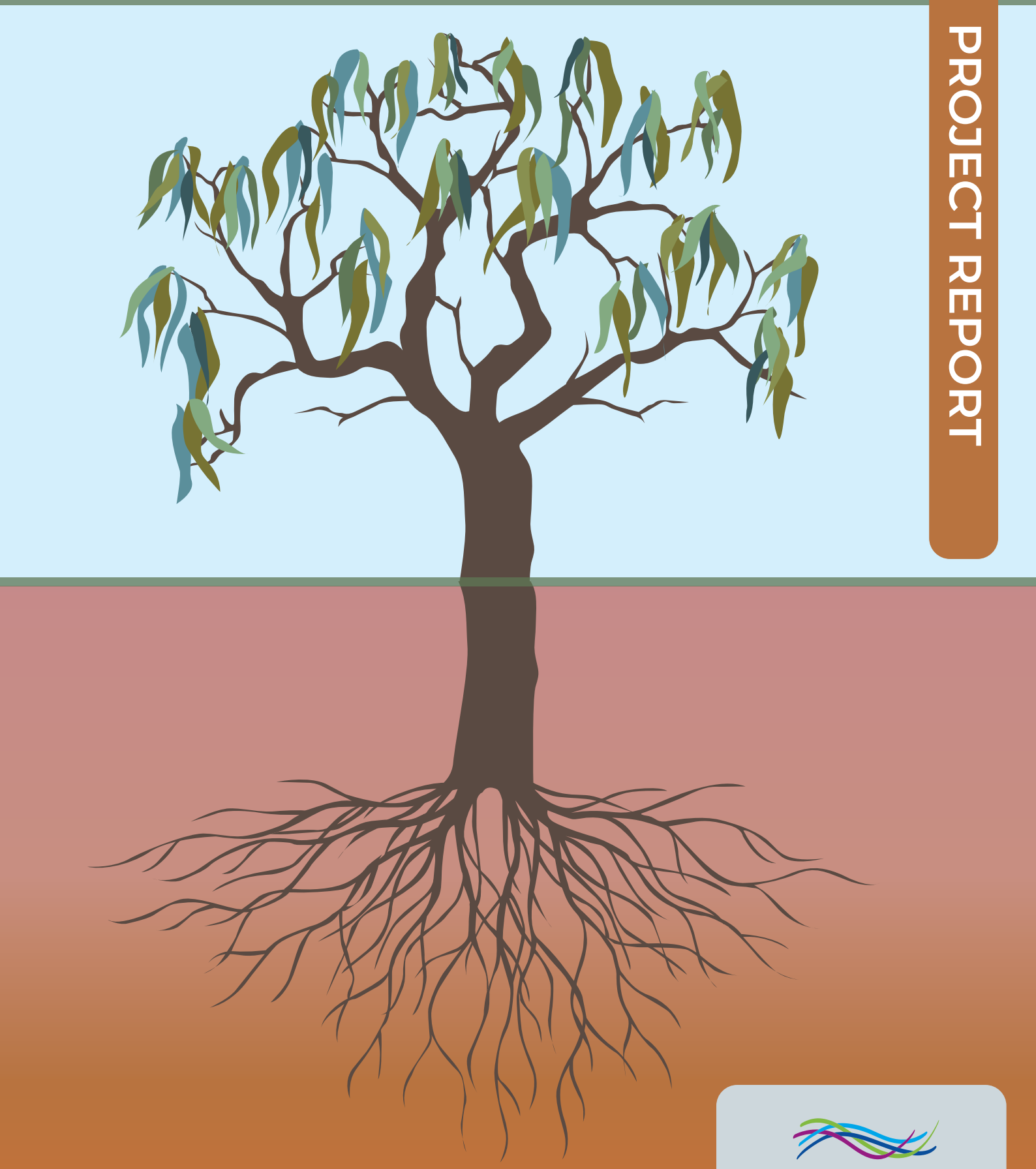
COMMUNITY ENGAGEMENT WITH PURPOSE

A guide for approaching community engagement in mental health settings

PROJECT REPORT



Victorian Transcultural
MENTAL HEALTH

Suggested citation: Victorian Transcultural Mental Health. (2023).
Community Engagement with purpose: Approaches to consider in mental health settings: Project report.

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Contents

ACKNOWLEDGEMENTS

Victorian Transcultural Mental Health (VTMH) is funded by the Mental Health and Wellbeing Division of the Victorian Department of Health (DoH) and administered by St Vincent's Hospital, Melbourne. VTMH works with organisations and agencies to strengthen their capacity to address inequity in mental health service provision, with the overarching goal of improving the mental health and social and emotional wellbeing of culturally diverse individuals, families, and communities.

We acknowledge that VTMH is located on the traditional lands of the Boon Wurrung and Woiwurrung (Wurundjeri) peoples of the Kulin Nation and pay our respects to Elders past, present and emerging. VTMH celebrates the continuing culture of the Aboriginal and Torres Strait Islander peoples. We know this land has history, custodians and stories spanning tens of thousands of years. In a spirit of reconciliation, we commit to walking the journey of learning and healing together.

We would also like to acknowledge individuals and carers who have lived experience of recovery, mental health challenges and suicide.

The project working group from VTMH included Shehani De Silva (Lead), Kimberley Wriedt, Radhika Santhanam-Martin and Nivanka De Silva. This report was written by Natasha Rajagopalan, who was also involved in the project working group during the final stages of the project. We would additionally like to acknowledge the generous contributions of the VTMH team who provided valuable feedback and suggestions, as well as the members of the Advisory Group, whose input was essential to the commencement, progression and finalisation of the project. Thank you to Dominic Hwang, George Yengi, Jackie Mansourian, James Lombe Simon, Niharika Suhas Hiremath, Nivanka De Silva, Resika KC, Summayyah Sadiq-Ojibara, and Violeta Peterson.

Finally, thanks are also due to the many individuals who participated in various stages of the project, from consultation to resource development. We acknowledge that several participants played multiple roles throughout the project (e.g. consultation/advisory group members also being involved in resource production). All of your contributions are immensely appreciated.

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Project background

Victorian Transcultural Mental Health (VTMH) works with organisations, health services, and communities to strengthen their capacity to address inequity in mental health access and service provision, with the overarching goal of improving the mental health and social and emotional wellbeing of culturally diverse individuals, families and communities. VTMH has also been supporting 'grass roots' initiatives for several years as part of our day-to-day business. We have done this directly by working with community groups, and indirectly when undertaking organisational development consultations, providing workforce education and supervision, and participating in interagency networks.

It is VTMH's belief that rather than imposing solutions on communities, solutions to community issues ought to come from communities themselves (McDonough et al., 2021). We are a country lucky enough to be home to an ancient race of Indigenous nations and a richly diverse migrant population, and these communities are invaluable sources of knowledge and support. However, mental health services seldom promote a culture of engaging with local communities or their practices, leaving this responsibility to local community organisations. This may be one of the reasons for communities' lack of uptake with mental health services and limited engagement with the mental health sector. In this context, VTMH has identified and introduced community engagement as one of the key strategies of culturally responsive practice for all mental health services (McDonough et al., 2021).

The Royal Commission into Victoria's Mental Health System identified that *"we need to invest in initiatives that will result in a cultural shift in the mental health system, where lived experience, diverse explanatory models and cultural perceptions of mental health are valued equally alongside the clinical knowledge and expertise of our workforce"* (Royal Commission into Victoria's Mental Health System [Royal Commission], 2021). Further, the sector should *"actively engage with Victoria's diverse communities throughout planning, implementing and managing the new mental health and wellbeing system"* (Royal Commission, 2021). In response to the Royal Commission and the mental health crisis that followed the COVID-19 pandemic, Ethnic Communities' Council of Victoria (ECCV) and VTMH made several additional recommendations relevant to developing a culturally responsive mental health system. Community engagement, collaboration and co-production were spotlighted as cornerstone (Plowman & Izzo, 2021).

Recently, the Department of Health has embarked on developing the Diverse Communities Framework and Blueprint for Action (Department of Health, 2023). However, at the time we started this project, there was no state-wide strategy for building capacity of mental health services to supporting the workforce to engage and work with communities. Responding to the learning, practice, skills and knowledge gaps of the public mental health workforce and other providers of health and social support services is one of VTMH's key functions. To this end, VTMH has undertaken work over the years with service providers to build their understanding around the importance of engaging and working with local communities. This culminated in the current project – 'Community Engagement with purpose: Approaches to consider in mental health settings'.

With the guidance of those with lived experience, community members and mental health practitioners, this project utilised a collaborative approach to co-design and produce a suite of resources to support the mental health workforce to improve their skills, knowledge and practices in engaging with diverse communities. This clearly aligns with contemporary perspectives and VTMH's core values and work, and seeks to support and equip organisations and service providers with the skills to bridge a significant competency gap within Victoria's mental health sector. The project was completed over two years and across four phases which will be expanded upon within the body of this report.

What does the current literature say about community engagement in the area of mental health?

Australia is a *"society defined by diversity"* (Plowman & Izzo, 2021), encompassing culturally and linguistically diverse (CALD) populations and Aboriginal and Torres Strait Islander peoples (Australian Bureau of Statistics, 2022). However, diversity extends beyond ethnicity to include those across the lifespan, LGBTQIA+ groups, religious and spiritual affiliations, rural and remote communities, and people with disability (Edgar et al., 2023; MacDonald, 2019; National Mental Health Commission [NMHC], 2023).

In this context, 'community' refers to more than simply geographical location (Brunton et al., 2017; Ife, 2016). Instead, community can be understood as a subjective experience. Community provides a sense of identity and belonging for individuals, requiring mutual obligations and participation of its members, and is founded upon a community-based culture (Ife, 2016). The complexity of community is difficult to capture, and will be discussed further within this report (see page 14). Importantly, communities have specific needs, priorities, strengths and knowledge (Kenny & Connors, 2017). This is increasingly being recognised in the literature and more broadly. Without organisational acknowledgment of and engagement with communities, our ability for safe and effective service provision is significantly diminished (Wood & Kallestrup, 2021).

This practice underlies community development, where governments and organisations must work with the assumption that communities have existing assets, resources and wisdom that they can draw upon. The role of those external to communities is to supplement and facilitate these strengths (Kenny & Connors, 2017). In this way, there is a commitment to empowering members of communities to take collective control and ownership for development and progress, enabling meaningful capacity building that is grounded in local culture and community resilience (Ife, 2016; Kenny & Connors, 2017).

In 2019, VTMH completed an evaluation of thirteen projects completed over the preceding two years by community-based agencies. These were managed by Tandem and the Victorian Mental Illness Awareness Council (VMIAC) and funded by the Department of Health and Human Services. These projects aimed to respond to the challenges and experiences of various cultural groups, and utilised community development principles with consequent improvements in mental health and social and emotional wellbeing of community members (McDonough, 2019). From this evaluation, a framework for *"building mental health and wellbeing capacity and capability in diverse communities"* was developed (McDonough, 2019; see Appendix 1 for details). Although it is beyond the scope of this literature review to speak to this framework in significant depth, it is worth acknowledging that many of the recommendations spotlight community engagement as key. Ultimately, *"communities know what they need and what is right for them"* (McDonough, 2019). There is a need for organisations and service providers to collaboratively identify needs and preferences, understand intersecting sources of inequity and power imbalance, draw on lived experience and community resources, actively seek community engagement throughout the development and implementation of initiatives, and invest in these processes to enable sustainable and meaningful change (McDonough, 2019).

Community engagement has been recognised by the World Health Organisation to have undeniable benefits in promoting the health and wellbeing of communities, as well as addressing existing and pervasive health inequities (World Health Organisation [WHO], 2020). Despite this, the current literature base can be difficult to navigate, with variable terminology used and significant conceptual breadth in the meanings ascribed to these terms (Brunton et al., 2017; O'Brien et al., 2020). In addition to 'community engagement', the language used in this area includes community-based participatory research, co-design and co-production, collaboration, partnership, capacity building, and community development. 'Community engagement' is also applied in different settings (e.g., health, policy, education), with different groups (e.g., consumers, families, communities), on different levels (e.g., government, local organisations), and for different reasons (e.g., development of initiatives/interventions, research). Moreover, there exists a lack of clarity on how community engagement should be implemented, and there is a paucity of Australian literature examining community engagement in mental health settings.

Despite these challenges, there is a growing evidence base that requires discussion. Tribe (2019) considers global mental health through the lens of neo-colonialism, where Western paradigms of mental illness are uncritically applied across populations. Community engagement is an active process that creates safe spaces for diverse community voices (MacDonald, 2019), thus aiming to address this issue. In this way, cultural idioms of psychological distress, co-production and bidirectional learning are prioritised (O'Brien et al., 2020; Tribe, 2019; Wood & Kallestrup, 2021). By viewing this process through the lens of social justice, organisations acquire a moral imperative to focus on the empowerment and development of communities, rather than simply aiming to achieve a given outcome (Brunton et al., 2017; Taffere et al., 2023; WHO, 2020).

Community engagement has been recognised on an international (IAP2 Australasia, 2019; WHO, 2020) and local (City of Melbourne, 2021; Department of Premier and Cabinet, 2021; Peucker et al., 2022) level. Several national organisations have already adopted co-design approaches within their policies (Mind; 2018; Neami National, 2018; Tandem, 2018). In Victoria, calls for community engagement to be prioritised in the mental health sector are pronounced (Embrace Multicultural Mental Health, n.d.; McDonough et al., 2021; NMHC, 2023; Plowman & Izzo, 2021; Royal Commission, 2021). In this context, there is a growing need for clarity and consistency regarding community engagement principles and practices that are relevant and applicable on a local level.

Key recurring themes in the literature include:

- Communities have inherent wisdom and understandings that must be valued by external stakeholders (Delman et al., 2019).
- Community engagement fosters community empowerment and autonomy, building on invaluable strengths and utilising community resources (Brunton et al., 2017; O'Brien et al., 2020; Russell et al., 2023; WHO, 2020).
- Community engagement acts to improve the quality, relevance, long-term sustainability and impact of initiatives and research (O'Brien et al., 2020; Taffere et al., 2023).
- The significance of building trust and relationships over time should not be overlooked (Taffere et al., 2023; WHO, 2020). Community engagement requires collective effort and a relational approach (O'Brien et al., 2020).
- Full participation, meaningful partnerships, and genuine collaboration should be prioritised (O'Brien et al., 2020; WHO, 2020). This can be developed through transparency and open dialogue (Taffere et al., 2023; Wood & Kallestrup, 2021).
- Community engagement is founded upon shared decision-making (Delman et al., 2019; WHO, 2020) and concerns itself with power imbalance (Brunton et al., 2017; O'Brien et al., 2020).
- Organisations need to commit time, resources, funding and infrastructure to community engagement work, without which success becomes out of reach (Brunton et al., 2017; Taffere et al., 2023).

Common dilemmas faced when utilising participatory approaches in mental health settings include (Wood & Kallestrup, 2021):

- Possible tension between community-based and evidence-based interventions;
- The relevance and specificity of local outcome measures compared with the practicality and ease-of-use of standardised measures;
- The challenges that occur when integrating local idioms with standardised, Western diagnostic classification systems;
- The importance of empowering communities but being aware of local power structures; and
- The difficulties in developing trust within the time and funding constraints of public health systems.

Description of the project processes

This project occurred across four phases:

1. Recruitment of members for an Advisory Group and multiple Consultation Groups
2. Consultation with the Consultation Groups over several sessions
3. Consolidation of the information gathered and subsequent design of the resources
4. Development of the resources

The project working group regularly liaised with the Advisory Group throughout these phases to ensure that their input was meaningfully incorporated into the work.

Phase 1: Recruitment

The development of an Advisory Group and multiple Consultation Groups occurred with the intent of integrating co-design principles and practices with the project's overarching goals. Overall, the recruitment process highlighted the importance of developing respectful, lasting relationships over time. It was from this pool of connections that both the Advisory Group and Consultation Group were formed. For both groups, we endeavoured to ensure that they were representative of a range of relevant experiences, including lived experience, family members/carers, young people, community members, mental health service providers as well as individuals working within the community development sector. Lived experience participants and community members were remunerated for their time and participation.

ADVISORY GROUP

The Advisory Group was created to support a process of co-design throughout the project, from beginning to end. Group members were involved in all phases of the project, including the development of consultation questions, review of the themes synthesised from subsequent consultations, design of the resources, and review of the resources regularly throughout development.

Members of the project working group contacted individuals or groups who we had previously worked with on community engagement projects or had other working relationships with. These individuals were also invited to make suggestions as to who they thought might be interested in the project. Scoping calls were initially made, and those who were interested in being involved were sent a project plan, a Terms of Reference outlining roles and responsibilities, and an official invitation to be involved. Whilst some declined the offer, the majority of those who were approached accepted the invitation.

Those who accepted the offer to be a member of the Advisory Group included:

- **Dominic Hwang** (Social Worker and Mental Health Recovery Practitioner, Star Health)
- **George Yengi** (Community Member Advocate)
- **Jackie Mansourian** (Community Development Officer, Darebin Council)
- **James Lombe Simon** (Community Development Officer, Community Planning and Development, City Life)
- **Niharika Suhas Hiremath** (National Mental Wellbeing and Intersectionality Advocate, Chair of Australian Institute for Diversity in Mental Health and Solis, Headspace National Board Youth Advisor)
- **Nivanka de Silva** (Psychiatry Registrar, VTMH)
- **Resika KC** (Service Manager and Clinical Lead, Neami National)
- **Summayyah Sadiq-Ojibara** (Psychotherapist and Counsellor, CEO/MD DEW Counselling, COMXtra Knowledge Concepts)
- **Violeta Peterson** (Director, Carer Lived/Living Experience, Alfred Mental Health)

Of note, the VTMH psychiatry registrar **(Nivanka)** was involved as both an Advisory Group member and a member of the project working group.

Pictured: Advisory Group (not pictured are Jackie Mansourian, James Lombe Simon, and Nivanka de Silva).

CONSULTATION GROUPS

The Consultation Groups were created to inform the content and major themes of the resources to be developed. This was to occur through a series of consultation sessions during Phase 2 of the project.

Members of the project working group contacted individuals and groups who we had previously worked with through partnerships, the Mental Health and Cultural Diversity Community of Practice (CoP), or stakeholders we had worked with on other projects. Those who were interested in being involved were sent a project plan with details of the requirements of the role. The majority of those invited accepted the offer to be involved.

Originally, consultations were planned to occur with all members together, regardless of background. However, concerns were raised from the Advisory Group about the risks of power imbalances if this were to occur (e.g., between a psychiatrist and a person with lived experience). With this in mind, three broad groups were identified including: (1) Mental health workers, (2) Community development workers, and (3) People with lived experience and community members. From these broad groups, six Consultation Groups were formed as follows:

Group 1: **Clinical and community-managed mental health workforce**

Group 2: **Clinical and community-managed mental health workforce (drawn from CoP)**

Group 3: **Community development workers from community organisations**

Group 4: **Community development workers from community organisations**

Group 5: **Peer workers in mental health settings**

Group 6: **People with lived experience and community members**

Each group was composed of different members who had various backgrounds/ roles. Notably, it was particularly challenging to achieve a gender balance in Groups 1 and 2 that included members of the mental health workforce, possibly reflecting the higher ratio of female to male workers in this area (Australian Institute of Health and Welfare, 2023).

Phase 2: Consultation

DEVELOPING THE CONSULTATION QUESTIONS

The project working group developed an initial set of consultation questions based on knowledge and assumptions accrued from previous community engagement work in mental health settings. These were reviewed by the Advisory Group and the feedback provided was addressed via several modifications to the question list. Initially, a single set of questions was thought to be sufficient for all Consultation Groups. However, with input from the Advisory Group, specific questions were developed that more closely appreciated the unique expertise and experiences of each Consultation Group.

THE CONSULTATION PROCESS

Six consultations occurred over the course of five months, each with a different set of participants as described above. Thirty-nine participants were involved across the consultations, where 5–8 participants attended each session. This number was chosen to facilitate supportive and robust discussions. Flexible options were offered for people with lived experience and community members (i.e., interpreter involvement, individual versus group, in-person versus phone/online). All consultations occurred via an online platform except for consultations with two individuals with lived experience, whereby one occurred by phone-call and the other as an in-person discussion. Each consultation transpired over 2.5 hours. Each consultation was facilitated by two members of the project working group. There were different facilitators for each consultation. The sessions were guided by the consultation questions previously developed, where everyone was allowed space and time to respond with their thoughts and ideas.

WHO DID WE ENGAGE WITH?

Clinical mental health and community-managed mental health workforce, CoP, community development workers from community organisations, peer workers in mental health settings, people with lived experience and community members

TIME TAKEN TO CONSULT?

Six consultation sessions over the course of five months.
Each consultation session transpired over 2–3 hours.

HOW MANY CONSULTED?

In total, 39 stakeholders were consulted, divided into groups as follows:

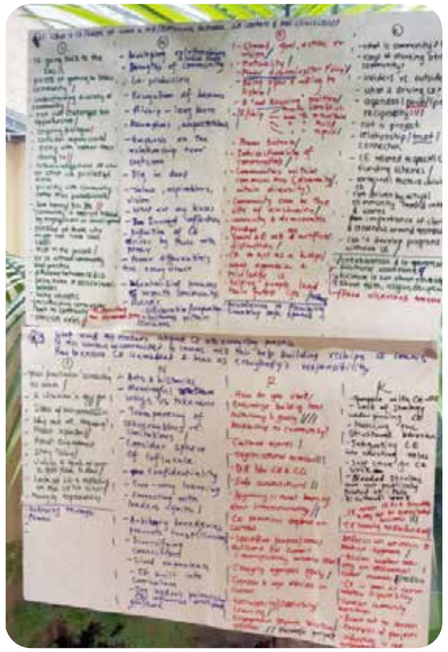
- Group 1 involved 8 participants
- Group 2 involved 7 participants
- Group 3 involved 5 participants
- Group 4 involved 7 participants
- Group 5 involved 5 participants
- Group 6 involved 7 participants

WHAT DID ENGAGEMENT LOOK LIKE?

Consultations occurred via an online platform, in-person discussions and over the phone. Each was facilitated by two members of the project working group.
Sessions were guided by a series of consultation questions, aiming to facilitate reflection and discussion.

Figure: Overview of consultation process

Phase 3: Consolidation and design



ANALYSIS OF THE CONSULTATION DATA

With the consent of participants, all six consultations were recorded and transcribed. The questions and associated responses from these transcripts were collapsed into ten common topics based on similarities. Each member of the project working group read through the re-organised information and individually identified several themes. Following this, a number of meetings occurred between the project working group members, each transpiring over 2–3 hours duration, to facilitate the comparison and consolidation of identified themes. The discussions that occurred aimed to develop a consensus regarding the common themes across all consultations, where all themes identified were considered and incorporated into a final summary. Before finalising the analysis, these themes were provided to the Advisory Group for review, where the data was further refined in a collaborative, oscillatory arrangement. A final summary formed the basis of the content explored and expanded upon within the resources. The themes identified were organised into core community engagement concepts and core practices, which were further divided into organisational and practitioner responsibilities.

DESIGNING THE RESOURCES

It was important that the breadth and depth of the information gathered from the consultations was captured in the final resource, in a way that was accessible and engaging for the target audience. It was also discussed that the end products of the project would act as a guiding resource for ongoing, lifelong work, rather than a step-by-step manual to a final destination. These discussions occurred in tandem with input from the Advisory Group. It was decided that a range of mediums would be most suitable to accomplish this. These mediums included a principal resource, several short videos, a podcast series, an accompanying workshop, and a final project report.

Phase 4: Resource development

Five resources were designed and developed through this project (i.e., the Principal Resource, Video Resources, Podcast Series, Workshop on Community Engagement, and Project Report). This required external support (i.e. creative producer for video production, practical podcast support, artist/designer to develop the resource) to finally bring the resources to fruition. The Principal Resource is a tri-fold booklet aiming to concisely present the information collected from the consultations in written format. The videos and podcast series were developed with the assistance of several talents (some of which were members of the Advisory Group and project working group) who were recorded (by video and audio respectively) as they discussed key topics identified in the Primary Resource in more depth. These resources are to be incorporated into a workshop designed to speak to community engagement. Finally, the Project Report was completed as a means of documenting the project in its entirety. As each resource was developed, the Advisory Group were given the opportunity to review progress and provide feedback that was then incorporated into subsequent revisions.

How community and community engagement was understood across the consultations

During the analysis, it became apparent that there were many ways in which consultation participants understood the concepts of 'community' and 'community engagement'. Therefore, we have prefaced the outcomes of this project by offering a description of these understandings. These concepts are useful to hold in mind when reading this report and viewing the corresponding resources.

It was raised by consultation participants that it might be useful to clarify what *community* was, who the members of community were, and which of these members organisations should engage with. Community was described as a *"bedrock"* within which individuals live and thrive, rather than simply *"empty vessels"* to be rescued. Communities have values, aspirations and concerns, and are sources of immense knowledge. Importantly, whilst the strengths and empowering nature of community were repeatedly highlighted, it was acknowledged that community could also be a source of exclusion and distress for marginalised subgroups. Often discussed was a need to take an intersectional lens when considering the nature of communities and the individuals that comprise them. This involves acknowledging and considering complex, intersecting and multi-dimensional identities and the various sources of privilege and oppression that may simultaneously be experienced. From community leaders to community members, the experiences of individuals within communities are unique and individualised, and the fabric of community is fundamentally reflective of *"diversity within diversity"*.

Community Engagement is a meaningful, continuous process driven by a desire for understanding communities and founded upon a *"not knowing"* position. It is the gathering of stories and learning from experiences. This work is premised on the notion that communities need to lead decision-making for matters that impact them, and aims to privilege community voices. Community engagement is incumbent upon mutual, reciprocal relationships created by open dialogue that dispenses with pre-conceived ideas and closed organisational agendas. These relationships are built over time, and facilitate collaborative partnerships and community-led solutions. Power sharing is key, enabling communities to advocate for themselves, their needs and their priorities. For community engagement to be sustainable, it requires dedicated, longitudinal resources and leadership support. Ultimately, definitions of community engagement must arise from within community, rather than from those outside and/or in positions of privilege and power, with the aim of addressing community-identified needs and encompassing community-specific values.

Through the process of community engagement and the exploratory consultation with communities that this entails, *capacity building* and *community development* can then occur in a way that is co-designed. The language surrounding community engagement and community development is sometimes used interchangeably; however, it is important to acknowledge that they are not the same. For community development to occur, relationships and trust need to be built over several years, the process of which is encompassed within the community engagement framework.

The Resources

The following is a description of the resources that arose as a direct result of the project processes described previously. Each resource has been developed with a particular intent in mind, which has been made apparent in the respective sections.

PRINCIPAL RESOURCE

The Principal Resource, titled 'Community Engagement with purpose: A guide for approaching community engagement in mental health settings', is a hardcopy resource for service providers and organisations. This resource has been developed as a booklet with two major sections. The first section provides a summary of the core concepts and core practices required of community engagement that arose through the consultation process. Neglect of these underpinning core concepts poses significant challenges to community engagement meaningfully and sustainably occurring. The second section outlines the core practices in further depth, describing a broad list of practitioner and organisational actions to facilitate this work (see Appendix 2 for examples of core concepts, core practices and actions). In this way, approaches can be considered on both individual and systemic levels, to enable service-wide implementation of community engagement practices.

VIDEO RESOURCES

A five-part series of short video clips were produced as part of this project. The videos were designed to supplement and enhance the concepts presented in the Principal Resource, as well to be utilised within the in-person workshop. The titles of the videos are as follows:

- What is Community Engagement?
- Community Engagement and understanding power
- Communities have solutions
- Committing to a Community Engagement approach: What does this involve?
- Community Engagement is not driven by crisis alone

Exploration of these topics within the videos aimed to develop understandings of key ideas that emerged through the consultation process, fostering a broader awareness of the context of community engagement work, the inherent and undeniable strengths of communities, and the challenges that can arise in the process of this work.

PODCAST SERIES

Similar to the video resources, a four-part Podcast Series was created in order to complement and expand upon the content presented in the principal resource. The series is entitled 'Conversations about Community Engagement in mental health', and involved several speakers who brought with them a diverse range of experiences. The titles of the podcasts are as follows:

- Varied lived experience – Not one size fits all
- Talking about power in engaging with communities
- Reimagining community work – How to start the journey of decolonisation in Australian healthcare?
- Diversity of communities – Who is left behind?

Each episode was up to 30 minutes in length. Through conversational dialogue, the Podcast Series explored different perspectives in a way that aimed to create depth and highlight the complexity of some particularly important concepts.

WORKSHOP ON COMMUNITY ENGAGEMENT

VTMH offers a range of workshops to provide education and training for individuals and groups within organisations. These aim to facilitate the provision of information by the use of presentation, media, small group interactive activities, and regular opportunity for group reflection. 'Community Engagement' has been a topic included in our suite of workshops in the past. The resources created through this project will inform the development of an updated workshop facilitated by VTMH on the topic of community engagement and mental health. Additionally, the themes identified through this project will be integrated across the range of other workshops developed by the unit.

PROJECT REPORT

The Project Report was written as a means of capturing the project journey from inception to final product. Complementary to the resources, the report aims to highlight the richness of the consultation discussions and nuances of the themes that arose, as well as to create transparency regarding the project processes.

Reflections arising from the project

A number of broader themes emerged during the development of and carrying out of the project. These will be explored in further depth below.

PRINCIPLE AND PROCESS OF CO-DESIGN

This project has attempted to integrate co-design principles into the process and development of the final resources (Roper et al., 2018). The project working group has made conscious efforts to meaningfully utilise these principles throughout the project, particularly through the regular participation of members of the Advisory Group and Consultation Groups. Collaboration with these key stakeholders has been embedded throughout the process. To facilitate this, attempts were made to be flexible (particularly with regards to communication), acknowledge power differentials (evidenced within the changes made to the consultation process as proposed by the Advisory Group), and to foster longer-term partnerships. Co-design is built upon trust, respect, collaboration and empowerment (O'Brien et al., 2020), and whilst formal guidance regarding co-design methodology is limited, it is hoped that the process utilised within this project might add to the current literature base.

EMBEDDING ANTI-RACISM INTO ORGANISATIONAL PRACTICE

Racism is known to have profound impacts upon physical and mental health (Abubakar et al., 2022), where these findings have been replicated in Victorian research (Department of Health and Human Services, 2017). Oppressive and discriminatory practices continue to underlie health systems and organisations. The project working group were surprised that the concepts of 'racism' and 'anti-racist practices' were not heavily featured in the consultations, only becoming more apparent with the input of the Advisory Group. We know that more work is required in this area, beyond cultural competency education and training. This is clearly reflected in the literature (Bhui et al., 2012). Racism needs to be acknowledged as a key determinant of health outcomes and anti-racist frameworks need to be integrated into policy and legislation to effect meaningful change. Similarly, anti-racism needs to be embedded within individual, organisational and broader systems approaches to cultural competency as a means of more actively promoting racial and health equity (Bhui et al., 2012; Mensah et al., 2021).

Considering the role of decolonisation in this process is central (Abubakar et al., 2022). The imperative for decolonisation in Australian healthcare has been further explored in the project's podcast series. Importantly, the development of partnerships and alliances with affected communities can be transformative in facilitating this work (Corneau & Stergiopoulos, 2012). Community engagement can support the relationship building required. Conversely, anti-racist reform is equally important to facilitate community engagement work

EVALUATION AND DATA COLLECTION

It is beyond the scope of this report to discuss the evaluation of community engagement work in significant depth; however, data collection and measurement of community engagement work was highlighted within the consultation process and is worth mentioning here. Evaluation aims to assess processes and outcomes, where the overarching goal is for quality improvement (Patton,1997). Whilst this is something that organisations consider, currently there do not seem to be clear guidelines or support for how to conduct evaluative processes within the community engagement sector.

The complexity of this process was identified during the consultations, particularly relating to how to meaningfully capture community input and how to determine what might be valid indicators of measurement (e.g. service accessibility, the nature and quality of relationships, mental health literacy). Furthermore, uncertainty exists as to how organisations could measure the impact of community engagement work for mental health consumers more directly. A Key Performance Indicator framework was thought to be inadequate in meeting these needs. Another consideration here is the

tension that might arise between evaluating outcomes that funding bodies value compared with those that communities value. Often, funding is thought to be better utilised for short-term, high-impact work, rather than the long-term, relational work required for effective community engagement to occur. The underlying question here is what and whose priorities are guiding the evaluation process.

Additionally, the process of data collection needs to occur sensitively and safely, and the information being collected must be transparently justified. Intuitively, communities need to be engaged in the evaluation of community engagement initiatives and interpretation of data via participatory and empowerment processes. However, challenges are likely to arise in ensuring meaningful stakeholder involvement. Without oversight and support, evaluative processes may easily default into traditional extractive means of data collection. In order to prioritise the collaborative nature of partnerships and create a genuine interest in the information being collected, adequate organisational structures and resources need to be in place.

Thus, for evaluation to be meaningful, a relational and dialogic approach is needed to establish shared understandings of what matters to all involved. This 'evaluative language' then allows communication about quality in terms that make sense to the experiences of those involved, fostering a level of authenticity that goes beyond traditional modes of data collection.

A NOTE ON LANGUAGE

The following is a collation of terms that were found to hold specific significance within this project. These are not set definitions, but instead reflect the ideas and thoughts that have evolved through the course of this project culminating in their use in the resource.

Collective witnessing – A shared story telling of our struggles and triumphs

Colonisation – The experience of being colonised by settler communities

Colonised institution – Education and health services/systems that have been deeply impacted from the process of colonisation in Australia

Community assets and strengths – The ability of the service provider to draw on community knowledge, connections and history

Critical reflection – The capacity to closely examine all aspects of an experience from different perspectives in order to change or improve practices

Cultural humility – Recognising your own and the community's needs and resilience when engaging in partnerships and negotiating boundaries, to ensure that power differentials are acknowledged and mutually beneficial outcomes can be achieved.

Decolonising practices – Practices that question and challenge existing structures of power and privilege

Embodied practices – Practices that are attuned with bodily experiences

Giving back practices – These are accountability practices i.e. when a community shares their time, knowledge and expertise, service providers should take responsibility in returning their generosity

Internalised racism – A process where unconscious bias, assumptions and prejudice is practiced in institutions

Justice initiatives – Practices and policies that promote equity and equality, thereby removing unjust institutional barriers

Local autonomy – To maximise control and agency of local community groups

Participatory and democratic frameworks – The phenomenon of people being able to participate and contribute to shared decision-making

Power – The capacity of individuals or groups to make decisions or influence the decision-making process

Reciprocity – The ability to share power and resources between communities and services

Rupture and repair – The ability to recognise when communication is broken down and the skill to rebuild the broken relationship

Varied lived experiences – Experiences beyond diagnosis that reflects peoples broader socio-political and cultural landscape

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Appendix 1

COMMUNITY PRACTICES
Map assets and strengths
Understand inequity, inequality, and intersecting relations of power
Explore explanations of wellbeing and healing
Collaboratively identify needs and preferences
Co-design and co-create

INSTITUTIONAL PRACTICES
Develop policies and practice guidelines
Plan for and implement diverstiy responsiveness
Use participatory frameworks
Allocate resources and prioritise in order to address inequity

KNOWLEDGE PRACTICES
Create resources for and with communities
Respect plurality and practice critical reflection
Adopt two-way or multiple-way learning approaches
Provide learning opportunities for communities and professionals
Learn from community capacity building 'champions'

LINKAGE MODELS
Facilitate information flow and networks
Create structures that connect communities and services
Develop a bilingual, multicultural, multi-faith paid and volunteer workforce
Collaborate at all levels of decision-making
Invest in systemic change, long-term and at scale

Image: Figure 1.2 Recommendations for building mental health and wellbeing capacity and capability in diverse communities (retrieved from McDonough, 2019)

Appendix 2

Image: Example of a Core Practice

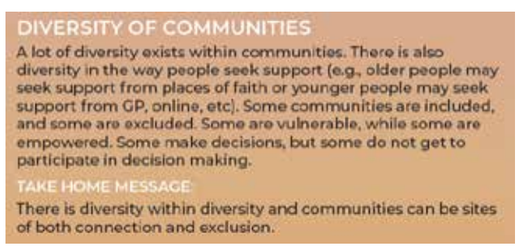
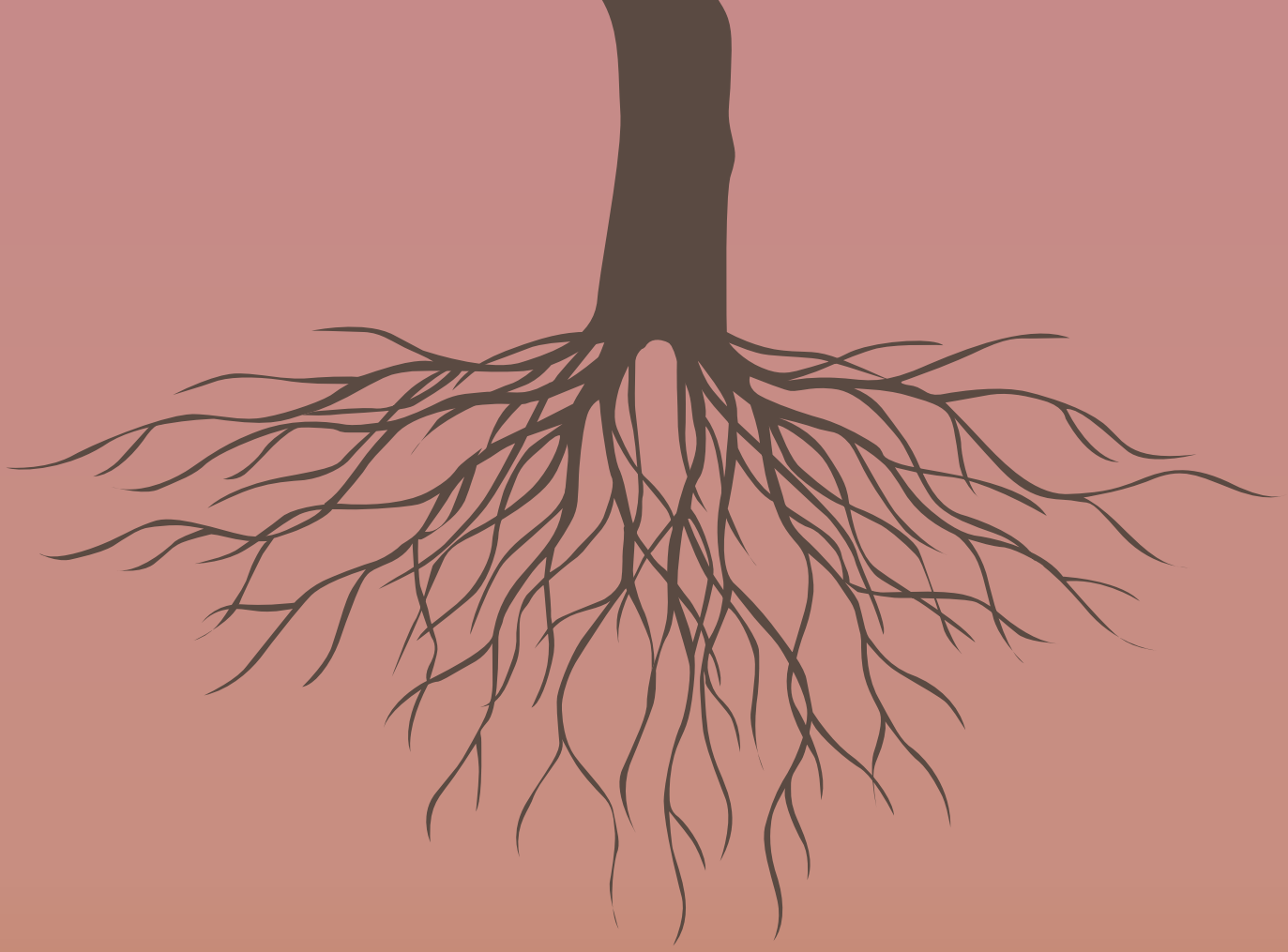


Image: Example of a Core Concept

Image: Example of a set of Actions



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