

**EVALUATION OF THE BILINGUAL CASE
MANAGEMENT PROGRAM IN COMMUNITY
MENTAL HEALTH SERVICES IN
MELBOURNE**

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Submitted in total fulfilment of the requirements
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School of Social Work and Department of Psychiatry

The University of Melbourne

ABSTRACT

This thesis describes the evaluation of a program to employ bilingual staff in case management positions in community mental health services in Melbourne, Australia. A literature review showed that no previous research in Australia had investigated the impact of bilingual staff on clients of mental health services. While research conducted in the USA shows that ethnic matching (matching clients and clinicians on the basis of language or ethnic background) increases service use, its impact on outcome domains such as social functioning remains uncertain.

Eleven bilingual staff, from psychiatric nursing, occupational therapy, social work and psychology backgrounds, were employed in case management positions in community mental health services during 1997. Funding was made available by the Victorian Government Department of Human Services, to conduct an evaluation of this program. The evaluation examined two main areas; the implementation of the program, and outcomes for clients. A meta-analysis of the effectiveness of case management in mental health services was also conducted as recent research had cast doubt on the conclusion that case management was an effective strategy for improving services. The implementation study compared the program's intended operation with its actual operation. The outcome evaluation examined outcomes for those non-English speaking (NESB) clients with a case manager of the same background compared to those clients who had a case manager from a different background. The outcomes examined were: medication management; clients' satisfaction with mental health services, in particular their cross-cultural sensitivity; levels of service utilisation, and improvement in social functioning over time.

The meta-analysis of previous research showed that clinical case management increased hospital admissions (as previously reported) but it also reduced total length of hospital stay, reduced drop-out rates, and was effective in improving clients' level of social functioning, reducing symptoms, increasing client and family satisfaction, and decreasing family burden of care.

The results of the implementation study showed that staff were recruited for the largest language groups in service catchment areas. About fifty percent of caseloads of the BCM staff were clients from the same ethnic background, as had been proposed. Early in the program (1998) the caseload size for BCM staff was around two-thirds of other staff, as had been planned to allow time for community work and secondary consultation. By early 2000, however, BCM caseloads had increased to 90 percent of those of other staff, due to pressures on services to accept more clients. A striking feature of the work of the BCM's was the emphasis on working with families. The staff were well-accepted by the services, and regarded as 'part of the team' rather than marginalised as 'ethnic workers'. These results suggest that the model implemented in Melbourne also managed to overcome some (but not all) of the difficulties previously encountered with bilingual positions.

A majority of clients preferred a case manager from their own ethnic background. They saw the primary benefits as being able to communicate in their first language, and also felt that bilingual staff would be able to understand them better. NESB clients with a case manager from their own ethnic background had better outcomes across a range of areas compared to other NESB clients. These included: better compliance with medication; lower rates of depot medication; greater satisfaction with the psychiatric service and its cross-cultural sensitivity; greater contact with case managers; less contact with Crisis Assessment and Treatment Teams, better long-term improvement in social functioning, and (for Vietnamese clients only) less hospital use (at an estimated saving of A\$57 000 per year for all services).

The effectiveness of BCM staff for clients of the same background can be attributed to several factors, including better communication and understanding of clients needs, more accurate monitoring of medication compliance and mental state, more timely detection and response to relapse, and the ability to establish rapport and a clinical relationship more effectively. These results showed that clinical and social outcomes are improved when clients have a case manager from their same ethnic background, and for clients from more newly arrived communities hospitalisation is also reduced. It was concluded that the introduction of the BCM program improved service outcomes for clients of non-English speaking backgrounds, and that bilingual positions should be created more widely throughout the mental health service system.

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LIST OF ABBREVIATIONS

ACT	Assertive Community Treatment
ADEC	Action on Disability within Ethnic Communities
AMHS	Area Mental Health Service
ANCOVA	Analysis of covariance
ANOVA	Analysis of variance
BCM	Bilingual Case Manager
CATT	Crisis Assessment and Treatment Team
CCM	Clinical Case Management
CCT	Continuing Care Team
CO.AS.IT.	Comunita Assistenza Italiana (Italian Community Assistance agency)
CPZe	Chlorpromazine equivalent
ESB	English speaking background
GAS	Global Assessment Scale
LOTE	Language other than English
MCAS	Multnomah Community Ability Scale
NESB	non-English speaking background
PRISM	Psychiatric Records Information System Manager
VITS	Victorian Interpreting and Translating Service
VTPU	Victorian Transcultural Psychiatry Unit

1. INTRODUCTION

PROBLEM STATEMENT

Australia is one of the most culturally diverse countries in the world, due in large part to mass immigration following the Second World War (Castles, Kalantzis, Cope & Morrissey, 1990). In 1997, Australia had a population of 18 million people of whom 4.3 million people (23 percent) were born overseas. (Australian Bureau of Statistics, 1998). People born in non-English speaking countries (2.8 million people) comprised approximately 15 percent of Australia's population. This percentage is larger in the main capital cities where most migrants have settled: 28.5 percent of Melbourne's adult population (aged 15 and over) were born in non-English speaking countries (Australian Bureau of Statistics, 1998).

People from ethnic minorities in Australia experience mental health problems at the same rate as the rest of the Australian population but face a range of problems in receiving help from mental health services. Previous research shows that ethnic communities have lower population rates of admission to psychiatric hospitals, (especially for those groups with less English proficiency or which are more 'culturally distant' from the mainstream), similar or longer length of hospital stay, and inadequate access to interpreters in hospital. In the community setting, ethnic minority clients have lower population rates of utilisation, lower duration of contact, and higher rates of premature termination. Although the results are mixed, some research suggests that outcomes from treatment for ethnic groups may be worse than for the majority population.

Ethnic minorities face a range of barriers or difficulties in gaining access to and using mental health services. These include: differing explanatory models of illness and treatment, greater stigma about mental illness, lack of knowledge of services, communication difficulties due to language barriers, greater responsibility taken for caring by family, a restricted range of treatment options for those who do not speak English, and culturally dissonant treatment and service models. Increasing attention has been paid to the need to improve the accessibility and cultural sensitivity of mainstream health and welfare services to people from ethnic minority backgrounds. Many strategies to this end have been proposed. These include community education, greater use of interpreters, training for health professionals (both as part of under-graduate curricula and post-employment professional development), better links with ethnic communities, the involvement of ethnic communities in service planning and evaluation, and the employment of bilingual/bicultural staff

While the employment of bilingual/bicultural staff has been seen as a key strategy, both in Australia and overseas, there is comparatively little research into its effectiveness. Some of the findings of this research are inconclusive, and no research has been conducted in Australia into the effectiveness of employing bilingual staff in mental health services. An opportunity to examine this area was presented by the establishment of the Bilingual Case Management (BCM) program at community mental health services in the Western Region of Melbourne. Eleven bilingual staff were employed in case management positions in community care teams at the four Area Mental Health Services during 1997. The staff were from psychiatric nursing, occupational therapy, social work and psychology backgrounds. Funding was made available by the Victorian Government Department of Human Services, Mental Health Branch, to conduct an evaluation of this program.

STUDY AIMS

There were two overall aims of this thesis. The first was to examine whether the BCM program in community mental health services was implemented as planned and whether it avoided commonly identified difficulties with bilingual positions. The second was to ascertain whether the BCM program improved service outcomes for clients of NESB.

RESEARCH STRATEGY

The service context for the program is provided in Chapter Two, which provides an overview of the mental health service system in Victoria. The policy context of multiculturalism and mainstreaming is discussed in Chapter Three, which traces the development of Australian multicultural policy, and its application to the human services field. Previous research into mental health service utilisation by ethnic groups is reviewed in Chapter Four and research into the impact of employing bilingual staff is summarised in Chapter Five.

Chapter Six provides a description of the design of the Bilingual Case Management program (BCM), including the local processes leading to its development, and the proposed roles, activities and accountabilities of the bilingual staff.

Chapter Seven describes the rationale, aims and methods used for the six separate studies which comprise this thesis. The first study was an analysis of the effectiveness of case management in mental health services. This study was undertaken because at the start of the evaluation of the BCM program, a Cochrane review into the effectiveness of case management in mental health was released which concluded that there was little evidence that (clinical) case management was effective. Given that a key assumption of the BCM program was that clinical case management was an effective strategy for improving service outcomes for people with serious mental illness, it was important to examine case management effectiveness in some greater depth. The second study was an examination of the implementation of the program and the relationship between its intended and its actual operation. The four other studies each assessed a separate outcome domain, and examined whether outcomes for NESB clients matched to a case manager of the same background were better than those for NESB clients with a case manager of a different ethnic background. The outcomes examined were (i) medication management, (ii) clients' satisfaction with mental health services and their cross-cultural sensitivity, (iii) service utilisation and (iv) improvement in social functioning.

Chapter Eight describes the results of these investigations. A summary of the results and a discussion of their implications is presented in Chapter Nine, and the strengths and limitations of the thesis are discussed.

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CATT	Crisis Assessment and Treatment Team
CCM	Clinical Case Management
CCT	Continuing Care Team
CO.AS.IT.	Comunita Assistenza Italiana (Italian Community Assistance agency)
CPZe	Chlorpromazine equivalent
ESB	English speaking background
GAS	Global Assessment Scale
LOTE	Language other than English
MCAS	Multnomah Community Ability Scale
NESB	non-English speaking background
PRISM	Psychiatric Records Information System Manager
VITS	Victorian Interpreting and Translating Service
VTPU	Victorian Transcultural Psychiatry Unit

1. INTRODUCTION

PROBLEM STATEMENT

Australia is one of the most culturally diverse countries in the world, due in large part to mass immigration following the Second World War (Castles, Kalantzis, Cope & Morrissey, 1990). In 1997, Australia had a population of 18 million people of whom 4.3 million people (23 percent) were born overseas. (Australian Bureau of Statistics, 1998). People born in non-English speaking countries (2.8 million people) comprised approximately 15 percent of Australia's population. This percentage is larger in the main capital cities where most migrants have settled: 28.5 percent of Melbourne's adult population (aged 15 and over) were born in non-English speaking countries (Australian Bureau of Statistics, 1998).

People from ethnic minorities in Australia experience mental health problems at the same rate as the rest of the Australian population but face a range of problems in receiving help from mental health services. Previous research shows that ethnic communities have lower population rates of admission to psychiatric hospitals, (especially for those groups with less English proficiency or which are more 'culturally distant' from the mainstream), similar or longer length of hospital stay, and inadequate access to interpreters in hospital. In the community setting, ethnic minority clients have lower population rates of utilisation, lower duration of contact, and higher rates of premature termination. Although the results are mixed, some research suggests that outcomes from treatment for ethnic groups may be worse than for the majority population.

Ethnic minorities face a range of barriers or difficulties in gaining access to and using mental health services. These include: differing explanatory models of illness and treatment, greater stigma about mental illness, lack of knowledge of services, communication difficulties due to language barriers, greater responsibility taken for caring by family, a restricted range of treatment options for those who do not speak English, and culturally dissonant treatment and service models. Increasing attention has

been paid to the need to improve the accessibility and cultural sensitivity of mainstream health and welfare services to people from ethnic minority backgrounds. Many strategies to this end have been proposed. These include community education, greater use of interpreters, training for health professionals (both as part of under-graduate curricula and post-employment professional development), better links with ethnic communities, the involvement of ethnic communities in service planning and evaluation, and the employment of bilingual/bicultural staff

While the employment of bilingual/bicultural staff has been seen as a key strategy, both in Australia and overseas, there is comparatively little research into its effectiveness. Some of the findings of this research are inconclusive, and no research has been conducted in Australia into the effectiveness of employing bilingual staff in mental health services. An opportunity to examine this area was presented by the establishment of the Bilingual Case Management (BCM) program at community mental health services in the Western Region of Melbourne. Eleven bilingual staff were employed in case management positions in community care teams at the four Area Mental Health Services during 1997. The staff were from psychiatric nursing, occupational therapy, social work and psychology backgrounds. Funding was made available by the Victorian Government Department of Human Services, Mental Health Branch, to conduct an evaluation of this program.

STUDY AIMS

There were two overall aims of this thesis. The first was to examine whether the BCM program in community mental health services was implemented as planned and whether it avoided commonly identified difficulties with bilingual positions. The second was to ascertain whether the BCM program improved service outcomes for clients of NESB.

RESEARCH STRATEGY

The service context for the program is provided in Chapter Two, which provides an overview of the mental health service system in Victoria. The policy context of multiculturalism and mainstreaming is discussed in Chapter Three, which traces the

development of Australian multicultural policy, and its application to the human services field. Previous research into mental health service utilisation by ethnic groups is reviewed in Chapter Four and research into the impact of employing bilingual staff is summarised in Chapter Five.

Chapter Six provides a description of the design of the Bilingual Case Management program (BCM), including the local processes leading to its development, and the proposed roles, activities and accountabilities of the bilingual staff.

Chapter Seven describes the rationale, aims and methods used for the six separate studies which comprise this thesis. The first study was an analysis of the effectiveness of case management in mental health services. This study was undertaken because at the start of the evaluation of the BCM program, a Cochrane review into the effectiveness of case management in mental health was released which concluded that there was little evidence that (clinical) case management was effective. Given that a key assumption of the BCM program was that clinical case management was an effective strategy for improving service outcomes for people with serious mental illness, it was important to examine case management effectiveness in some greater depth. The second study was an examination of the implementation of the program and the relationship between its intended and its actual operation. The four other studies each assessed a separate outcome domain, and examined whether outcomes for NESB clients matched to a case manager of the same background were better than those for NESB clients with a case manager of a different ethnic background. The outcomes examined were (i) medication management, (ii) clients' satisfaction with mental health services and their cross-cultural sensitivity, (iii) service utilisation and (iv) improvement in social functioning.

Chapter Eight describes the results of these investigations. A summary of the results and a discussion of their implications is presented in Chapter Nine, and the strengths and limitations of the thesis are discussed.

2. MENTAL HEALTH SERVICES IN VICTORIA

INTRODUCTION

As described in Chapter One, the BCM program was implemented in community mental health services in Melbourne. To place the program in the context of the larger psychiatric service system, this chapter describes the structure of mental health services in Victoria. It includes a description of recent policy developments at Commonwealth and State level, the target group for services, and the main elements of public adult mental health services. As the title 'Bilingual Case Management Program' implies, the staff were employed in case management positions – the latter part of this chapter briefly describes case management in mental health and previous research into its effectiveness.

THE CONTEXT OF SERVICE PROVISION

Psychiatric services operate within the context of deinstitutionalisation, which has occurred in many fields (mental health, intellectual disability, corrections and others) over the past thirty years. In mental health, the move from hospital to community-based care is often ascribed to the introduction of major tranquillisers in the 1950's which had unprecedented success in controlling symptoms of psychotic conditions (Dax, 1992; Mechanic, 1995). More effective medications allowed people with a mental illness, who would previously been hospitalised, to live independently outside of institutions. In contrast, Scull (1989) argued that the primary cause of deinstitutionalisation was a need on the part of governments to control sharply increasing health expenditure while cloaking this in the language of reform. Scull argued that:

‘the primary value of that rhetoric ... seems to have been its usefulness as ideological camouflage, allowing economy to masquerade as benevolence and neglect as tolerance.’ (Scull, 1989, p. 152)

As studies in the USA and Australia have shown, deinstitutionalisation initially left the needs of a large number of people with psychiatric conditions unmet (Mechanic, 1995). For example, one Victorian study found that approximately 50 percent of homeless people had a current diagnosable psychiatric disorder (Herrman, McGorry, Bennett, van Riel & Singh, 1989). During the 1980’s it appeared that financial concerns were indeed a major driving force during a period of downsizing of the welfare state (Garton, 1988).

However, mental health policy did, albeit belatedly, start to come to terms with deinstitutionalisation. There was substantial policy development in Australia during the 1990’s, with the entry of the Commonwealth government to the mental health arena in 1992. Previously, mental health had been solely a State government responsibility, and the Commonwealth had virtually no involvement. The States and the Commonwealth in 1992 agreed to a National Mental Health Strategy aimed to improve services and bring about greater uniformity between the States in relation to legislation, standards of treatment and the range of services available (Australian Health Ministers, 1992).

Part of the reason for the entry of the Commonwealth at this time may well have been the immanent release of the Human Rights and Equal Opportunity Commission inquiry into the human rights of people with a mental illness (Human Rights and Equal Opportunity Commission, 1993). The report of the Commission (commonly referred to as the Burdekin report) was scathing in its criticism of mental health services and drew a great deal of media attention to mental health issues during the latter part of 1993.

In early 1994, the Victorian Department of Health and Community Services released a strategic planning document titled ‘Victoria’s Mental Health Services: the Framework for Service Delivery’ (Department of Health and Community Services, 1994a). This policy, also known as the ‘Frameworks’ document, followed the principles of the National Mental Health Policy. It can also be seen as an attempt by the State government to address the criticisms offered by the Burdekin report.

A major component of the document was an emphasis on expanding the range of services available in each area to include; crisis assessment, community mental health services, mobile intensive care teams (each of which are described below), accommodation and non-government disability support and rehabilitation services.

One of the reasons for the lack of community mental health services in the past has been the difficulty of moving resources away from hospitals. While there may be several reasons for this, a key reason has been that large institutions have been the power base of the major medical professions. Daniel, for example, argued that:

‘Medical practice, like nursing, is closely identified with the hospital and the status of medicine has been firmly tied to the ascendancy of the modern hospital, now the citadel of medical science.’ (Daniel, 1990)

The State government showed some willingness to address the issue of resource redistribution: the Frameworks document stated that by 1997, 50 percent of funding for psychiatric services would be directed to community based services. At the time (1994), the figure was around 24 percent (Department of Health and Community Services, 1994a).

Another major change affecting mental health services was the philosophy of mainstreaming. A central tenet of the National Mental Health Policy, mainstreaming refers to the practice of locating specialist psychiatric services within general hospitals rather than in stand alone institutions. It was argued that this would assist in reducing stigma associated with mental illness by ending the separation between services dealing with physical and mental illness (Australian Health Ministers, 1992). Mainstreaming was implemented in Victoria during 1995, after which most clinical psychiatric services were administratively controlled by general hospitals, excluding psychiatric disability support services, which were mainly run by non-profit community agencies.

TARGET GROUP

Another concern with community mental health services has been the lack of focus on those with serious mental illness (Human Rights and Equal Opportunity Commission, 1993). In an attempt to more tightly focus mental health services, the Frameworks policy stated that the adult public psychiatric system in Victoria would be targeted toward people with a 'serious mental illness' (Department of Health and Community Services, 1994a).

While the meaning of 'serious mental illness' was not defined in legislation, mental health services currently work mainly with people with a diagnosis of schizophrenia or another psychotic disorder, or bipolar affective disorder. The public system does come into contact with people with other diagnoses such as anxiety conditions, personality disorders and depression but these are a small minority. In the services which participated in this study, approximately 70 percent of clients had been diagnosed with schizophrenia, and a further 10-20 percent with bipolar affective disorder or another psychotic condition. Apart from being diagnosed with a psychiatric condition, two other characteristics of most service users are the duration of their conditions, and the disability associated with them. Although some clients are seen for brief treatment, the majority have long-term conditions and receive services for years, and even decades. This also reflects the fact that most are quite severely disabled by their conditions, in terms of inter-personal relationships, daily living skills, social networks, employment and recreation, and financial management (Department of Health and Community Services, 1994a). This is a characteristic of public mental health services internationally (Kanter, 1989 Onyett, 1992).

The dominant paradigm for the treatment of mental illness has become what is commonly referred to as the 'biopsychosocial model'. This model, first proposed by Engel (1977), assumes a biological basis to conditions such as schizophrenia and bipolar disorder, but also considers the influence of psychological and social factors on causation, relapse, treatment, and client functioning. For example, there has been considerable research into the influence of family communication processes and environmental stress on relapse amongst those with schizophrenia (Butzlaff & Hooley,

1998; Onyett, 1992). The primary form of treatment is medication, but there is a recognition that this in itself is insufficient as many symptoms and the disabling impact of the condition are enduring.

ELEMENTS OF VICTORIAN MENTAL HEALTH SERVICES

At the time the study was conducted, public psychiatric services in Victoria were separated by age group of clients (Department of Health and Community Services, 1994a). Child and Adolescent Mental Health Services (CAMHS) generally targeted children and adolescents up to 16 years of age. Adult services targeted those aged between 16 and 60 years of age, and psycho-geriatric services were generally provided to those aged over 60, although some flexibility in these ranges remained. For adult mental health services, which are the focus of this study, three distinct categories of services can be identified: inpatient treatment services, community based treatment services and non-government psychiatric disability support services.

Hospital inpatient units, increasingly located in general hospitals, provided acute care to people with a major mental illness in a crisis or who were potentially dangerous to themselves or others. Approximately half the admissions to these units were involuntary. The average length of stay in these units continues to steadily decline, and was around 14 days in 1999 (North Western Health, unpublished data). There were also a smaller number of long-stay rehabilitation wards, and Community Care Units – group accommodation with 24-hour staffing for people unable to live independently at all.

Community treatment services comprised three type of teams, usually co-located. Crisis Assessment and Treatment Teams (CATTs) were established throughout Victoria during the early 1990's. CATTs were the first point of contact for people with mental illness in crisis, and also had the responsibility for making decisions about admission to psychiatric inpatient units. CATTs provided short-term crisis intervention and referral and generally did not play a long term role for individual clients.

Community Care Teams (CCTs) have been established in Victoria since the mid-1970's. They provided centre-based (and some outreach) individual contact with

medical staff and case managers, and to a far lesser extent, psychotherapy and group-work. Medical services were provided by psychiatrists with five years post-medical degree training, medical officers with medical registration but no specialist training, and psychiatric registrars with medical degrees undergoing the five year psychiatry training course. Case management was provided by psychiatric nurses, psychologists, occupational therapists and social workers.

The third service type were Mobile Support and Treatment Teams (MSTT's), which provided an outreach support service to a relatively small number of clients with severe psychiatric disabilities at greatest risk of readmission (Department of Health and Community Services, 1994a). These teams were explicitly based on the Program of Assertive Community Treatment (PACT) model developed and evaluated by Stein, Test and others in Madison, Wisconsin (Stein & Test, 1980; Test & Stein, 1980; Weisbrod, Test & Stein, 1980). The replication of the model by Hoult and colleagues in Sydney with equally successful results (Hoult, Reynolds, Charbonneau-Powis, Weekes & Briggs, 1983) was also very influential in its establishment in Australia and overseas.

The clinical services described above – inpatient units, Community Care Units, CATTs, CCTs and MSTT's – were combined in Area Mental Health Services (AMHS) managed by public hospitals (and one private hospital). There were 22 such Area Mental Health services in Victoria. There was some variation in management structure, but the four AMHS's included in this study had an area manager responsible for all mental health services in each area, and team managers responsible for inpatient units, CATTs, CCTs and MSTT's.

Finally, psychiatric disability support services were provided by non-government community based services, usually with an elected board of management. These services provided support services such as accommodation, training in daily living skills or communication skills, leisure and recreation activities, employment services and social activities. They did not claim to provide 'treatment' for a mental illness and most of their clients would also attend a continuing care team, a mobile support team, or a private psychiatrist or general practitioner.

CASE MANAGEMENT IN MENTAL HEALTH SERVICES

Case management is a phrase which is used so widely and in so many ways that Rothman and Sager argued that 'it takes on a multifarious and amorphous coloration (Rothman & Sager, 1998, p.15). Thornicroft defined it in broad terms as 'coordination, integration and allocation of individualised care within limited resources' (Thornicroft, 1991, p. 125), which includes ongoing contact with one or more identified key personnel. Rothman and Sager described the key components of case management as: goals which include community living and enhancement objectives; community-based services which have a longitudinal as well as a cross-sectional orientation; and practice which is focussed both on support and skill development for individuals and environmental intervention.

Case management approaches have developed in response to the deficiencies in community care resulting from deinstitutionalisation. These deficiencies included fragmented and disjointed service systems, lack of continuity of care, and a reluctance among some service providers to work with those with the most pervasive disabilities (Rothman & Sager, 1998). Case management programs aim to ensure that a broad range of clients needs are addressed, and to make the range of services more accessible to clients. Case management has been implemented in many mental health services from the early 1980's onwards (Onyett, 1992), initially as discrete programs, but more recently as a guiding principle for community based services.

Kanter (1989) argues that clinical case management in mental health aims to address a person's physical and social environment as well as maintaining a traditional focus on biological and social functioning. Tasks include assessment of social and health needs, planning, identifying and using available resources (both formal and informal) to meet these needs, coordinating overall care plans, and monitoring progress towards agreed goals (Onyett, 1992). In mental health, case managers often also carry out mental state assessment and monitoring, monitoring medication use and side-effects, and provide supportive counselling within a framework of a long-term therapeutic relationship (Kanter, 1989).

In Victoria, a Statewide case management framework was introduced with the Victorian government policy document 'Coordinated Client Care' (Department of Health and Community Services, 1994b). At the time of writing, case management had become central part of adult mental health service delivery, and staff employed in Continuing Care Teams and Mobile Support Teams had case management as their primary treatment orientation.

Although many models of case management in mental health have been proposed (Mueser, Bond, Drake & Resnick, 1998; Solomon, 1992), a distinction is commonly made between individual or clinical case management and assertive community treatment. Marshall and colleagues (Marshall, Gray, Lockwood & Green, 1998; Marshall & Lockwood, 1998) distinguish Assertive Community Treatment (ACT) from other models of case management on several dimensions, including lower caseload, team rather than individual case management, an emphasis on outreach, and an orientation to providing as many services as possible from the ACT team rather than referring to other providers. Arguably, ACT has some elements in common with other forms of case management as well as some unique features.

In Victoria, ACT corresponds most closely to the structure and operation of Mobile Support and Treatment Teams, while clinical case management corresponds to the case management role of staff in Continuing Care Teams (CCTs). The BCM's were employed in case management positions in CCTs and were thus working to a clinical case management model.

THE EFFECTIVENESS OF CASE MANAGEMENT

Numerous reviews of studies of the effectiveness of case management in mental health services have been conducted (Bond, McGrew & Fekete, 1995; Burns & Santos, 1995; Chamberlain & Rapp, 1991; Damron-Rodriguez, 1993; Dietzen & Bond, 1993; Draine, 1997; Dvoskin & Steadman, 1994; Gorey, Leslie, Morris, Carruthers, John & Chacko, 1998; Holloway, 1991; Holloway, Oliver, Collins & Carson, 1995; Mueser, Bond, Drake et al., 1998; Olfson, 1990; Rubin, 1992; Santos, Henggeler, Burns, Arana & Meisler, 1995; Scott & Dixon, 1995; Solomon, 1992; Taube, Morlock, Burns & Santos,

1990; Test, 1992; Torrey, 1986), the majority indicating that case management improves outcomes for clients.

At the start of the evaluation of the BCM program in 1997, findings of a recent Cochrane review emerged which concluded that (clinical) case management ‘approximately doubles the number of hospital admissions with little evidence of causing an improvement in mental state, social functioning or quality of life’ (Marshall, Gray, Lockwood et al., 1998 - this was first released in 1996). These findings called into question the effectiveness of clinical case management. This review was conducted as part of the Cochrane collaboration, a network of researchers dedicated to ‘systematically reviewing the effects of health-care within their areas of interest’ (Mulrow & Oxman, 1997) which is argued by some to provide ‘the highest levels of evidence ever achieved on the efficacy of preventive, therapeutic and rehabilitative regimens’ (Sackett & Rosenberg, 1995, p.623).

However, Marshall and colleagues were able to reach conclusions for only two domains of outcome: they found that case management increased the proportion of clients admitted (although this is also reported as increasing total admissions), but decreased drop-out rates from mental health services (Marshall, Gray, Lockwood et al., 1998). Due to the limitations of this review, others have called for a broader investigation into the effectiveness of case management (Parker, 1997), and it was decided to conduct such an investigation as part of this thesis.

CONCLUSIONS

The difficulties for mental health service provision resulting from deinstitutionalisation have led to a considerable policy and service development in recent years. These have included attempts to more tightly specify the target group for services, the establishment of a greater range of community-based services, and the introduction of case management as the organising framework for community mental health services. The Cochrane review of case management, however raised some questions about the effectiveness of case management, and this led to this issue being considered more closely in this thesis.

As well as the broad changes outlined in this chapter, another feature of health and mental health policy in Australia has been the recognition of the need to address the needs of particular groups, including immigrant communities. These changes reflect the rise of multiculturalism in Australia, and the next chapter provides an overview of this trend, and the ways that multiculturalism has been incorporated into service delivery.

3. MULTICULTURALISM AND HEALTH SERVICES

INTRODUCTION

As foreshadowed at the end of Chapter Two, multiculturalism as a framework for service delivery has come to prominence over the last thirty years. This chapter aims to describe the development and implementation of multiculturalism in Australia. It provides a brief overview of the demographic characteristics of the Australian population, and then discusses the shift from a policy of assimilation to that of multiculturalism. Following this, the chapter describes the change of emphasis from ethno-specific programs delivered by ethnic community agencies to the access and equity approach which stressed access to mainstream health and welfare services for all ethnic groups. Lastly, the chapter considers the application of access and equity approaches to health and mental health services.

IMMIGRATION TRENDS IN AUSTRALIA

Large-scale immigration following the Second World War has significantly changed Australia's population profile, making it one of the most culturally diverse countries in the world (Castles, Kalantzis, Cope et al., 1990). In 1997, Australia had a population of 18 million people of whom 4.3 million people (23 percent) were born overseas. Of the overseas-born, 28 percent were born in the United Kingdom or Ireland, 7.5 percent in New Zealand, 5.9 percent in Italy, 3.8 percent in Vietnam, 3.3 percent in Greece, 3.0 percent in China and the rest in other non-English speaking countries (Australian Bureau of Statistics, 1998).

People born in non-English speaking countries (2.8 million people) comprised approximately 15 percent of Australia's population (Australian Bureau of Statistics, 1998). This percentage was much greater in the large cities of Sydney and Melbourne where most migrants have settled. For example, in 1996, people born in non-English

peaking countries comprised approximately 21 percent of Victoria's and 28.5 percent of Melbourne's population aged 15 and over (Klimidis, Lewis, Miletic, McKenzie, Stolk & Minas, 1999).

With such a diverse population, questions about language and ethnicity have become increasingly important for policy-makers and service providers, especially in the large capital cities.

ASSIMILATION AND MULTICULTURALISM

Since the late 1960's, ethnicity has come to increasing prominence in social policy. In a seminal work, Glazer and Moynihan (1975) argued that ethnicity had come to rival class as a mode of group mobilisation. Martin (Martin, 1978) argues that Jupp's work 'Arrivals and departures' (1966) was the first important study of migrants in Australia. Jupp found that migrants were excluded from decision making processes and that migrants views were neither known nor sought. He concluded that 'For all the apparent influence of Australia's 2,000,000 migrants, they might just as well not exist' (Jupp, 1966, p. 122). Since the mid-sixties, ethnicity has increasingly become the focus of attention for both research and policy. There are at least three major reasons for this trend.

First, the policy of assimilation adopted by post-war governments assumed that migrants of all ethnic backgrounds would abandon their ethnic heritage and become 'Australian', by which was meant an Anglo-Saxon identity with an emotional and cultural attachment to Britain. Glazer and Moynihan (1975) argue that social scientists after the Second World War had assumed that with large scale immigration, ethnic differences would disappear as ethnic groups became assimilated. The continued presence of ethnic groups led to an upsurge of interest from academics from the early 1970's onwards. In reality, migrants maintained separate ethnic identities, and formed community networks and organisations of their own. Some writers argue that the concept of assimilation was in any case merely an advertising ploy developed to sell the idea of large scale non-British immigration to a sceptical public and hostile union movement by a government interested in population growth for both defence and

industrial purposes (Jakubowicz, Morrissey & Palser, 1984). According to this argument, assimilation was never a real goal and was never going to be attained.

The second reason was remigration. The mid to late 1960's also saw increasing attention by both academics and government to the rate of remigration, i.e. immigrants leaving Australia to move back to their country of origin (Martin, 1978). Faced with a large number of social barriers, racism, poor working conditions, and a culturally insensitive service system, migrants became disillusioned and left the country. While the actual rates of remigration were disputed, 'they took on a serious aspect to a government now threatened with a migration shortage' (Martin, 1978, p.31).

Third, and perhaps most importantly, ethnic community agencies (such as CO.AS.IT. in the Italian community and the Australian Greek Welfare Society) began to be established in the late 1960's. These groups actively publicised the difficulties faced by migrants, and lobbied government departments and politicians to support specialist services to ethnic communities. Many migrants joined the Australian Labor Party and a number were successful in gaining parliamentary seats (Jupp, 1993). The potential of an ethnic voting block was promoted strongly. These groups lobbied strongly for the cultural diversity of Australia to be accepted, and for migrants to have the right to retain their ethnic identities, language and culture; i.e. for a policy of multiculturalism.

Multiculturalism in Australia is often associated with the Whitlam Labor government (1972-75) and in particular with that government's first Minister for Immigration, Al Grassby. Under Whitlam, though, there was little clarity about whether the maintenance of ethnic differences were merely being recognised or whether the right to maintain them was also being advocated (Castles, Kalantzis, Cope et al., 1990). A number of writers (Jakubowicz, 1984; Castles, Kalantzis, Cope et al., 1990) argue that while multiculturalism was first espoused publicly by the Whitlam government, little was done in institutional or policy terms until the Fraser Coalition government came to power in 1975.

The Fraser government formally adopted multiculturalism as a policy principle after the release of the review of post-arrival programmes and services to migrants (also known as the Galbally Report) in 1978 (Commonwealth of Australia, 1978). Multiculturalism

according to Galbally was both a recognition and affirmation of cultural pluralism: recognition that Australia was comprised of many distinct cultural groups; and affirmation of the right of these groups to maintain their own cultural traditions and ethnic identities. Jakubowicz (1984) claims that Fraser was anxious to win and keep the support of the ethnic middle class, a group which it was felt wielded a degree of power within ethnic communities and had largely been won over by Labor. Multiculturalism was the strategy to be used to co-opt the ethnic vote. The Galbally Report was to be 'a base point of reference for government policies relating to migrants over much of the following decade' (Castles, Kalantzis, Cope et al., 1990, p. 67).

The Galbally definition of multiculturalism was almost wholly cultural in emphasis. Social problems of migrants were explained in essentially ethnic or cultural terms as opposed to a more structural explanation that located migrants at the bottom of the social and economic ladder, or subject to racism and discrimination. The solution was to fund ethnic agencies to provide services while also encouraging mainstream agencies to better meet the needs of migrants, although the first strategy was the most actively pursued. Although the government did fund ethnic agencies to provide services, this did not mean an overall increase in resources allocated to ethnic groups: as a result of one of the Galbally recommendations, for example, the government abolished the rebates on remittances sent overseas by migrants. The savings from this measure in the 1978, 1979 and 1980 budgets were more than 50 percent greater than the total expenditure on Galbally related programs (Castles, Kalantzis, Cope et al., 1990, p. 68).

ACCESS AND EQUITY POLICY

Following the election of a Federal Labor government in 1983, a new policy definition of multiculturalism emerged. This placed greater emphasis on rights to access to services through the policy of 'access and equity' and is often referred to as 'mainstreaming' (not to be confused with the same term in mental health policy). Jamrozik and Boland (1988) placed multiculturalism firmly in the context of access to mainstream services. They argued that the service sector of the welfare state such as education, health and child-care was critical in developing capacities for production and consumption and that unequal access to these services had been a contributing factor to

the growth of inequality over recent years. Accordingly, multiculturalism had to focus on access to these services and not remain marginalised in special 'migrant units' in order to improve the social and economic position of migrants.

At the national level, the Federal Labor government released a new statement of multiculturalism (Office of Multicultural Affairs, 1989) which stressed access and equity principles and which led to the introduction of 'ethnic access' policy statements for service delivery departments. There was now a choice between the ethnic agency approach and the mainstreaming approach.

New South Wales chose to emphasise the mainstreaming option by requiring all State government departments to draft Ethnic Affairs Policy Statements which would ensure that their services would be accessible to all people regardless of ethnic background and language (Crowley, 1985). Victoria relied more heavily on ethnic community organisations. For example a paper released by the Victorian Ethnic Affairs Commission (Victorian Ethnic Affairs Commission, 1985) acknowledged the need for ensuring access to mainstream services but provided little in the way of strategies or policy to achieve this and instead focused on the important role played by ethnic organisations. Given that the Ethnic Affairs Commission was comprised largely of representatives of ethnic organisations this emphasis was perhaps not surprising. Over time, though, Victoria also adopted the mainstreaming approach.

ETHNIC HEALTH POLICY

Palmer and Short (1989) argue that the principles of access and equity began to be introduced in health policy in New South Wales in the early 1980's. In 1983, the NSW Health Department issued the 'Guidelines to Improve Migrant Access to Hospitals' which was the 'first time that responsibility was placed on the system, not on the individual client.' (Palmer & Short, 1989, p.232). The Victorian Ethnic Affairs Commission and Health Department Victoria (Health Department Victoria, 1988) published a report in the late 1980's documenting the current health issues facing ethnic communities. This paper did not propose any policy initiatives or changes nor any

strategies to overcome the problems of access to services, information and participation in decision making which were identified in the report.

In 1990 the Victorian Labor government established a Ministerial Taskforce on Ethnic Health. This committee produced a background discussion paper again documenting the current problems (Health Department Victoria, 1991) but which included numerous recommendations aimed at improving health service delivery. The recommendations covered; participation of ethnic communities in planning services, training for staff, employment of bilingual staff and clarification of their roles, data and information collection, monitoring and evaluation of health services, increased use of language services (interpreting and translating), and greater health promotion aimed at ethnic communities. One of the major outcomes of the report was the development of a set of policy guidelines: 'Working with people of non-English speaking backgrounds: guidelines for health agencies' (Health Department Victoria, 1992). A report from a national review of health services provided further impetus for the mainstreaming of ethnic health (National Health Strategy, 1993). A study conducted in the mid-nineties, however, showed that the Health Department guidelines had been implemented infrequently in mental health services, suggesting that a renewed approach was necessary (Ziguras, 1997).

In 1996, the mental health branch from the new Victorian Department of Health and Community services released a policy document aimed at improving mental health services for people from non-English-speaking backgrounds (Department of Human Services, 1996), which drew heavily on previous ethnic health policies discussed above. The report summarized current problems of access and quality of care and listed key areas for change, including service planning, interpreting and translating services culturally-sensitive service delivery, access to information, quality assurance, and research. The document included goals and standards that all services were expected to meet in each area. Examples from existing practices were also included as guides to possible strategies that could be implemented.

One of the recommendations was that mental health services facilitate access to services by the involvement of bilingual/ bicultural workers, including strategies aimed at 'using currently employed bicultural workers in a more targeted manner, ... developing

reciprocal relationships to encourage sharing of bicultural staff, ... directly employing bicultural/ bilingual clinical staff.' (Department of Human Services, 1996, p. 21). This policy provided part of the impetus for the development of the BCM program.

CONCLUSIONS

This chapter has shown how policies in relation to immigrants of NESB have developed over the last forty or so years. Assimilation was prevalent in the 1960's but gave way in the 1970's to a version of multiculturalism primarily concerned with recognising and respecting cultural diversity and which emphasised service provision by ethnic community agencies. In the mid-1980's multiculturalism developed a stronger emphasis on improving access to mainstream services, and the 1990's saw significant policy development in the health and mental health fields. These policies aimed to have services adjust their own planning, information gathering strategies, practices, staffing profiles and community education activities to provide greater opportunities for NESB people to gain access to services, and for services to become more culturally relevant. The implementation of the BCM program proceeded from such a policy.

Before considering the BCM program in more detail, it would be useful to examine the particular problems encountered by NESB communities in relation to mental health services, and to review research into this question. This task is taken up in the next chapter.

4. ETHNICITY AND MENTAL HEALTH SERVICES

INTRODUCTION

The last chapter outlined the development of multiculturalism in Australia. A key theme was the increasing emphasis placed on the importance of mainstream services meeting the needs of people of non-English speaking backgrounds. Starting from that broad framework, we need to understand the specific issues in the delivery of mental health services to ethnic minority groups. This chapter begins by discussing conceptualisations of ‘ethnicity’ and the relationship between immigration and mental health status in Australia. It then reviews Australian and overseas research into the provision of mainstream mental health services to ethnic minorities, and concludes with a discussion of these findings.

DEFINITIONS OF ‘ETHNIC MINORITIES’

Before proceeding further, it is necessary to consider how the term ‘ethnic minority’ is used and defined. Jayasuriya, Sang and Fielding (1992) suggest that the term ‘ethnicity’ has been employed in two main ways. Objective approaches define ethnic groups on the basis of observed characteristics such as common language, ancestry, religion or country of origin. Subjective definitions, on the other hand, emphasise an individual’s sense of belonging to a group, leading to the concept of ethnic identity (Phinney, 1990). The concept of race has been used to refer to groups of people distinguishable by biological or genetic differences, but there is now a consensus that such a distinction is not supported by any scientific evidence. ‘Race’ is more often used to refer to ethnic identity based on shared physical features, such as skin colour (Jayasuriya, Sang & Fielding, 1992).

Operational definitions of ‘ethnicity’ or ‘ethnic minority’ in the mental health area vary across countries, and across studies (Minas, 1996). In the United States of America

(USA), it is common to define ethnicity in terms of broad self-ascribed ethnic categories (often also referred to as 'race') such as 'African-American', 'Hispanic-American', or 'Asian-American' (e.g. Ponce & Atkinson, 1989; Cheung & Snowden, 1990; Flaskerud & Hu, 1992; Hu, Snowden & Jerrell, 1992; Atkinson & Lowe, 1995; Malgady, 1996). Some US studies nevertheless examine specific sub-groups – such as countries of origin amongst the Asian-American community, but it is not always clear whether these refer only to the overseas born or also to American-born populations from the same ethnic background (e.g. Atkinson & Gim, 1989; Browne, Fong & Mokuau, 1994; Takeuchi, Mokuau & Chun, 1992; Uehara, Takeuchi & Smukler, 1994). In the United Kingdom (UK), ethnicity sometimes refers to the region of birth of immigrants as in 'Black Caribbean', 'Black African' or 'Asian' (which usually refers to people born in India, Pakistan, Bangladesh and Sri Lanka) (e.g. Brewin, 1980; Birchwood, Cochrane, Macmillan, Copestake, Kucharska & Cariss, 1992; Carpenter & Brockington, 1980; Shaikh, 1985), and sometimes to groups based on ethnic identity such as 'White' and 'Black' (which is sometimes used to refer to anyone of non Anglo-Saxon background) (e.g. Ayonrinde, 1999; Bhugra, 1993; Bhui, Christie & Bhugra, 1995; Callan & Littlewood, 1998; Thornicroft, Davies & Leese, 1999), although this distinction is sometimes made in the USA (e.g. Helms & Carter, 1991; Padgett, Patrick, Burns & Schlesinger, 1994; Pomales, Claiborn & LaFromboise, 1986; Snowden, Storey & Clancy, 1989).

In Australia, ethnicity is usually defined in terms of country of birth of immigrants, and by making the distinction between those born in a primarily English speaking country (including Australia) or a non-English speaking country (e.g. Burvill, Raymond, Stampfer & Carlson, 1982; Castles, Kalantzis, Cope et al., 1990; Eipper, 1983; Jakubowicz, Morrissey & Palser, 1984; Krupinski & Stoller, 1965; Minas, 1990; Minas, Lambert, Kostov & Boranga, 1996; Mitchell, 1989). There are some problems with this definition. People born in the same country do not necessarily share the same ethnicity: this is most obviously true of countries like the former Yugoslavia, where major ethnic groups included Serbs, Croats, Bosnians, Albanians, Slovenians, Macedonians and many others, but it is true of most countries. Vietnam, for example, contains significant Chinese-speaking minorities and tribal groups such as the Hmong. In order to overcome these problems with country of birth, the Australian Bureau of Statistics attempted to

collect data about self-defined ethnicity in one census, but this was abandoned because the results were too inconsistent.

Moreover, many people born in a non-English speaking country (where English is not the major or official language), may speak English well. A more accurate method of determining English proficiency would be to measure this directly. The Australian Bureau of Statistics includes population census questions about fluency in English. This provides more specific data about those who could be considered to be ‘non-English speaking’, but there is some evidence that migrants tend to over-estimate their English proficiency. At least one study has found that of those people who rate themselves as speaking English ‘well’, 41 percent were found to have a level of English at or below the ‘survival’ category of the Australian Language Proficiency Rating scale. This is below the ‘minimum social’ level necessary to have ‘the confidence and ability to establish normal relationships with native speakers’ (Australian Bureau of Statistics, 1978, p. 30).

This discussion highlights some of the complexities involved in operationalising the concept of ethnicity. Several dimensions are present - ethnic self-identity, self-defined membership of an ethnic group, immigrant status, languages spoken, English fluency, and cultural differences – which often but do not always overlap. For example, children born in Australia of migrant parents will usually speak English, have not experienced the migration process themselves, and are likely to be familiar with Australian cultural norms, yet they may still adopt cultural practices or hold cultural values of their parents ethnic group. Are they a part of an ethnic minority or not? In spite of the difficulties with country of birth as an indicator of ethnicity, it does permit broad comparison between groups of immigrants facing language and cultural differences to the mainstream Australian-born population. It is also the most widespread indicator of ethnicity collected by service providers in Australia; other indicators such as ‘preferred language’, ‘English proficiency’, ‘ethnic background’, ‘parents’ birthplace’ and ‘need for an interpreter’ are also used but inconsistently and sporadically.

In this thesis, according to current practice in Australia, the term ‘non-English speaking background’ (NESB) will be used to refer to those born in a non-English speaking

country and English speaking background (ESB) to refer to everyone else (i.e. all Australian-born clients and immigrants from English speaking countries).

While the indigenous peoples of North American and Australia face many of the same issues as those confronting migrants and members of other ethnic communities, there are also significant differences. In Australia, Aboriginal people have been subject to invasion, cultural extinguishment, family separation as a result of government policy, and social exclusion (Reser, 1991). Policies in relation to Aboriginal issues have been developed separately to those dealing with NESB immigrants, partly of these separate concerns and also because migrants have sometimes been seen by Aboriginal people as part of the invasion of their country and therefore part of the problem (Jayasuriya, Sang & Fielding, 1992).

Aboriginal communities have placed more emphasis on providing services through Aboriginal-controlled community health agencies rather than through mainstream health agencies which is now the dominant approach to culturally sensitive service delivery for NESB groups (Reser, 1991). The Victorian Transcultural Psychiatry Unit, which was the organisational auspice of this research, had no mandate (either through its funding agreement or from Aboriginal communities themselves) to include Aboriginal issues in its work. In keeping with this tradition, this thesis does not address the needs of Aboriginal people but focuses on those of immigrant communities, although some of the issues and findings may also apply to indigenous groups.

RATES OF ILLNESS/ DISORDER AMONG ETHNIC COMMUNITIES

A central issue in mental health service research among ethnic groups has been whether NESB people are adequately represented among service users, spurred on by arguments about barriers to access preventing ethnic minorities from gaining access to services in the first place. In order to address the question of under-use of services, it is necessary to know both the proportion of the population using different forms of services, and the corresponding need in each of the communities studied. It has often been assumed,

implicitly or explicitly that need is equivalent across groups, but this has also been questioned.

Odegaard's classic study in 1932 compared admission rates of Norwegian immigrants in the USA with Norwegians in Norway, and with American-born immigrants of Norwegian background, (Odegaard, 1932). Odegaard found a higher rate of admission (and therefore a higher rate of disorder) among migrants in the USA compared to both other groups. Since, it has been argued that ethnic minorities may have higher rates of psychiatric disorder, attributable to stresses experienced during the migration and settlement process (Krupinski, 1984). Although it is beyond the scope of this thesis to consider this issue in any detail, some recent Australian research is reviewed below.

Stuart and colleagues analysed the results of the 1991 National Health Survey conducted by the Australian Bureau of Statistics. This survey of a random sample of the Australian population, via a self-completed questionnaire in English, enquires about health actions (including taking medication and visiting a medical practitioner) in the prior two weeks. Stuart et al. investigated rates of self-reported psychiatric disorder by birthplace of respondents, and found that the proportion of NESB born with a diagnosable mental illness was similar to the Australian-born, although there was some variation by birth region (Stuart, Klimidis & Minas, 1998). Analysis of the use of psychotropic medication from the same survey showed that those from Southern and Eastern Europe generally had higher rates of psychotropic medication use, and those from South East Asia had substantially lower rates.

The Australian Bureau of Statistics conducted the first large-scale epidemiological study of mental illness in Australia in 1997. This study had a randomly selected sample of 10 000 people, who were rated for symptoms of psychiatric disorder by trained interviewers (Australian Bureau of Statistics, 1997). The results showed no difference in the rates of affective or anxiety disorders between the Australian-born and those born in a non-English speaking country, although the countries of birth of the latter group was not described. This study did not examine low-prevalence disorders such as psychosis, which was being investigated in a separate study.

While there is no Australian research comparing the prevalence of psychosis for the Australian population by birthplace, the studies of schizophrenia conducted by the World Health Organisation suggest that the rates in different countries are similar (Jablensky, Sartorius, Ernberg, Anker, Korten, Cooper, Day & Bertelsen, 1992; World Health Organisation, 1979). A working assumption has generally been that the rates of schizophrenia among ethnic groups in Australia are similar to the mainstream population (Minas, Lambert, Kostov et al., 1996). The claim that migrants generally have higher rates of mental illness appears without foundation.

RESEARCH INTO MENTAL HEALTH SERVICE PROVISION TO ETHNIC MINORITIES

This section provides a review of research into mental health service use by ethnic minorities in Australia, the USA, the United Kingdom, and elsewhere. There are limitations in the extent to which research from overseas can be generalised to Australia: although the mental health service systems of each country have much in common (particularly in the move from hospital based to community based services over the last twenty years), they also differ (for example, funding and user charges, types and extent of community services), and these differences make comparisons more difficult (Chisholm, Knapp, Knudsen, Amaddeo, Gaité & van Wijngaarden, 2000).

In spite of these limitations, most of the studies reviewed here make some comparison between people who belong to an ethno-cultural minority group (or groups) and the majority (usually English-speaking) population of the same country. It is assumed that these two groups differ on the key issues of ethnic identity (both self identity and that ascribed by others), cultural norms, practices and values, preferred language, migration and settlement experience and/or racial discrimination.

Psychiatric hospitals

Admission rates

Numerous studies in Australia have found lower rates (per head of population) of admission to psychiatric hospitals for ethnic minority groups compared to the Australian-born population (Bruxner, Burvill, Fazio & Febbo, 1997; Hassett, George & Harrigan, 1999; Klimidis, Lewis, Miletic, McKenzie, Stolk & Minas, 1999; McDonald & Steele, 1997; Minas, Ziguras, Klimidis, Stuart & Freiden, 1995; Stuart, Minas, Klimidis & O'Connell, 1996; Stolk, 1996; Trauer, 1995). Within the overseas born, a common finding has been that Eastern Europeans have higher rates than the Australian born, and most other groups have lower rates, with Asian communities having far lower rates of admission. In Perth, Bruxner, Burvill, Fazio et al. (1997) found that the rates for Southern Europeans had moved towards the Australian-born rate over time.

Similar findings of lower admission rates for migrants have been found in Canada (Morgan & Andrushko, 1977) and Germany (Haasen, Lambert, Mass & Krausz, 1998; Haasen, Lambert, Yagdiran & Krausz, 1997). There is some evidence that ethnic minority admission rates are closer to those of the general population for schizophrenia, but are much lower for non-psychotic disorders (McDonald & Steele, 1997; Morgan & Andrushko, 1977; Stolk, 1996). Morgan & Andrushko (1977) also found lower rates for non-psychotic disorders for more culturally distant groups (measured by proportion of each group speaking their native language at home). These results suggest that immigrants with psychoses have admission rates closer to the general population whereas those with milder conditions are much less likely to be hospitalised.

Results of studies in the USA have been somewhat mixed. One study found that admission rates were higher for 'non-Whites' compared to 'Whites' for the three decades between 1950 and 1980 (Cheung & Spears, 1995), whereas other studies have found no difference in probability of admission. One difficulty is that there appears to be significant variability in the 'non-White' groups. A more consistent finding is that African-Americans have higher rates of admission and use of psychiatric emergency services (Hu, Snowden, Jerrell & Nguyen, 1991; Scheffler & Browne Miller, 1991;

Snowden & Holschuh, 1992), and that Asians and Hispanics have lower rates of admission (Hu, Snowden, Jerrell et al., 1991; Leong, 1994; Matsuoka, Breaux & Ryujin, 1997; Swanson, Holzer & Ganju, 1993).

Padgett and colleagues (1994) found no ethnic differences between Blacks, Whites and Hispanics in admission in a sample of privately insured employees. They argued that this may have been because the people from ethnic minority groups in their sample were more acculturated to mainstream values, and more proficient in English than others in their ethnic communities.

In an interesting study, Snowden & Hu (1997) examined the use of community and in-patient services in two county mental health service systems. One county had implemented extensive minority mental health programs, including many contracts with minority providers to provide care. In this county Latino, Asian and, to a lesser extent African-American clients, made more use of community services and less use of inpatient care than Whites. In the other county, which had done little to address service provision to ethnic minorities, the pattern was reversed - that is ethnic minorities used community services less and in-patient services more than Whites.

In the UK, a consistent finding has been that West Indian and African communities have higher rates of admission per head of population compared to the White British-born population (Cochrane & Bal, 1987; Flannigan, Glover, Feeney, Wing, Bebbington & Lewis, 1994; Flannigan, Glover, Wing, Lewis, Bebbington & Feeney, 1994; Koffman, Fulop, Pashley & Coleman, 1997; Littlewood & Lipsedge, 1981), while Asian communities have similar rates to the White population (Cochrane & Stopes-Roe, 1981; Koffman, Fulop, Pashley et al., 1997).

Explanations for the difference in admission rates between the West Indian, White and Asian populations include arguments that West Indians have higher rates of schizophrenia (Flannigan, Glover, Feeney et al., 1994; Flannigan, Glover, Wing et al., 1994; Littlewood & Lipsedge, 1981) or other psychoses (Cochrane & Stopes-Roe, 1981), and that admission rates are influenced by unemployment levels, and social isolation. For example Harrison, Barrow & Creed (1995) found high correlations between rates of admission and measures of social deprivation in counties in the UK for

schizophrenia but not for other diagnoses. Social and family networks are also considered important and these are stronger in the Asian community than the West Indian community (Thornicroft, Davies & Leese, 1999).

One difficulty with much of this research is that many studies assume equivalent rates of illness or need. One study which investigated this issue directly found that Mexican-Americans were over-represented amongst admissions and that all other ethnic groups (except Cambodians and Laotians) were under-represented (Meinhardt & Vega, 1987). The researchers then conducted a community survey to examine rates of mental illness and found that Whites and non-refugee ethnic Chinese had lower rates of need for services while other ethnic groups had higher rates of need. When taking relative need into account, all ethnic minorities were found to be under-utilising services to a much greater extent than was shown by examining simple population rates.

In summary, Australian research has consistently found lower rates of utilisation of psychiatric hospitals for people from ethnic minority backgrounds, whereas overseas research shows much more heterogeneous results. Some research suggests that under-utilisation may be even greater when community rates of need for services are included in the analysis.

Legal status of admission

Australian studies have generally found that among admitted patients, a higher proportion of NESB immigrants are admitted involuntarily compared to the Australian born (Bruxner, Burvill, Fazio et al., 1997; Hassett, George & Harrigan, 1999; Klimidis, Lewis, Miletic et al., 1999). Klimidis, Lewis, Miletic et al. (1999) for example, found in a sample from Victoria that 59.6 percent of NESB patients were admitted involuntarily, compared to 48.4 percent of Australian born patients.

However when population rates of voluntary and involuntary admissions are examined, NESB communities generally have similar rates of involuntary admission, but far lower rates of voluntary admission compared with the Australian born (McDonald & Steele, 1997; Trauer, 1995). These results suggest that the difference in the proportion of

patients admitted involuntarily is due to the lower rate of voluntary admissions rather than an increased risk of involuntary admission. Trauer concluded that where NESB people have a choice, they stay away from psychiatric hospitals far more than the Australian-born (Trauer, 1995).

Two studies have also highlighted the importance of English proficiency on admission legal status. Stolk (1996) found no difference in legal status by birthplace, but found that people who preferred a language other than English had rates of involuntary admission 2.5 times higher than English speakers. Hassett, George & Harrigan (1999) examined admissions to a psychogeriatric inpatient unit in Melbourne during 1996, and found that NESB patients were more likely to be admitted involuntarily, and that involuntary admissions were more likely amongst patients who required an interpreter than for those NESB patients who did not.

British research has shown that the population rates of involuntary admission are far higher for Black Caribbean community (including those born in the UK) compared with the White community (Bebbington, Feeney, Flannigan, Glover, Lewis & Wing, 1994; Davies, Thornicroft, Leese & al, 1996; Flannigan, Glover, Feeney et al., 1994; Flannigan, Glover, Wing et al., 1994; Harrison, Ineichen, Smith & Morgan, 1984; Ineichen, G & Morgan, 1984; Koffman, Fulop, Pashley et al., 1997; McGovern & Cope, 1987; Singh, Croudace, Beck & Harrison, 1998; Thornicroft, Davies & Leese, 1999). Burnett, Mallett, Bhugra, Hutchinson, Der & Leff (1999) found that initial rates of involuntary admission were no different but these differences developed over time with increasing exposure to mental health services. They suggested that the problematic experience of Black people with mental health services, involving racism and discrimination, led to increased involuntary admission rates over time. Generally research has found little difference for Asians in the UK in terms of involuntary admissions (Burnett, Mallett, Bhugra et al., 1999; Koffman, Fulop, Pashley et al., 1997; McGovern & Cope, 1987; Singh, Croudace, Beck et al., 1998).

Explanations for the higher risk of involuntary admission among West Indians include higher rates of schizophrenia among this group (Bebbington, Feeney, Flannigan et al., 1994; Flannigan, Glover, Feeney et al., 1994; Flannigan, Glover, Wing et al., 1994; Harrison, Ineichen, Smith et al., 1984; Ineichen, G & Morgan, 1984; McGovern &

Cope, 1987) greater unemployment and social disadvantage (Burnett, Mallett, Bhugra et al., 1999; Hutchinson & Hickling, 1999), problematic experiences with mental health services (Harrison, Ineichen, Smith et al., 1984; Ineichen, G & Morgan, 1984), racist social stereotypes whereby Blacks are likely to be perceived as dangerous, and poor relationships between Blacks and the police (Hutchinson & Hickling, 1999).

It can be concluded that NESB migrants in Australia are more likely to be admitted involuntarily, mostly because the rates of voluntary admission are much lower for this group compared to the Australian-born. Overseas research suggests that some ethnic groups' negative experiences of mental health services, including perceived racism, may contribute to the development of higher rates of involuntary admission over time.

Length of stay

Australian research into ethnic differences in hospital length of stay has produced varied results. Some studies show that NESB groups have a longer average length of stay (Falconer & Ziguras, 1994; Klimidis, Lewis, Miletic et al., 1999; Minas, Ziguras, Klimidis et al., 1995; Trauer, 1995). In Trauer's study, the median length of stay for NESB patients was 46 percent greater than for ESB patients. However other studies have found no difference in length of stay (Hassett, George & Harrigan, 1999; Klimidis, McKenzie, Lewis, Minas & Renzaho, in press; McDonald & Steele, 1997; Stolk, 1996). While it is difficult to reconcile these results, it is possible that ethnic differences in hospital length of stay are moderated by differences between ethnic groups, by English ability, or service differences.

North American research has generally shown little effect of ethnicity on length of stay in hospital (Hu, Snowden, Jerrell et al., 1991; Padgett, Patrick, Burns et al., 1994; Temkin-Greener & Clark, 1988), although one study in Canada found that immigrants in general tended to have longer length of admission (Morgan & Andrushko, 1977).

In summary, while some research suggests longer length of hospital stay for NESB patients, this is subject to debate. In spite of this Minas, Ziguras, Klimidis et al. (1995) computed that the longer length of stay for ethnic communities found in their study

resulted in an additional cost to the State government of between \$2.7M and \$6.0M per year.

Community mental health services

Utilisation rates

Studies conducted in New South Wales (McDonald & Steele, 1997) and Victoria (Klimidis, Lewis, Miletic et al., 1999; Minas, Ziguras, Klimidis et al., 1995; Stolk, 1996) consistently show that migrant groups in Australia under-utilise community mental health services. One of the most recent studies (Klimidis, Lewis, Miletic et al., 1999) analysed psychiatric service use in Victoria by country of birth for the 1995/96 financial year. This study found lower rates of adult community mental health service use by NESB people, particularly by Asian and South East Asian communities. This under-utilisation was more pronounced when comparing non-English speakers to English speakers. In New Zealand, Cheung & Spears (1995) analysed service use by Cambodians living in Dunedin, and also concluded that this group under-utilised psychiatric services.

While there is less research into non-government services, one study of psychiatric disability services in the Western region of Melbourne found that NESB people were under-represented compared to the Australian born in clients per head of population (Ziguras, 1993).

Some studies have found that there is a strong relationship between rates of hospital admission and rates of community mental health service utilisation: ethnic groups with low rates of hospital admission also have low rates of community mental health service use (Klimidis, Lewis, Miletic et al., 1999; McDonald & Steele, 1997). When analysed by country of birth, the difference between English speakers and those speaking a language other than English is even more pronounced. These findings suggest that some features that vary across ethnic groups may be responsible for differential service use. English language ability of the community seems the most salient factor, but this is

correlated with other important variables such as length of time resident in Australia, degree of acculturation, amount of knowledge of services and social isolation.

There is also consistent evidence from the US that ethnic minorities under-use community mental health services. Many studies have reported findings of lower use by ethnic groups including African Americans (Gallo, Marino, Ford & Anthony, 1995; Meinhardt & Vega, 1987; Padgett, Patrick, Burns et al., 1994; Snowden, 1999), Hispanics (Hough, Landsverk & Karno, 1987; Padgett, Patrick, Burns et al., 1994), Asians and Pacific Islanders (Leong, 1994; Matsuoka, Breaux & Ryujin, 1997), and ethnic minorities generally (Meinhardt & Vega, 1987; Scheffler & Browne Miller, 1991; Temkin-Greener & Clark, 1988). In the case of African-Americans, the under-utilisation is not likely to be due to language barriers, so researchers have pointed to other factors such as cultural differences in help-seeking, and discrimination (Meinhardt & Vega, 1987; Padgett, Patrick, Burns et al., 1994; Snowden, 1999).

In summary, the available research suggests that ethnic communities in Australia under-use community mental health services, and that the communication barrier due to limited English proficiency is likely to be a major contributor to this under-utilisation.

Quality of care

Do NESB people receive the same quality of care as the Australian-born? Difficulties with communication, cultural differences and ethno-centrism of some service providers and treatment models suggest that the quality of care for NESB people may be inferior. Measuring quality of care is a difficult process, and there has been relatively little research into quality of care for ethnic groups. In this section research into indicators of quality will be reviewed; provision of interpreters, amount of time clients spend with service providers, staff views about quality of care, rates of premature termination, use of emergency services, client and family satisfaction and clinical outcomes.

Access to interpreters

The provision of interpreters in mental health services is obviously important, given the communication barriers facing clients who are not fluent in English. Two reports (Falconer & Ziguras, 1994; Minas, Ziguras, Klimidis et al., 1995) analysed interpreter use in Victorian psychiatric hospitals and found that patients with poor or no English had access to an interpreter an average of only once per week. Another, and probably more accurate, study found far less use of interpreters but reported a significant increase in interpreter use after the introduction of a ward policy for interpreter use, training for staff, and greater monitoring of interpreter bookings (Stolk, Ziguras, Saunders, Garlick, Stuart & Coffey, 1998).

Trauer found a lower than expected rate of use of interpreters in two community mental health services in Melbourne (Trauer, 1995), and Stolk (1996) found that interpreters were booked for only one third of appointments with clients with a preferred language other than English. These studies suggest under-use of interpreters, in both hospital and community based services, raising questions about the adequacy of treatment provided. It could be presumed that difficulties in communication may lead to poorer outcomes for clients not fluent in English.

Contact with services

A crude measure of quality is the amount of contact clients have with service providers. One Australian study found that NESB clients had significantly fewer contacts than the Australian born (Stolk, 1996), but others show no ethnic differences in the number of contacts with services once the first contact has been made (McDonald & Steele, 1997; Klimidis, McKenzie, Lewis et al., in press; Trauer, 1995) or in time between contacts (Klimidis, McKenzie, Lewis et al., in press).

Two other American studies have reported ethnic differences in amount of service use. Both Temkin-Greener & Clark (1988) and Padgett, Patrick, Burns et al. (1994) found that Blacks and Hispanics had significantly lower mean number of visits per year than Whites in community mental health services. Padgett, Patrick, Burns et al. concluded

that their results showed a 'clear pattern of lower use by Blacks and Hispanics compared with Whites' (1994, p.225). Other American (Klinkenberg & Calsyn, 1997) and British research (McGovern & Hemmings, 1994; McGovern, Hemmings, Cope & Lowerson, 1994), though, has shown no ethnic differences in number of treatment sessions.

It would be expected that NESB clients would have longer average duration of contact with service providers; at least some of these clients have language difficulties requiring an interpreter and interpreted interviews generally take more time. However, two studies show that NESB people in fact have less duration of contact (Stolk, 1996; Trauer, 1995). Stolk also found that NESB people less likely to see an allied health staff member, and more likely to see a doctor.

Staff opinions

Another indicator of service quality are the opinions of staff. Minas, Stuart & Klimidis (1994) surveyed staff working in public psychiatric services, and asked respondents to rate the quality of services provided to, and clinical outcomes for, clients born in Australia compared to those born in a non-English speaking country. A majority (58.8 percent) of staff thought that services to the Australian born were good or very good quality but only 19.3 percent thought that NESB clients received this standard of care. Conversely, 8.5 percent felt that Australian-born clients received poor or very poor standard of services, but 49.9 percent believed that NESB people received services of this quality. In terms of clinical outcomes, 53.8 percent of staff thought that clinical outcomes for NESB clients were worse than for Australian-born clients, but only 2.7 percent thought that outcomes for NESB clients were better than for the Australian-born. This study also points to a lower standard of care provided to ethnic groups.

Rates of premature termination

The rate of premature termination, or drop-out, is usually defined as the percentage of clients failing to return to the service despite the clinician's belief that they still require treatment (Reis & Brown, 1999). It provides an indication that clients may see the

service as inadequate or not meeting their needs. Only one Australian study has examined drop-out rates from mental health services, albeit indirectly. Klimidis, McKenzie, Lewis et al. (in press) found that the number of contacts and amount of time between contacts did not differ between NESB and Australian-born clients, suggesting that NESB clients were not more likely to drop-out prematurely.

However, overseas research suggests that premature termination by ethnic minorities is a common occurrence across a range of mental health services. American studies conducted in the 1970's showed that ethnic minority groups had higher rates of premature termination than Whites (Andrulis, 1977).

In a groundbreaking study of utilisation of 17 community mental health services in Seattle, (Sue, 1977) found that ethnic minorities had poorer outcomes as measured by premature termination rates. O'Sullivan, Peterson, Cox & Kirkeby (1989) repeated this study in the same services 10 years later. In the intervening period, ethnic-specific mental health centers had been developed in the black, Hispanic, native American and Asian communities. There had been an increase in the number of professionals who were members of these groups, and some efforts had been made to encourage and fund culturally relevant treatment modalities. The results showed a dramatic decrease in drop-out rates for ethnic minorities compared to those found 10 years earlier (from 52 to 12 percent for Asians, from 52 to 22 percent for Blacks, and from 30 to 18 percent for Whites).

Kazdin, Stolar & Marciano (1995) examined factors which predicted dropping out from mental health treatment for children and families, and found that Black families dropped out of treatment at a greater rate and earlier in treatment. Blacks were more disadvantaged on socio-economic indicators, but after these were controlled for, the differences in drop-out rates were maintained. Reis & Brown (1999) reviewed research into drop-out rates from psychotherapy, and concluded that low socio-economic status and ethnic minority status were the only two consistent predictors of early termination.

This body of research implies that premature termination may well be a concern for NESB clients in Australia.

Use of emergency services

The use of crisis or emergency services can be considered as another indicator of service quality. Some American research has found that African Americans tend to use emergency services more than Whites, but that there is no difference for other ethnic groups (Hu, Snowden, Jerrell et al., 1991; Snowden & Holschuh, 1992), but this may be confounded with clinical and sociodemographic factors. Snowden (1999) for example found that African Americans were more likely to use emergency care but this disappeared after controlling for socio-demographic and clinical differences.

Satisfaction with services

Measuring client satisfaction is a recent phenomenon in mental health services research. Comparatively less research has been conducted into ethnic differences in satisfaction.

McGovern & Hemmings (1994) investigated satisfaction with a number of different domains of health care among second generation Afro-Caribbeans and their relatives and white British patients and relatives. Interviews were conducted between five and ten years of the person's first admission. All patients were diagnosed with schizophrenia. Black patients and relatives were slightly less satisfied on the global satisfaction score and all but one of the individual domains but these differences were not statistically significant. Open ended interviews were also conducted, and the authors concluded that 'many black patients and relatives view the service as racist' (McGovern & Hemmings, 1994, p. 125), but could not explain why the level of satisfaction was similar in spite of these beliefs. Two possibilities were discussed: First, other aspects are more important in overall satisfaction and racism is tolerated because it is less important. Second, Blacks may expect inferior care to Whites, and Whites may not represent a valid point of comparison for evaluating care – i.e. satisfaction was partly related to expectations.

Another study in the UK also reported a common perception among Black patients (55 percent) of racial discrimination (Hutchinson & Gilvarry, 1998) and that second generation Black patients were more likely than any other group to express a preference for a case manager of the same ethnic background.

Leavey, King, Cole, Hoar & Johnson-Sabine (1997) assessed satisfaction by interviewing fifty-nine patients and their relatives one year after their first contact with a psychiatric service. The most prominent areas of dissatisfaction amongst patients and relatives were a lack of information about the illness, that too little time was spent by doctors and nurses talking to patients and families, and that not enough information about what to do in the event of another crisis was provided. Patients born overseas were significantly more satisfied in each of the four domains examined than those born in Britain. No differences were found between Black (including second generation patients of West Indian and African origin) and other patients, but there was a non-significant trend for Black relatives to be less satisfied overall ($p=0.1$). Black relatives also reported less assistance in finding community care services, and less participation in the patient's treatment program. The authors argued that 'those patients born abroad, including refugees, were from countries with poor or non-existing welfare services. Higher satisfaction scores in this group may be a reflection of lower expectations about service provision than in the British-born groups.' (p. 56).

Parkman, Davies, Leese, Phelan & Thornicroft (1997) interviewed a random sample of all people identified with a psychosis living in South London in 1993-93, and analysed differences in global satisfaction between Black Caribbeans (overseas and British-born) and Whites (overseas and British-born). The comparison of Black versus White groups showed no difference in satisfaction, but when birthplace was included, the Black UK born were less satisfied than the other three groups. This study concluded that there is a difference in satisfaction by ethnicity, the pattern of which becomes more apparent when the groups are distinguished between those born in the UK and those born overseas. It was suggested that Blacks born overseas had lived and worked under more favourable economic circumstances in the UK, while the UK born Blacks had experienced economic dislocation, were more likely to be unemployed and were marginalised from mainstream society (presumably including mainstream mental health services).

Callan & Littlewood (1998) interviewed 19 white and 62 black patients about satisfaction with services and their explanatory models of illness. They found no ethnic differences in 'overall' satisfaction Of patients with explanatory models broadly in

agreement with the medical model, all were satisfied (those answering 'a bit' or 'very' satisfied), whereas for those with divergent explanatory models, 79 percent were satisfied. The authors pointed out that the sample of black patients may not have been that culturally different – 41 percent were of European origin and 21 were born in UK, but suggested that explanatory model was a more important factor in determining satisfaction with treatment than ethnicity.

In the USA, Zane, Enomoto & Chun (1994) found that Asians in the USA were less satisfied with treatment in an outpatient clinic compared with White Americans, while some anecdotal evidence from an Australian study points to dissatisfaction among NESB patients. In the Royal Park Ethnic Health Audit, (Falconer & Ziguras, 1994) clients reported a lack of information, difficulty in communicating with staff and some dissatisfaction with a lack of family involvement in their care while in hospital. Some clients with poor English stated that the only person they could communicate freely with was a cook or gardener who spoke their language and they felt that these staff had been more understanding and helpful than any of the mental health professionals.

No clear ethnic differences in satisfaction emerge from the studies examined, although some may have lacked power to detect differences in satisfaction due to small sample sizes. There is some evidence that second generation Black Caribbean clients and their families may be less satisfied with mental health services in the UK. Many Blacks felt that service providers were racist, suggesting that this is a cause of lower satisfaction among the second generation, rather than language and communication difficulties or cultural differences. On the other hand, some studies showed that overseas born clients were more satisfied with services than the native born; it has been argued that these clients were more satisfied because their expectations of services generally were based on their countries of origin, where health and welfare services were much less common.

Clinical and social outcomes

Three studies have assessed differences in clinical outcome by ethnicity (others have explored this issue in relation to ethnic matching, but these will be discussed later).

Uehara, Takeuchi & Smukler (1994) studied public mental health services in King County USA, in order to compare level of community functioning of (i) Whites against Asians as a group, (ii) Whites against subgroups of Asians (Japanese, Chinese, Vietnamese, Laotian and Filipino), and (iii) Asian groups against each other. English language was a significant predictor of outcome ($\beta=-0.10$, $p<0.001$), with those less proficient in English having more difficulty in social functioning. Asians as a group had better social functioning than Whites, but when examined by Asian sub-group this was only significant for Chinese. Comparison of Asian groups showed that Laotians had more difficulty functioning than Chinese after controlling for physical symptoms and psychiatric symptoms, but there was no difference between other Asian groups. The authors argued that the Chinese were primarily immigrants while Laotians included mostly refugees, and refugees would have experienced extraordinary stressors including war-related trauma and its sequelae, which most other immigrants would not. The major limitation of this study though, is that it does not assess change over time, and so cannot be seen as an indicator of outcome from mental health services.

Jerrell & Wilson (1996) examined differences in outcomes in three dual diagnosis services for 40 non-white clients (26 Hispanic, 8 African-American, 3 Asian-American and 3 Native American) and 92 white clients in the USA. Outcomes were global psychosocial functioning, social adjustment, and cost of service provision. Although the mean functioning scores for non-Whites were lower at the six month follow-up, there was no difference in change in functioning between the two groups from baseline to follow-up. There was also no difference in the total cost of service. White clients received a greater number of supportive services (case management, supportive housing and day service programs). Researchers also conducted interviews with clients, allowing more open-ended comments. Non-white clients said they had inadequate community and family supports, mostly due to a lack of understanding of their conditions. A major conclusion of this research was that non-white clients received fewer supportive intervention services although they, and their clinicians believed that they experienced more problems in psychosocial functioning.

Zane, Enomoto & Chun (1994) found that Asian-Americans had poorer self-reported outcomes after treatment compared to Whites and that there was a tendency for therapists to rate Asians as having poorer psychosocial functioning.

Summary of service quality

This review of research provides evidence that quality of service provision to ethnic minorities is inferior, at least by some measures. Interpreters are not provided as often as needed, especially in in-patient units, and staff believe that NESB clients have poorer quality care. There is little difference in number of contacts with service providers but overall duration of contact is less, when it would be expected to be greater. Overseas research suggests that NESB people may have higher rates of premature termination, and possibly greater contact with emergency services. There is little Australian research into satisfaction or clinical outcomes. Research conducted elsewhere demonstrates inconclusive results, with some studies finding that ethnic minority clients have lower satisfaction or poorer outcomes, some finding no ethnic differences on these domains, and at least one study finding that overseas born patients may be more satisfied than the native born.

DIFFICULTIES FACING ETHNIC COMMUNITIES IN RELATION TO MENTAL HEALTH SERVICES

The primary group of interest in this thesis are immigrants to Australia born in non-English speaking countries. To discuss the social and psychological impact of immigration in any detail is beyond the scope of this thesis, but Rogler (1994) has usefully highlighted three of the major issues; change in social networks, change in socio-economic status, and change in culture. The process of immigration means leaving established family and friendship networks behind, and many migrants face a period of social isolation when they first settle in a new country. Moreover, for many migrant women, traditional roles as homemakers can diminish opportunities for social contact. Second, many migrants face difficulties in gaining employment upon settlement, and language barriers and problems in having qualifications recognised mean that their employment is often at a lower level than in their country of origin. Third, immigrants are exposed to cultures with values, beliefs and norms often very different from their own, and the resulting psychological dislocation has been referred to as 'culture shock' (Oberg, 1960).

Refugees face particular problems. Many recent refugees to Australia have come from more 'culturally distant' societies. The major refugee groups over the last twenty years have come from South East Asia (mostly Vietnam and Cambodia following the end of the Vietnam war), from the former Yugoslavia following the break-up of that country during the early 1990's, and more recently from the Horn of Africa (e.g. Somalia, Ethiopia, Eritrea) and the Middle East (e.g. Iraq, Iran, Afghanistan) (Department of Immigration and Multicultural Affairs, 1999). These refugees face much greater cultural differences with the mainstream Australian community, compared to immigrants from the United Kingdom and Europe (Jayasuriya, Sang & Fielding, 1992).

More significantly, refugees have experienced significant trauma associated with war, loss of loved ones, flight, refugee camps, resettlement and family separation (Silove, Tarn, Bowles & Reid, 1991; Zane, Hatanaka, Park & Akutsu, 1994). Many refugees have been victims of torture, and are at increased risk of psychological problems, specifically post-traumatic stress disorder, but also a range of other psychological and physical health problems (McGorry, 1991).

Many writers have argued that ethnic minorities generally face significant barriers in gaining access to specialist mental health services (for example, Dalrymple, O'Doherty & Nietzsche, 1995; Hu, Snowden & Jerrell, 1992; Rhi, Ha, Kim, Sasaki, Young, Woon, Laraya & Yanchun, 1995; Wen, Goel & Williams, 1996; Yamashiro & Matsuoka, 1997). These are discussed below.

Explanatory models of illness - which include beliefs about causes, onset, prognosis and cure of illness, and the roles and behaviour of healers - vary across cultures (Kleinman, 1980). For example, meta-physical and magical explanations for illness or distress are common in some countries (Lien, 1991; Murdock, Wilson & Frederick, 1978). People from ethnic minority backgrounds living in developed Western countries may have very different conceptions of illness to the broad biopsychosocial model (Engel, 1977) held by mainstream health professionals. Two consequences are that NESB people may be less likely to identify symptoms as mental illness (Kleinman, 1980; Li, Logan, Yee & Ng, 1999), and more likely to seek help from lay therapists in preference to mainstream

services (Callan & Littlewood, 1998; Cheung & Spears, 1995; Lam & Kavanagh, 1996; Morgan & Andrushko, 1977).

Ethnic community workers routinely assert that the stigma attached to mental illness is greater in ethnic communities, and there is some research to support this view (Fan, 1999; Takeuchi, Leaf & Kuo, 1988; Whaley, 1997). This stigma may make it more difficult for those experiencing mental health problems to admit to them, either to themselves, their families or to health professionals, for fear of censure from members of their community. As ethnic communities are often small, and the social networks of migrants diminished, this fear may become more potent.

There is evidence that some ethnic groups are less predisposed to disclose mental health problems (Chen, 1995; Zhang, Snowden & Sue, 1998) compared to Anglo-Saxon groups. This may be due to greater stigma, but may also reflect general cultural norms about the verbalisation of suffering.

Collective cultures emphasise interdependence more strongly than independence. This often means that families take greater responsibility for caring for those with an illness (Hofstede, 1984; Hofstede, 1990; Lam & Kavanagh, 1996; Lin, Inui, Kleinman & Womack, 1982; Minas, 1988), and may be reluctant to seek help from a service provider because this may indicate an inability to fulfil cultural expectations about family responsibilities.

People experiencing an illness usually turn to general practitioners (GP's) as the first source of help. However, GP's appear less likely to identify mental illness among minority groups, perhaps because of a higher degree of somatic expression in some groups, and are less likely to refer NESB people to specialist mental health services (Commander, Sashi Dharan, Odell & Surtees, 1997a; Commander, Sashi Dharan, Odell & Surtees, 1997b; Flaskerud & Hu, 1994; Ford et al., 1995; Gallo, Marino, Wilson & Maccarthy, 1994; Harrison, Ineichen, Smith et al., 1984; Ineichen, G & Morgan, 1984; Rwegellera, 1980).

Migrants have less knowledge of services available, including mental health services (Bhugra & Bhui, 1997a; Bhugra & Bhui, 1997b; Lefley, 1984; Minas, Lambert, Kostov

et al., 1996; Takeuchi, Leaf & Kuo, 1988). Their opinions about mental health services may be based on their knowledge or experience of such services in their countries of origin. Lien, for example, wrote that many Vietnamese migrants identified mental health services with very large and isolated institutions where patients were housed in their hundreds in huge dormitories, and routinely chained to their beds (Lien, 1991). In such circumstances, individuals or families may be very reluctant to seek help from services.

There are also significant language barriers which must be faced when first contacting a service, and these may prevent NESB people from approaching services for help, or from gaining access when they do approach a service (Cheung & Spears, 1995; Minas, 1990; Minas, Lambert, Kostov et al., 1996; Stuart, Minas, Klimidis et al., 1996; Trauer, 1995). Chung & Lin (1994) have shown, for example, that English language fluency was a significant predictor of use of services by South East Asians in the USA, and Australian research has shown that members of the community who speak a language other than English are much less likely to use mental health services (Klimidis, Lewis, Miletic et al., 1999; McDonald & Steele, 1997). There are also ongoing communication barriers in service provision, due to inadequate interpreter use and a lack of bilingual staff in hospitals and community services (Cheung & Spears, 1995; Minas, 1990; Minas, Lambert, Kostov et al., 1996; Stuart, Minas, Klimidis et al., 1996; Trauer, 1995)

Many clinicians believe that NESB people are more seriously ill when they first enter services. This may be because the factors identified above mean that they delay seeking help from specialist services, and hence have a longer delay between onset of symptoms and obtaining treatment. There is some empirical support for this assertion (Gallo, Marino, Ford et al., 1995; Lin, Inui, Kleinman et al., 1982; Lin, Tardiff, Donetz & Goresky, 1978). In Australia, Lam & Kavanagh (1996) compared pathways to care of 30 Indochinese psychiatric patients with 30 Australian born over a 6 month period in 1993. They found that 18 Indochinese patients used traditional remedies before receiving professional psychiatric treatment but none of the Australian born. Only one Indochinese person had used Western medicine compared with 24 Australian-born. Importantly, Indochinese clients took more than double the time of Australian-born clients to reach psychiatric services after the first illness episode (an average of 51 weeks compared with 21 weeks).

Some writers have argued that racist stereotypes affect some ethnic groups' access to services (Harrison, Ineichen, Smith et al., 1984; Ineichen, G & Morgan, 1984).

Hutchinson & Hickling (1999) argued that police were more likely to be involved in the admission of Black patients in the UK because young black men were stereotyped as dangerous and more likely to come to the attention of police. Klinkenberg & Calsyn (1997) also found that police were more involved in the admission of African-American patients in the USA.

Difficulties in assessing and diagnosing patients from culturally different backgrounds, make misdiagnosis more likely among this group (Bhugra, 1993; Minas, 1990; Bhugra & Bhui, 1997; Flaskerud, 1986; Minas, 1990; Russell, Fujino, Sue, Cheung & Snowden, 1996; Sue, Fujino, Hu, Takeuchi & Zane, 1991; Westermeyer, 1989). These difficulties may be compounded when interpreters are used, due to distortions inherent in the interpreting process (Marcos, 1979; Marcos, Alpert, Urcoyo & Kesselman, 1973). Misdiagnosis, or delayed diagnosis may negatively impact on treatment and outcomes.

There is a restricted range of treatment options for NESB clients. Most self-help groups, family support and education, rehabilitation, and supported accommodation services are only available to those who speak English reasonably well (Jerrell & Wilson, 1996; Minas, Ziguras, Klimidis et al., 1995). There are also cultural values embedded in service models which can make them inappropriate or insensitive. For example, Yip, Yu, Law & Chan (1993) described the introduction of the therapeutic community model in Hong Kong. The English model stressed resident participation and empowerment, decision-making by the resident group rather than by professionals and an unstructured program. Chinese clients, however, found these values to be very foreign, and the program had to be adapted before local clients and families became comfortable with it.

The difficulties identified above suggest that NESB clients may have worse outcomes from treatment, but there appears to be little research into this issue. The higher rates of premature termination discussed above could reflect poorer outcomes. As far as direct research is concerned, (Uehara, Takeuchi & Smukler, 1994) found that those less proficient in English had poorer outcomes, and (Zane, Enomoto & Chun, 1994) reported poorer outcomes for Asians

Conclusions

The research summarised above has shown that ethnic communities have lower population rate of admission to psychiatric hospitals, (especially for those groups with less English proficiency and more 'culturally distant' from the mainstream), similar or longer length of hospital stay, and inadequate access to interpreters in hospital. In the community setting, ethnic minority clients have lower population rates of utilisation, lower duration of contact, and higher rates of premature termination. Although the results are mixed, some research suggests that outcomes from treatment for ethnic groups may be worse than for the majority population.

People of NESB face a range of barriers or difficulties in gaining access to and using mental health services. These include: differing explanatory models of illness and treatment, greater stigma about mental illness, lack of knowledge of services, communication difficulties due to language barriers, greater responsibility taken for caring by family, a restricted range of treatment options for those who do not speak English, and culturally dissonant treatment and service models.

Given these findings, many strategies have been proposed to improve service provision to ethnic groups. The next chapter discussed strategies to overcome these problems, with particular reference to the employment of bilingual staff.

5. BILINGUAL STAFF AND MENTAL HEALTH SERVICES

INTRODUCTION

Chapter Four showed that NESB people experience a range of problems in gaining access to mental health services, and there is evidence to suggest that the quality of service provision to this group is inferior. A range of strategies to improve services to NESB groups have been proposed; the employment of bilingual/bicultural staff is one of the most common. This chapter examines the rationale and conceptual arguments for the employment of bilingual staff, the difficulties identified with such positions and, finally, reviews research into ethnic matching in mental health services.

STRATEGIES TO IMPROVE SERVICES

A range of strategies have been proposed to overcome barriers to psychiatric service use for ethnic communities. These include community education, greater use of interpreters, training for health professionals (both as part of under-graduate curricula and post-employment professional development), involvement of ethnic communities in service planning and evaluation, and the employment of bilingual/bicultural staff (Bhui, Christie & Bhugra, 1995; Department of Human Services, 1996; Health Department Victoria, 1992; Minas, Lambert, Kostov et al., 1996; Minas, Ziguras, Klimidis et al., 1995; National Health Strategy, 1993; Stolk, 1996).

In a review of strategies proposed for the development of culturally-sensitive service delivery, Dana, Behn & Gonwa (1992) found that the two most common recommendations were the establishment of better links with ethnic communities and the employment of bilingual/bicultural staff. Similarly, numerous policy documents and reports in Australia (Office of Multicultural Affairs, 1989; Health Department Victoria, 1992; National Health Strategy, 1993; Department of Human Services, 1996) and

writers overseas (Arredondo & McDavis, 1992; Fong & Gibbs, 1995; Lin, Tardiff, Donetz et al., 1978; Sue, 1977; Sue, Olfson & Pincus, 1994; Sue, 1998; ten Have & Bijl, 1999) have called for the employment of bilingual/bicultural staff in health services as a central strategy to improve access to, and the quality of, services

The Multicultural Victoria Inquiry (1995), for example, recommended that:

‘More bilingual mental health professionals be employed and trained to provide assessments and provide support for other mental health professionals.’ (Victorian Ethnic Affairs Commission, 1995, p. 84)

In 1996, the Psychiatric Services Branch, Department of Human Services, released the policy document ‘Victoria's mental health service: improving services for people from a non-English speaking background’ (Department of Human Services, 1996). The report summarised current problems of access and quality of care and listed key areas for change, including service planning, interpreting and translating services culturally-sensitive service delivery, access to information, quality assurance, and research. The document included standards that all services were expected to meet in each area, and examples from existing practices as guides to possible strategies that could be implemented.

The policy suggested that mental health services facilitate access to services by the involvement of bilingual/ bicultural workers, including strategies aimed at ‘using currently employed bicultural workers in a more targeted manner, ... developing reciprocal relationships to encourage sharing of bicultural staff, ... directly employing bicultural/ bilingual clinical staff.’ (Department of Human Services, 1996, p. 21).

THEORIES OF ETHNIC MATCHING

Given that it is such a frequently proposed suggestion, what is the conceptual basis for the employment of bilingual staff? The key arguments are reviewed below.

Communication

In the Australian literature, the most common argument for employing bilingual staff is that it is the most effective way of overcoming language barriers for immigrants from non-English speaking countries (e.g. Commonwealth of Australia, 1978; Minas, Ziguas, Klimidis et al., 1995; Trauer, 1995; Department of Human Services, 1996; Minas, Lambert, Kostov et al., 1996; Office of Multicultural Affairs, 1989; Minas, 1990; Health Department Victoria, 1992; Silove, Manicavasagar, Beltran, Le, Nguyen, Phan & Blaszczyński, 1997; Stolk, 1996; Stuart, Minas, Klimidis et al., 1996). Lack of a common language is identified as the greatest barrier to service access, and to effective service provision, and being able to communicate in the same language is considered superior to the use of interpreters (Flaskerud, 1986; Sue, Fujino, Hu et al., 1991).

Clients and families also identify improved communication as an important benefit of bilingual staff (Falconer & Ziguas, 1994; Li, Logan, Yee et al., 1999; Takeuchi, Sue & Yeh, 1995). For example, Li, Logan, Yee et al. (1999) found that the main cause of dissatisfaction with health services among Chinese immigrants in the UK was difficulty in communicating effectively, and those interviewed called for greater access to bilingual health professionals.

General understanding of culture

Although many writers highlight the importance of language in terms of communication, most also discuss cultural issues in care. At a general level, these may be differences in terms of etiquette, customs, religious beliefs, family roles, gender roles. Staff from the same ethnic background as clients are argued to be able to better understand these general cultural differences, and minimise cultural misunderstandings (Kagawa-Singer & Chung, 1994; Sue, 1998; Minas, 1990; Sue, Fujino, Hu et al., 1991). Flaskerud (1986) for example, highlighted cultural variations in self-disclosure, and styles of emotional expression.

Cultural differences and assessment

In the context of psychiatry, many writers have highlighted the importance of culture in assessment and diagnosis and the possibility that cultural differences can lead to misinterpretation of symptoms and misdiagnosis (Flaskerud, 1986; Minas, 1990; Minas, Lambert, Kostov et al., 1996; Russell, Fujino, Sue et al., 1996; Sue, Fujino, Hu et al., 1991). Further, when working with clients who do not speak English, the use of interpreters can introduce a range of distortions to the communication process (Marcos, 1979; Marcos, Alpert, Urcoyo et al., 1973), which can lead to errors in assessment, and ineffective treatment. Staff from the same backgrounds are argued to have a key role in ensuring that diagnosis is as accurate as possible. Russell, Fujino, Sue et al. (1996), found that clinicians of the same ethnic background rated clients as having a higher level of functioning compared to clients rated by a clinician from a different ethnic background. They attributed this pattern to more accurate diagnosis by ethnically similar clinicians.

Flaskerud & Hu (1994) discussed the issue of somatization in Asian cultures, suggesting that somatic symptoms may not be recognised by therapists unfamiliar with the culture. They claimed that 'culturally sensitive' treatment for this group would include medication, as the symptoms would be interpreted by clients as reflecting a physical illness rather than a psychological condition.

Shared ethnic identity and identified as being more understanding by clients

Others have highlighted the importance of client ethnic identity in the counselling process. Sue, Fujino, Hu et al. (1991) and Yeh, Eastman & Cheung (1994) argued that shared ethnic background allowed a better rapport to develop, and that clients feel that a counselor from the same background will understand them better. Abreu (2000) found that Mexican American college students had higher expectations of a counselor from the same ethnic background, and expected that the counselor would be better able to identify their feelings, behave more respectfully, and give more encouragement and support. However, this may place unrealistic expectations on counsellors of the same

background. Yeh, Eastman & Cheung (1994) found that language match was significant for Mexicans but not Asians and speculated that this was because physical appearance may be a more salient issue for Asians than a shared language.

Sue, Fujino, Hu et al. (1991) suggested that clients may regard therapists from the same ethnic background as being more attractive, and may be more motivated to remain in counselling as a result, and Flaskerud (1986) suggested that clients from the same background may be more willing to self-disclose.

Sue (1998) argued that the importance of ethnic match may depend on a range of factors related to ethnic identity; the level of acculturation of clients (i.e. that it would be most salient for less-acculturated clients), the ethnicity of clients (that matching would be more relevant to some ethnic groups than others), or to the ethnic identity of clients (that ethnic matching would be more relevant or effective for clients who identify more strongly with an ethnic group).

More compatible explanatory models

Some writers (Flaskerud, 1986; Kagawa-Singer & Chung, 1994; Sue, 1998) suggest that the effect of ethnic matching may be related to shared explanatory models (Kleinman, 1980), with the assumption that staff who are familiar with and perhaps share the explanatory models of clients would be more effective. Sue (1998) reported that research conducted by his group showed that congruence between therapist and client on explanatory models was associated with better treatment outcomes and client satisfaction. 'Shared explanatory model' was defined as shared objectives for treatment, and agreement on means for resolving problems. Sue also stated that an effect for acculturation level of clients was also found, but did not provide any details.

More compatible values and world-view

Kagawa-Singer & Chung (1994) proposed that ethnic matching was really a proxy for shared worldview and values. They argued that definitions of the self, styles of verbal

and non-verbal communication, and therapeutic objectives were also key issues, and that staff who understood and shared the clients values would be more acceptable and more helpful. They assumed that clinicians would share the values of clients from the same background.

However, Mahalik, Worthington & Crump (1999) found that therapists from different ethnic backgrounds tended to share the same worldview, based on Kluckhohn's value dimensions (Kluckhohn & Strodtbeck, 1961). This study suggests that therapists from the same ethnic background as clients will not necessarily share the same values. The authors argued that clients prefer therapists with similar values and that it would be more effective to match therapists and clients on worldviews rather than on demographic characteristics such as race or ethnicity.

DIFFICULTIES IN EMPLOYING BILINGUAL STAFF

Although commonly recommended, several potential or actual difficulties in employing bilingual staff have been noted, and recommendations to increase the number of bilingual staff have been hampered by the lack of a model for the appropriate roles and responsibilities of such staff.

Ayonrinde (1999) has argued that 'Black' patients may associate 'White' doctors with quality care and Black psychiatrists with second class treatment, although why this distinction would be made is not explicated.

Client concerns about confidentiality have also been suggested as a limitation – clients from ethnic minority backgrounds may refuse to see a therapist from the same background because they fear that information about their condition may reach their communities. Similarly, some may be ashamed to see someone from their own culture, and not wish to 'disclose and discuss acts or events which are taboo within their own culture' (Ayonrinde, 1999, p.194). As there is some evidence to suggest that the stigma of mental illness is higher in some ethnic groups, this is a real possibility.

Some writers have also suggested that Black clinicians may be seen as distant from patients 'street culture' because of their education and professional status, and that the presumed similarity in terms of language and cultural knowledge do not really exist in the minds of patients (Ayonrinde, 1999; Musser-Granski & Carrillo, 1997). Similarly, differences within ethnic groups are often overlooked, but differences between clients and clinicians in gender, age, political affiliations and cleavages within refugee communities may all act to undermine the supposed benefits of ethnic matching (Musser-Granski & Carrillo, 1997).

While such concerns have been based on theoretical or anecdotal grounds, research into the actual experience of bilingual staff appears rare. One important study into the employment of bilingual mental health staff was conducted by Mitchell, Malak & Small (1998), who reviewed the roles and activities of staff employed in the Bilingual Counsellor Program in NSW. Most bilingual staff had roles similar to those of other staff in their services, and some additional roles. These were conceptualised along two dimensions – (i) direct provision of services versus service development, and (ii) focus on individual clients versus a focus on communities.

Clinical service provision (direct service provision to individual clients) was similar to that of other staff with two major additions. One difference was that the bilingual staff addressed a broader range of issues which included (as well as those concerned with mental illness) migration and settlement problems, and marital and inter-generational conflict. Bilingual staff felt that clients with a mental illness would be reluctant to seek or accept help for their mental illness until trust was established by receiving help for practical problems. The staff also felt they needed clinical supervision from a professional with experience and sensitivity to the needs of migrants, but that this was rare. Another major difference in direct clinical work was that the bilingual staff believed they provided a more comprehensive service to their NESB clients (compared to Australian-born clients) because cultural barriers and a lack of ethno-specific programs prevented them from getting as much assistance from other services.

Eleven of the 17 bilingual mental health workers did some type of co-work and consultancy with other professionals (service development for individual clients). One difficulty was that there was a tendency for all clients from their ethnic group to be

automatically referred to the bilingual worker. Bilingual staff argued that ongoing co-work was an effective way of enhancing cross-cultural knowledge and skills of monolingual staff, and that this was more effective than traditional, didactic methods. A barrier to co-work, raised by a broad range of respondents, was that the environment focussed on individual casework services and this tended to work against cooperation and mutual support. One team leader said his service was replacing individual case management with team case management because of this.

The most frequent community development activity dealing with individual clients was establishing support groups for people with mental health problems, and a small number of staff conducted programs through ethnic media. Most bilingual counsellors carried caseloads of the same size as other workers, and some were doing their community development work outside office hours. The main problem was insufficient time and resources to carry out these tasks. The most successful projects involved collaboration between several workers. Mitchell et al. argued that a barrier to community work was the low level of community-focussed work in mental health services generally, and that this area was given low value and priority.

Only a small number of staff were involved in organisational service development focussed on communities; this tended to be around community needs assessment, but seemed to have little impact on the service. Mitchell, Malak & Small concluded that:

‘simply inserting bilingual professionals into existing models of community mental health work is unlikely to lead to maximal realisation of the benefits that bilingual professionals can provide. Service managers need to develop awareness of wider organisational adjustments that may be necessary in the pursuit of culturally sensitive services.’ (1998, p. 432).

Mitchell et al. described several difficulties faced by the bilingual staff in this program: some have also been noted elsewhere. One difficulty was that the staff felt that they needed clinical supervision from a professional with experience and sensitivity to the needs of migrants, but such people were rare. Supervisors often had little knowledge of ethnic issues or cultural sensitivity and staff felt inadequately supported (Mitchell, Malak & Small, 1998).

Bilingual staff also believed they provided a more comprehensive service to their NESB clients (compared to Australian-born clients) because cultural barriers and a lack of ethno-specific programs prevented them from getting as much assistance from other services (Mitchell, Malak & Small, 1998). Musser-Granski & Carrillo (1997) argued staff can feel torn in two by cultural demands and expectations from the community and requirements of the agency. Staff in such positions in the past have been inundated with a vast range of expectations from both ethnic communities and the service employing them; these have included counselling, casework, interpreting, translating, community education, group-work, individual and group advocacy, service development, secondary consultation, family support, financial counsellor, community representative and family friend (Health Department Victoria, 1991). These expectations, combined with the fact that bilingual staff may perceive their clients to have greater needs, means that the staff could be easily overwhelmed by the demands of their work. Musser-Granski & Carrillo (1997) have suggested that staff may need some help with boundary issues as a result.

Another limitation described by Mitchell was that there was a tendency for all clients from their ethnic group to be automatically referred to the bilingual worker (Mitchell, Malak & Small, 1998). This meant that bilingual staff could end up managing all clients from their own ethnic background, and other staff do not deal with this group at all. Yet it has generally been regarded as desirable that bilingual staff assist monolingual staff in developing the skills to work more effectively with ethnic groups. Fong & Gibbs (1995) suggested that services should avoid automatic staff-client ethnic matching, and instead encourage sharing of ethnic clients among a wide range of staff, with bilingual staff in support and consultation roles. However, as suggested above, a barrier to collaborative work in Mitchell's study was that the mental health service culture focussed on responsibility for direct clinical work resting with an individual, and there was little encouragement for joint work. This tended to work against cooperation between bilingual and other staff in working with individual clients.

A separate issue is the possible marginalisation of staff who are seen to have very specialised or circumscribed roles, or who are regarded as different to the main staff group. Bilingual positions have sometimes been marginalising for staff, possibly because of different roles, client groups or ethnic differences with other staff (Fong & Gibbs, 1995; Health Department Victoria, 1991; Mitchell, Malak & Small, 1998). Fong

& Gibbs suggested that services should find ways of employing a number of culturally diverse staff to create a 'critical mass' so they are not singled out or isolated (1995).

Services creating bilingual positions have also been criticised for assuming that one bilingual staff member will take responsibility for ensuring that all services provided by an agency will be accessible and relevant to a particular ethnic group. That is, the responsibility for culturally-sensitive service delivery is located with one staff member rather than the service as a whole (Health Department Victoria, 1991). In contrast, services need to ensure that reaching ethnic communities is seen as a responsibility of organisation as a whole, not just one person (Fong & Gibbs, 1995).

Finally, dictating that services have discrete geographical catchment areas poses barriers in matching clients with bilingual staff. Ethnic communities are geographically distributed across many service catchment areas, but services seldom employ bilingual staff for every ethnic group. So, while Minas et al. found that there were a substantial number of staff already working in mental health services in Victoria, most of these were not employed in positions, or geographical locations where they could use their languages for clinical work (Minas, Stuart & Klimidis, 1994). Clients from outside the catchment area of a service employing a bilingual staff member could not be seen at that service even if that person was the only bilingual mental health professional for that community available. A similar issue has been raised in relation to catchment areas for general practitioners in the UK (Li, Logan, Yee et al., 1999). This is not a limitation of employing bilingual staff *per se*, but a limitation of the service system in which they are employed.

In spite of the difficulties identified above, there is a consensus that employing bilingual/bicultural staff is an important component of any strategy to improve service delivery to ethnic communities. The following section describes research into the impact of employing bilingual staff in mental health services.

RESEARCH INTO THE IMPACT OF BILINGUAL STAFF

The recommendation to employ more bilingual staff is a common one, but what difference does it make? While Australian research is limited, there is some overseas research into the effect of ethnic-matching (matching clients of ethnic minority backgrounds to a clinician of the same background) on hospitalisation, service contact, drop-out rates, and social/clinical functioning. These studies are reviewed below.

Client preference

Ethnic communities show a consistent preference for health professionals from their own ethnic backgrounds. Australian studies show NESB clients exhibit a preference for general practitioners from their own ethnic backgrounds (Stuart, Minas, Klimidis et al., 1996), and qualitative studies with mental health clients found that same result with regard to mental health staff (Falconer & Ziguras, 1994). A considerable body of US research has reached the same conclusion (Atkinson & Lowe, 1995; Cheung & Spears, 1995; Hutchinson & Gilvarry, 1998; Li, Logan, Yee et al., 1999; Lin, Tardiff, Donetz et al., 1978; McGovern & Hemmings, 1994).

A considerable amount of research has examined client preference for the ethnicity of counsellors (Abreu, 2000; Atkinson, Casas & Abreu, 1992; Atkinson, Poston, Furlong & Mercado, 1989; Atkinson & Matsushita, 1991; Atkinson, Wampold, Lowe, Matthews & Ahn, 1998; Coleman, Wampold & Casali, 1995; Helms & Carter, 1991; Lopez, Lopez & Fong, 1991; Mahalik, Worthington & Crump, 1999). A recent review of studies of ethnic similarity in counselling situations concluded that there was 'consistent and strong evidence that, other things being equal, ethnic minority participants prefer an ethnically similar counselor over an ethnically dissimilar counselor' (Atkinson & Lowe, 1995, p. 392). The authors also concluded that there is 'strong evidence that, in general, ethnically similar counseling dyads are associated with more positive counseling process and outcome, than are ethnically dissimilar counseling dyads' (p. 405).

One study examining similar issues in Australia was conducted by Silove, Manicavasagar, Beltran et al. (1997) in Sydney. This study looked at differences in satisfaction for Vietnamese clients of mainstream psychiatric services (inpatient and community) compared with clients of a specialised mental health service for refugees. Clients of the refugee service were more satisfied than those of mainstream services. Two satisfaction items were significantly different between the two types of service; extent of information offered, and ease of negotiating changes. Clients with low English fluency found treatment more useful than those with better English ability, but there was no analysis of whether this varied across service types. Clients of the refugee service were more likely to report that clinicians' explanations were easy to understand, and that their diagnosis had been communicated directly to them. One conclusion was that 'it is possible that the bicultural counselor model used by the specialized service may have contributed to improved communication at that service, but this inference is only tentative given the limitations of the study.' (p.1068).

There is also support from service providers for more bilingual staff: in the survey of psychiatric service staff reported by Minas, Stuart & Klimidis (1994), most respondents (72.6 percent) thought that it would be desirable to recruit more bilingual clinical staff. Given these findings, it might be expected that ethnic matching in mental health services would lead to better outcomes.

Service utilisation

Several studies have investigated service utilisation outcomes for clients with an ethnically matched clinician. The most common findings of this research are that client-therapist ethnicity or language match is associated with reduced rates of premature termination (Flaskerud & Liu, 1991; Fujino, Okazaki & Young, 1994; Sue, Fujino, Hu et al., 1991). Takeuchi, Sue & Yeh (1995) found the same results for Asian Americans but not African Americans or Mexican Americans, and Yeh, Eastman & Cheung (1994) found an effect for adolescents but not children.

Similarly there is a consistent finding that ethnic match increases contacts with services (Flaskerud & Hu, 1994; Flaskerud & Liu, 1991; Fujino, Okazaki & Young, 1994;

Jerrell, 1995; Jerrell, 1998; Sue, Fujino, Hu et al., 1991; Yeh, Eastman & Cheung, 1994; Ying & Hu, 1994). Takeuchi, Sue & Yeh (1995) found a similar effect for Asian Americans but not African Americans or Mexican Americans. Two studies showed that ethnic match reduced contacts with emergency or crisis services (Jerrell, 1995; Snowden, Hu & Jerrell, 1995), and one showed that it reduced days in hospital (Jerrell, 1995). Flaskerud (1986) found that clients matched with a therapist of the same background and language had the same treatment duration and frequency of contact as Whites.

Research into the effect of employing bilingual staff on utilisation rates (i.e. clients per head of population) is less common, but Takeuchi, Mokuau & Chun (1992) cite the establishment of several ethno-specific mental health services which led to increased utilisation by ethnic minority clients.

There is also some indirect evidence about the impact of ethnic matching on service utilisation. O'Sullivan, Peterson, Cox et al. (1989) found that drop-out rates among minorities had decreased over a period of 10 years during which a number of initiatives (such as increases in the number of professionals who were members of these groups, and efforts to encourage and fund culturally relevant treatment modalities) were implemented.

Similarly Zane, Hatanaka, Park et al. (1994) compared outcomes by ethnicity from a clinic specialising in treating Asian Americans where each clinical staff member was bilingual in at least one Asian language. They concluded that for most Asian American groups, 'equitable service and treatment outcome can be achieved using a parallel service delivery model' (p. 79).

Snowden & Hu (1997) examined patterns of in-patient and community service utilisation in two county mental health services systems. In one county, which had not implemented any ethno-specific programs, ethnic minorities used community services less than Whites and inpatient services more. The other county had implemented extensive minority mental health programs, including many contracts with minority providers to provide care. Here, Latino and Asian-American and, to a lesser extent African-American clients, made more use than Whites of outpatient community

services, and all three minority groups made less use of inpatient care than Whites. These latter studies are limited in that they not directly compare ethnic minority clients with an ethnic match to those without. It is also possible that other differences between the services contributed to the different outcomes. However, the evidence points to a consistent impact of ethnic matching on service use.

Social functioning

As Flaskerud (1986) has argued, service utilisation is an indirect measure of outcome and research should also investigate measures of clinical and social functioning. In contrast to service use, though, research into the effect of ethnic matching on clinical outcomes is less conclusive. Several studies found that ethnic matching had no effect on outcomes measured using the Global Assessment Scale (Flaskerud & Hu, 1994; Flaskerud & Liu, 1991; Fujino, Okazaki & Young, 1994; Takeuchi, Sue & Yeh, 1995).

There were some exceptions. Yeh, Eastman & Cheung (1994) found an effect for adolescents but not children. Ying & Hu (1994) evaluated public mental health services in Los Angeles, and found that ethnic match was related to improved functioning for Chinese clients but not others (Japanese, Filipino, Korean and SE Asians). Sue, Fujino, Hu et al. (1991) found that ethnic match was a significant predictor of outcome for Mexican Americans but not African Americans or Asian Americans. However, when considering only clients for whom English was not the primary language, ethnic match was significantly related to improved functioning. Having both ethnic and language match for these clients was particularly important.

This study concluded that:

‘the findings suggest that match is important because it is related to length of treatment. Results for match are more equivocal for outcomes, except for clients who do not speak English as the primary language. The recruitment of bilingual and bicultural ethnic mental health workers for these clients is advisable.’ (p. 539)

Overall, the research into the effect of ethnic matching on clinical outcomes appears inconclusive. It is possible that ethnic match has no impact on this domain of outcome, or if it does, it may be limited to particular groups of clients, such as those who speak a language other than English as their first language.

LIMITATIONS OF PREVIOUS RESEARCH

There are a number of limitations with the 'ethnic matching' research. First, none of the studies found used experimental designs; all used either quasi-experimental or cross-sectional designs which could be prone to bias in allocation of clients to clinicians. This has also been noted by Sue (1998), who commented that he could not find any rigorous studies of efficacy of treatment for ethnic minorities.

A second limitation is that the amount of treatment is fairly small. In the Sue, Fujino, Hu et al. (1991) study, clients had an average of 4-6 sessions each. In two of the Flaskerud studies (Flaskerud & Hu, 1994; Flaskerud & Liu, 1991) 81 percent of clients had 10 or fewer sessions. Contacts with public mental health services in Australia at present are typically much longer, with clients having contact every few weeks over a period of several years - whether the findings of the studies reviewed above can be generalised to this setting is unknown. The effect of ethnic matching on clinical or social measures of outcome may only become apparent over a longer time frame, especially for clients with severe and long term psychotic conditions, and relatively few of the studies reviewed included this client group.

Third, most studies of clinical outcome used the Global Assessment Scale (Endicott, Spitzer, Fleiss & Cohen, 1976). However, Sue (1998) has suggested that this scale may not be sensitive enough to measure changes in outcomes and this could have been why some studies have not detected an effect of ethnic match on outcomes.

CONCLUSIONS

In conclusion, many, and probably most, NESB people prefer a mental health clinician of the same ethnic background. Overseas and Australian research suggests that ethnic matching reduces drop-out rates, increases the number of contacts with services, reduces contact with crisis services, and may reduce hospital stay. It appears to have little impact on social and clinical functioning, perhaps except for clients with a first language other than English.

Previous research suffers from several limitations; exclusive use of quasi-experimental designs, short time frames with clients having relatively little exposure to treatment, and questions about the sensitivity of outcome measures used.

One implication for the present research is that it could be expected that the employment of bilingual staff may lead to increased rates of contact with staff by NESB clients, and perhaps to less contact with crisis teams, or decreased hospitalisation. No Australian research has investigated these issues. Possible difficulties with uni-dimensional measures of clinical or social functioning such as the GAS suggest that multi-dimensional measures should be considered. Finally, the lack of research into client satisfaction with services suggests that this is an important domain for investigation.

Writing on the potential difficulties of hiring bilingual staff suggests several issues which need to be considered in the design and evaluation of the BCM. These include client concerns about confidentiality or shame in seeing a clinician from the same background, unrealistic expectations of bilingual staff on the part of services and clients, services' tendency to refer all clients to a clinician from the same background, marginalisation of bilingual staff, and responsibility for cultural sensitivity being located with a single worker. The BCM program attempted to address some of these issues; the design of the program is described in the following chapter.

6. DESIGN OF THE BILINGUAL CASE MANAGEMENT PROGRAM

INTRODUCTION

As illustrated in Chapter Four, NESB people experience a range of problems in gaining access to mental health services, and there is evidence to suggest that the quality of service provision to this group is inferior. In Chapter Five, it was observed that the employment of bilingual/bicultural staff is one of the most common recommendations for improving service provision to ethnic minorities, but that some previous attempts to establish bilingual positions have met with difficulties. One of the aims of the BCM program was to overcome problems experienced with bilingual positions in the past by specifying various aspects of the program in more detail. This chapter describes the background and design of the BCM program, with a focus on the roles, accountabilities and caseload composition of BCM staff.

BACKGROUND TO THE PROGRAM

The Western Region is the most ethnically diverse area of Melbourne. Many post-war migrants found employment in the region, which has been home to Victoria's oil, manufacturing, meat processing, clothing and textiles industries, and many settled there. In 1996, the date of the most recent census, the population was 560 000 adults (between 15 and 65), of whom 33 percent were born in a non-English speaking country. The most common countries of origin were Italy (24 898), Vietnam (23 824), countries of the former Yugoslav republic (18 059), Malta (13 990), Greece (12 066) and Turkey (7 599) (Klimidis, Lewis, Miletic et al., 1999).

There were four Area Mental Health Services (AMHS) in the Region: South West AMHS, Mid West AMHS, Inner West AMHS and North West AMHS. Each of these contained a community mental health service which included a Crisis Assessment and

Treatment Team (CATT), a Continuing Care Team (CCT), and a Mobile Support Team (MSTT). North West AMHS also included a separate adult community mental health team which was located at Broadmeadows Community Health Service. An Area Manager had overall responsibility for each AMHS, and each community team (CATT, CCT and MSTT) had a program coordinator.

Mental health services in the Western region of Melbourne have a history of innovation in attempting to meet the needs of ethnic communities. South West AMHS created a Croatian position in 1992 after funding for a mental health position at a Croatian ethnic welfare service expired. The South West position was established to work closely with the Croatian community, and continued under the BCM program, although it remained vacant for some time because of difficulty recruiting. In 1995, the service created a half-time Vietnamese position with similar aims to the Croatian position, and a Vietnamese worker started half-time in January 1996.

In April 1995, the Western Metropolitan Region office of the Victorian Department of Health and Community Services (later renamed the Department of Human Services) established a working party to consider psychiatric service provision to NESB people, and to develop strategies to improve services. This process included a detailed analysis of service utilisation (Stolk, 1996) which found a substantial under-utilisation of community mental health services by ethnic communities. It also reported that NESB clients in contact with such services were under-represented amongst contacts with allied health staff. The analysis suggested that there were barriers to accessing counselling and case management even amongst those NESB people who became clients of an area mental health service.

The working party discussed the idea of employing bilingual staff in specific identified positions as one way of improving services at the time. A proposal for a pilot bilingual case management program was developed which was partly based on experience with the Croatian and Vietnamese positions already implemented at South West AMHS, and which took into account the limitations of similar positions in the past. It was also proposed as a response to the policy statement 'Victoria's mental health service: improving services for people from a non-English speaking background' released by the Department of Human Services in 1996 (Department of Human Services, 1996).

The Western Region office of the Department adopted the bilingual case management program as policy in early 1996 and decided to require the services it funded to implement the program. This was to be done through the Funding and Services Agreements signed with the service providers. Managers of the services involved expressed their interest in the program, but argued that because of budget deficits facing the service at that time, they would only be able to create bilingual positions as other staff left over a period of one or two years. After further discussions, the Western region office agreed to provide additional funding for the establishment of the program. An additional \$300 000 (the equivalent of five positions) was provided for the 1996/97 financial year to establish the program, with the understanding that the services would provide the additional five positions immediately from their current allocation.

Position statements were developed by Area managers and VTPU staff during the second half of 1996, and the positions were advertised in December 1996.

The outline of the program is provided below.

PROGRAM DESCRIPTION

Aims

The aims stated in the proposal for the program were to:

1. Improve access to area mental health services for NESB people.
2. Improve the adequacy of area mental health services for NESB people.
3. Assist in accurate diagnosis and assessment of NESB people presenting to a mental health service.
4. Assist in the development of individual service plans for NESB people in conjunction with case managers
5. Establish, in conjunction with other staff, targeted support and educational programs for NESB clients and their families

Criteria for bilingual case manager involvement

The program was not intended to cover all possible clients from a particular ethnic group. Primary case-management from a bilingual case manager was to be targeted to those NESB people who had experienced difficulties in accessing services or where there were difficulties in providing treatment by staff not proficient in the client's preferred language.

In order to ensure that the program was targeted at those to whom it would most benefit, it was proposed that the bilingual staff would be involved when the client expressed a preference for a bilingual case manager and,

- there appeared to be significant cultural issues in the presentation of symptoms which made assessment difficult, or
- the client had not successfully engaged with other clinic staff.

Staffing

Staff were to be drawn from professional backgrounds currently working as case managers in the mental health system: social work, psychiatric nursing, psychology and occupational therapy.

Roles

Case management

The role of the bilingual case manager in direct clinical work was conceptualised as covering a continuum from direct case management to secondary consultation. At one end, the bilingual staff member would act as the primary clinical case manager as outlined in the Department of Health and Community Services Coordinated Client Care policy (Department of Health and Community Services, 1994b). At the other end, the bilingual staff member would not have an ongoing clinical role, but would act in a purely secondary consultation capacity to the primary case manager. This would entail

the provision of information about cultural factors, values, assumptions and beliefs to the primary case manager, and assistance in assessment when needed.

Secondary consultation

Bilingual case-managers were expected to act as the primary case manager for some clients (a maximum of 15-20) and as joint case manager for others. Staff were to also have a secondary consultation role and to be available to assist the primary case manager with advice about cultural norms, beliefs, values and practices. Bilingual staff were also meant to assist the clinical team in developing an individual program plan in conjunction with the client and relevant family members.

Staff training

While this was not the primary objective of the program, team members were expected to have a role in educating individual clinicians about cultural issues relevant to their clients, and to also participate in training and education programs.

Education and support programs

One of the biggest gaps in service options for NESB people was perceived to be the lack of education, support and socialisation programs, particularly for those with poor English (Stolk, 1996). Members of the bilingual team were expected to work with staff from psychiatric disability services, mental health services and ethnic agencies to establish targeted programs in areas with a high population of the relevant language group. It was thought that these programs would be available to clients from outside the individual's service catchment area, and would focus on daily living skills, socialisation, communication skills, illness management and education.

Family and carer education

Another of the major gaps was seen as the inaccessibility of family education programs to NESB people (Stolk, 1996). Part of the role of BCM staff was to work with relevant agencies such as the Schizophrenia Fellowship, ethnic agencies and psychiatric disability services, in order to establish education and support programs for carers.

Location and accountability

The positions were located in the Continuing Care Teams in four services and in the adult mental health team at Broadmeadows Community Health Centre. Staff were to be accountable for clinical matters to the Director of Clinical Services at each service (delegated to professional discipline supervisors), and accountable for administrative matters (e.g., client data recording, participation at staff meetings) through the manager of the CCT to the Area manager.

Caseload size and composition

Due to additional roles in joint case management and assessment, staff development, client and carer education, Area managers agreed that the BCM staff should have a lower direct clinical caseload than other staff to allow time for this additional work. This was nominally set at about two-thirds of other staff or about 20 clients based on the caseloads in CCTs of around 30.

Another area which received some attention in the program design phase was the question of the composition of caseloads for the BCM. As discussed above, it was not intended that BCM would accept all clients of the same ethnic background within the service. Managers were keen to ensure that other staff could learn about cultural issues from the BCM's so that the service as a whole could improve the way it worked with NESB clients. Partly this was based on the experience of South West AMHS, which had had a Croatian worker for some time but whose role had not included joint case management or much emphasis on working with other staff.

In addition, previous experience of a totally ethno-specific approach had shown that when bilingual staff saw only clients from one ethnic group they tended to be marginalised and excluded from the rest of the service (Health Department Victoria, 1991; Mitchell, Malak & Small, 1998). It was also believed that having clients from a range of backgrounds would give the BCM a wider range of experience of cultural issues, and enable them to deal with cross-cultural situations themselves. This was felt to be important so that the BCM also had some understanding of the issues that other staff might face in cross-cultural work.

In light of these considerations, it was agreed that half the caseloads of the BCM should consist of clients from the same ethno-linguistic background, and the other half to be made up of clients from any other ethnic background (including Australian-born Anglo background clients).

Languages to be targeted

Languages to be covered at each service were determined by the demographic distribution in the catchment area and across the region (Stolk, 1996). The following tables indicate the demand for language services at each of the centres. Table 6.1 shows preferred language (where recorded) of clients of Western Metropolitan Region area mental health services for the year 1993-94.

Table 6.1 Preferred language of clients for 1993-94 by AMHS. Source: (Stolk, 1996)

Clients preferred language	South West	Mid West	Inner West	North West (incl. Broadmeadows)	Total
Turkish	8	5	8	77	98
Italian	32	11	10	40	93
Vietnamese	35	9	18	9	71
Greek	20	12	4	15	51
Serbo-Croatian	28	10	7	5	50
Polish	11	11	3	3	28
Macedonian	13	10			23
Maltese	13	7		3	23
Arabic	4	2	2	12	20
Spanish	10	1	2	2	15
Other	92	36	107	178	214
Total	266	114	111	195	686

The comparatively large number of Turkish clients may have been due to the presence of a Turkish psychiatrist at the VTPU during this period, and whose patients were included in this data. Table 6.2 shows interpreter bookings with the Victorian Interpreting and Translating Service for the same period.

Table 6.2 Interpreter bookings for 1994, by AMHS Source: (Stolk, 1996)

Interpreter bookings	South West	Mid West	Inner West	North West	Broadmeadows	Total
Italian	87	13	212	174	44	530
Vietnamese	187	120	170	5	21	503
Greek	161	82	65	168	4	480
Croatian	216	74	51	13	22	376
Arabic	7	64	11	125	15	222
Macedonian	63	103	0	0	8	174
Turkish	25	35	9	22	73	164
Serbian	68	24	47	3	3	145
Polish	42	20	46	0	7	115
Spanish	31	27	4	0	13	75
Maltese	2	15	0	7	2	26
Assyrian	0	4	0	21	0	25
Other	30	46	62	44	3	185
Total	919	627	677	582	215	3020

The final decision about the languages of staff was to be made by the services involved according to their perceived needs. A suggested breakdown of languages was:

- North West AMHS: Greek, Arabic;
- Inner West AMHS: Vietnamese, Italian;
- Broadmeadows CMHT: Turkish;
- Mid West AMHS: Macedonian, Greek;
- South West AMHS: Croatian, Vietnamese, Italian or Serbian.

Part of the rationale for these languages was a desire to cover as many languages as possible across the region with the expectation that each centre could make some use of staff at other services within the region, particularly in regard to assistance with assessment, secondary consultation, family support and education groups, and community education. The eight languages identified above (Arabic, Croatian, Greek, Italian, Macedonian, Serbian, Turkish and Vietnamese) constituted 86 percent of all interpreter bookings for the region at that time (Stolk, 1996).

CONCLUSIONS

The main features of the proposed BCM program were that: staff would be bilingual and have the same standard of professional qualifications as other case managers; BCM staff would have a direct case management role and provide secondary consultation to other staff; the BCM staff would have caseloads comprised of approximately equal numbers of clients from the same ethnic background and from other backgrounds (including Australian-born); and that they would see same-background clients where there appeared to be significant cultural issues which made assessment or treatment difficult. A key role was to facilitate family and client education and support programs. In recognition of these additional responsibilities (compared with other case managers), the BCM were to have caseloads only two-thirds of those of other case management staff. The BCM staff were not to be interpreters, and the positions were to target the largest language groups in Area Mental Health Service catchment areas.

These aspects of the program were designed to avoid the difficulties associated with the employment of bilingual staff in ethno-specific positions. Specifying a proportion of caseloads to include clients from other backgrounds was intended to prevent staff being marginalised as the 'ethnic worker' who dealt with only one ethnic group. Establishing the role to include secondary consultation was intended to encourage BCM staff to pass on knowledge to other staff working with clients from their ethnic background, and for other staff to make use of this knowledge. Having lower caseloads for the BCM was intended to allow them to participate more in community work, and prevent burnout due to unrealistically high expectations.

The questions which are raised immediately are whether these intentions were translated into practice. For example, were staff available who were both fluently bilingual and who had the appropriate qualifications? Did BCM have lower caseloads once they were employed? Questions such as these were considered to be an important part of the evaluation, the method for which is described in the following chapter.

7. METHOD

INTRODUCTION

This chapter provides the details of the methods used in the six studies comprising this thesis. It begins with a brief discussion of program evaluation theory, followed by an overview of the research. The background and rationale, and then the aims, for each study are then described. In the methods section, the design and sampling strategy, measures, procedure, and analysis for each study are presented.

PROGRAM EVALUATION THEORY

The approach taken in this thesis is an explicitly realist one. That is, it is assumed that there is a real world external to human perceptions, and regularities occur which are observable and understandable, and sometimes predictable (Pawson & Tilley, 1997). A scientific approach is considered to be a superior method for understanding these patterns, both because it holds out the possibility of discovering and rejecting false beliefs and because it has demonstrated the ability to predict accurately (Bradley & Schaefer, 1998; Neuman, 2000; Sokal & Bricmont, 1998).

Social science method is here broadly defined to mean the process of; generating theory about human relationships and social structures, systematically and carefully comparing the implications of theory with empirical observation, and rejecting, modifying, or accepting (albeit perhaps temporarily) theoretical propositions (Neuman, 2000; Sokal & Bricmont, 1998). Science is held to be both deductive (i.e. empirical testing hypotheses generated from theory) and inductive (i.e. generating theoretical propositions based on observed patterns of data). In the physical sciences, theory is usually represented mathematically, with explicit definitions of variables, and data are collected quantitatively (Bradley & Schaefer, 1998; Sokal & Bricmont, 1998).

There are several problems in applying the principles of scientific method (at least as practiced in the physical sciences) to the social domain. These include; human beings

are conscious and actively respond to features of the environment, so that the research process itself can influence that being observed (the Hawthorne effect), it is far more difficult to isolate social phenomena from their context, especially when considering areas of human service policy and delivery, theories are generally less well developed than in the physical sciences, there is less agreement about major theoretical paradigms (and more usually strident disagreement), the definition of variables is also less well developed, there are often many measures for the same variable, measurement of variables is complicated by a range of sources of uncertainty (such as natural variation in the population on the dimension being measured, sampling error, less than perfect reliability of measures, and socially desirable responding), and values are often embedded in social 'facts' (for example, in measuring 'outcomes' of service provision) (Bradley & Schaefer, 1998; Campbell & Stanley, 1963; Cronbach, 1982; Sokal & Bricmont, 1998).

In recognition of these limitations, it is sometimes argued that the scientific paradigm cannot claim a superior status for creating and testing human knowledge, especially in the social sphere. The logical extension of this argument leads to epistemic relativism – the assertion that no method can claim a more 'truthful' view of the world than any other (Sokal & Bricmont, 1998). One problem with epistemic relativism is that by its own definition, it is just a belief as valid as any other. Epistemic relativism leads to the conclusion that all knowledge claims must be treated as having equal status, but this is patently absurd. How many people would seriously entertain the belief that 'the Prime Minister is a Martian' should be accorded equal status with the belief that 'the Prime Minister is a human being'? So, while the scientific paradigm is problematic, it is still the best guide available.

Social research includes both quantitative and qualitative methods. While quantitative methods are often associated with a deductive approach, and qualitative methods with an inductive approach (Marshall & Rossman, 1995; Neuman, 2000), both methods can be and are used in either manner (even if they are generally applied to one and not the other). The approach taken in this thesis is that both quantitative and qualitative methods have advantages and disadvantages. Quantitative research enables greater precision in specifying the amount or degree of an area of interest (often a focus of research), and enables more accurate comparisons between groups on this variable

(Neuman, 2000; Pawson & Tilley, 1997). Qualitative research enables the researcher to investigate and clarify meanings held by human beings through an interactive process, and is useful in describing social settings (Marshall & Rossman, 1995; Patton, 1990).

When used to obtain data directly from people (e.g. via interviews), quantitative measures allow greater consistency and reliability, and for groups to be compared on a variable of interest. However, quantitative measures (e.g. scale-type questions) may also be misinterpreted because clarification of meaning usually proceeds through an exchange process (i.e. a conversation), and quantitative methods sometimes do not allow this. Hence, validity can be compromised (Neuman, 2000). Qualitative methods allow the meaning of questions and answers to be explored more thoroughly, and can therefore have greater validity (Marshall & Rossman, 1995). However, such approaches are less likely to maintain consistency (e.g. that everyone answers exactly the same question) and therefore may have lower reliability. In addition they make comparisons between groups (for example, on the degree of satisfaction with services) more difficult (Neuman, 2000).

In program evaluation it is important to examine both the context of the program and its implementation, as well as outcomes. Context is important as it affects the way in which programs operate and may also affect the outcomes for clients. Describing the context is necessary for the results of an evaluation to be applied in a different setting (Patton, 1990; Pawson & Tilley, 1997). A particularly important aspect of the service context is how policies or new programs are implemented. Pressman & Wildavsky (1973) have documented many examples of 'implementation failure', where the complexity of service delivery may completely change the way that programs operate compared to the intention of policy makers. If an outcome evaluation finds that this program did not achieve its aims, it might be concluded that the original program was ineffective, but it is possible that if it was implemented in its original form, it may have been effective after all. Hence, the study of implementation is a vital part of program evaluation (Patton, 1990).

Generally, in program evaluation, quantitative methods are better suited to examining effectiveness by comparing outcomes on some domain for different groups. Experimental designs, or randomised controlled trials, are most likely to allow the

attribution of causal relationships between variables (for example, between treatment and outcomes), but practical problems often prevent random allocation of subjects to groups. Quasi-experimental designs are often used as a result (Campbell & Stanley, 1963; Cook & Campbell, 1979; Cronbach, 1982; Rossi & Freeman, 1989).

Qualitative methods are useful in describing the context of service provision, and aspects of program implementation (Marshall & Rossman, 1995; Patton, 1990; Rossi & Freeman, 1989), and in understanding the perspectives of service clients. Using a combination of methods, or triangulation (Neuman, 2000), allows the limitations of individual approaches to be offset by using the strengths of a complimentary approach. For example, in gaining the opinions of clients about aspects of the services (for example their satisfaction), some writers suggest that both quantitative and qualitative methods be used, by the inclusion of scale-type questions with fixed responses, and open-ended questions enabling people to respond in their own words (Perreault, Leichner, Sabourin & Gendreau, 1993; Ruggeri, 1994; Ruggeri & Dall'Agnola, 1993).

The approach taken in this thesis was to use quantitative methods to measure different outcomes from mental health services and to compare outcomes for NESB clients with a case manager of the same background to those for clients with a case manager of a different ethnic background. Qualitative methods were used to explore the context of programs and implementation of program models, and also for exploring clients' views about services and their cross-cultural sensitivity.

Pawson & Tilley (1997) have pointed out that a missing ingredient in much evaluation research has been a consideration of the causal mechanism by which programs operate. By mechanism, they refer to 'choices and capacities' (of clients and staff) which lead to regular patterns of social behaviour. The 'black-box' approach used by some in the past (Pawson & Tilley cite Campbell & Stanley, 1963, and Cook & Campbell, 1979) established causation through the use of research design, but often did not investigate processes – Pawson and Tilley argue that an explicit concern with mechanism is important in theory building. They believe that the failure to adequately consider program mechanisms, and the relationship between mechanism, context and client group is one of the reasons why evaluation studies demonstrate inconsistent results, and that evaluation research so rarely leads to a cumulative body of knowledge. More focus

on these issues would enable decisions about whether a program would be effective if implemented in a different context or under differing conditions. So, for example, it may be possible to conclude that psychotherapy is effective using experimental or quasi-experimental designs (within the limits of such methods), but Pawson and Tilley would argue that it is necessary to ask why psychotherapy is effective, for whom, and under what circumstances, if this research is to be generalised. While the main focus of this thesis was on describing the context and implementation of the BCM program, and investigating the effectiveness of ethnic matching (in Pawson and Tilley's words, establishing whether there is a relationship in the first place), the question of mechanisms is given some consideration in the last chapter when discussing the results.

OVERVIEW OF STUDY METHODOLOGY

The data for this thesis came from six separate studies. The first was an investigation into the effectiveness of case management prompted by the findings of the recent Cochrane collaboration reviews of case management in mental health (Marshall, Gray, Lockwood et al., 1998; Marshall & Lockwood, 1998).

The second study was an examination of BCM program in operation, compared to the model proposed. As Pressman and Wildavsky (1973) have previously shown, social programs are often implemented and operate in a very different manner to that planned by policy-makers or service managers. Part of the rationale for the implementation study was also to investigate whether the BCM program had managed to avoid some of the problems associated with the employment of bilingual staff.

The other four studies investigated the effectiveness of the BCM program for clients, by analysing the impact of matching clients with a case manager of the same ethnic background on four outcome domains: medication management; satisfaction with services and their cultural sensitivity; service utilisation; and improvement in social functioning. An overview of the main features of the study are shown below in Figure 7.1. These four outcome domains are among the most commonly used in evaluations of mental health service effectiveness, and the rationale for their inclusion is discussed below. Some other domains were considered (quality of life and family satisfaction

measures) but not included due to resource constraints. It had been intended to interview family members about their satisfaction, but the difficulty in recruiting clients (whose permission would have been necessary to approach families) and lack of time remaining for the study prevented this. It would have also been desirable to assess clients' quality of life from either the clinician's or client's perspective. However, both clients and clinicians were already being asked to contribute significant amounts of time to the other domains (measuring social functioning for clinicians, and interviews about satisfaction and cultural sensitivity for clients) and it was felt that adding another set of questions would be too onerous.

Research questions	Design	Data	Method of analysis
1. Is case management effective?	Search for all previously published studies	Effect sizes calculated from the results of previous studies	Meta-analysis
2. Was the program implemented as proposed?	Naturalistic	Interviews with staff and managers Caseloads and contacts	Content analysis, frequencies
3. Did ethnically matched clients have better management of their medication?	Cross-sectional	Medication type, dose, method of administration and rating of compliance	ANCOVA, multiple regression, logistic regression
4. Were ethnically matched clients more satisfied with the service and its cultural sensitivity?	Cross-sectional	Interviews with clients including rating scales and open-ended comments	Content analysis frequencies, non-parametric statistics
5. Did ethnically matched clients have a different pattern of service utilisation?	Quasi-experiment	Frequency and duration of contacts with continuing care team, crisis assessment teams and admission to hospital	Multiple regression
6. Did ethnically matched clients have better social functioning over time?	Quasi-experiment	Ratings of social functioning over two years using the Multnomah Community Ability Scale	Hierarchical linear modelling, ANCOVA

Figure 7.1. Main features of the six studies comprising the thesis

BACKGROUND AND RATIONALE FOR EACH DOMAIN

Case management effectiveness

The BCM program was based on the assumption that case management improved outcomes for clients of mental health services, and that bilingual staff would be able to heighten the benefits of case management to NESB clients; that is, that bilingual staff could provide a case management service to NESB clients similar to that provided to English speaking clients. If case management itself had no effect on outcomes for clients, it is doubtful that bilingual case managers would make any difference to NESB clients.

Most previous reviews of the effectiveness of case management in mental health services have been narrative accounts which compare the number of studies finding positive results to those finding negative results in order to determine overall trends. However, as Glass, McGaw and Smith (1981) and others have shown, such methods can lead to inaccurate conclusions, due to bias on the part of the reviewers, selective sampling of studies, and problems with the ‘vote-counting’ method.

There have been four attempts to combine results quantitatively using meta-analytic methods (Bond, McGrew & Fekete, 1995; Gorey, Leslie, Morris et al., 1998; Marshall, Gray, Lockwood et al., 1998; Marshall & Lockwood, 1998). Meta-analysis is a method which aims to minimise bias when combining the results of several studies. It consists of a number of techniques for combining research findings on a particular topic, which include: developing a research question, operationalising the variables to be examined (eg how outcome is to be measured), specifying criteria for which studies of this question will be included (eg whether to include only randomised controlled trials or also quasi-experimental studies), searching for studies that meet these criteria, calculating ‘effect sizes’ for each study for the domains being examined (i.e. the size of the difference, if any, between the intervention and control groups on the outcome measure), combining effect sizes across studies to calculate a ‘weighted mean’ effect size, examining the results for possible threats to internal and external validity, (eg from publication bias, generalisability from the samples to broader populations),

interpretation of the results (Cook, Cooper, Cordray, Hartmann, Hedges, Louis & Mosteller, 1992; Cooper, 1989; Cooper & Hedges, 1994; Glass, McGaw & Smith, 1981; Hedges & Olkin, 1985; Rosenthal, 1984).

Bond and colleagues examined studies of the implementation of the Thresholds Bridge program (based on the ACT approach) in nine sites (Bond, McGrew & Fekete, 1995), while Gorey and colleagues used a meta-analytic approach to evaluate the effectiveness of case management more broadly (Gorey, Leslie, Morris et al., 1998). However, both analyses included controlled studies as well as studies which used a baseline versus intervention design, but the latter design confounds change due to intervention with change occurring over time due to non-intervention factors.

The meta-analytic studies of Marshall and colleagues (Marshall, Gray, Lockwood et al., 1998; Marshall & Lockwood, 1998) analysed ACT and clinical case management separately. The meta-analysis of the effectiveness of ACT (Marshall & Lockwood, 1998) found that ACT clients were more likely than clients of usual treatment to remain in contact with services, less likely to be admitted, spent less time in hospital, and had better outcomes on accommodation status, employment and satisfaction with services. For other models of case management, the authors were able to reach conclusions for only two domains of outcome, and found that case management increased the proportion of clients admitted (although this is also reported as increasing total admissions), but decreased drop-out rates from mental health services (Marshall, Gray, Lockwood et al., 1998).

To compare the effectiveness of ACT directly with generic or clinical case management, Marshall et al. examined only those studies which randomly allocated clients to one model or another. However, as only six trials met this criterion, firm conclusions could not be drawn (Marshall & Lockwood, 1998). Given that a key assumption of the BCM program was that clinical case management was an effective strategy for improving services, it was important to examine case management effectiveness in some greater depth - especially given the limitations of the Cochrane reviews.

This study used a complementary approach to increase the number of studies and outcome domains to be analysed. An alternative to the within-study approach is to carry out a comparison between groups of studies which employed different types of case management. Although this is a less strictly controlled method, more studies can be included. All reported measures were also included, rather than only those with previously published reliability and validity data. While the inclusion of some unreliable measures will attenuate the estimated average effect size, it may nonetheless increase the power of the analysis to determine whether there is any effect at all. The combination of these methods allowed a broader examination of the effectiveness of case management (Parker, 1997), and extended the range of outcomes subjected to meta-analysis.

Implementation of the program

Good intentions do not always translate into actions. The study of program implementation is an important aspect of any evaluation, but one which has been somewhat overlooked by those interested in program effectiveness (Rossi & Freeman, 1989). As Michael Quinn Patton has argued:

It is important to know the extent to which a program is effective after it is fully implemented; but to answer that question it is important to learn the extent to which the program was actually implemented. (Patton, 1990, p. 104)

In Chapter Six the design of the BCM program was described. At the end of that chapter some questions were raised about how some aspects of those intentions would be realised in practice. The purpose of implementation evaluation then, was to examine the extent to which the program was implemented as intended, and if not, why not? It was also considered important to identify whether some aspects of the program needed to be, or could be, improved. A second reason for considering the details of the operation of a program was that it may help to understand the mechanism by which it was effective, if that was the case. That is, a better understanding of the real practices can help to answer the question; if the program is effective, why?

Medication management

The provision and management of psychotropic medication are central aspects of community mental health service delivery. The management of medication type, dose size and compliance are important parts of service quality (Segal, Bola & Watson, 1996; Young, Sullivan, Burnam & Brook, 1998), but there has been comparatively little research investigating the influence of clients' ethnicity on medication management practices in mental health services. This is surprising given that research has shown that ethnic groups vary in their tolerance of psychotropic medications (Pi & Gray, 1989). In particular, antipsychotic medications (also known as 'neuroleptics') may have quite different pharmacokinetic and pharmacodynamic profiles in some ethnic groups. For example, research has indicated that Asian clients require lower doses for control of psychotic symptoms and, at doses commonly used in Caucasians, Asian clients may experience toxic side effects, such as extrapyramidal movement disorders (EPS) (Gray & Pi, 1998; Lin & Finder, 1983; Lin, Poland, Nuccio, Matsuda, Hathuc, Su & Fu, 1989; Pi & Gray, 1989;), which are a major cause of concern in all groups receiving antipsychotic medication.

There is some reason to expect that there may be ethnic differences in medication management practices. Language differences or communication difficulties may cause symptoms to be over or under diagnosed or misinterpreted, or side-effects from medication to be missed (Minas, 1990; Minas, Lambert, Kostov et al., 1996). Because of greater uncertainty about compliance, symptomatology and side-effects, or negative stereotypes about particular ethnic groups, clients from ethnic minority backgrounds may be more likely to be treated conservatively (i.e., higher doses and more frequent use of depot antipsychotic preparations). There is some evidence to suggest this might be the case. Segal, Bola and Watson (1996) analysed prescription of antipsychotic medications in psychiatric emergency services over a five-year period. African Americans patients were prescribed more medications and higher average doses than White patients by the predominantly White clinicians.

It is also possible that due to these problems, clinicians might be reticent to place clients of NESB on the novel ('atypical') antipsychotics such as clozapine, risperidone and olanzapine. In addition, it could be expected that compliance with medication would be less amongst NESB clients due to greater difficulties in communicating about side-effects and monitoring compliance (Minas, Lambert, Kostov et al., 1996) or differing explanatory models of illness (Callan & Littlewood, 1998; Kleinman, 1980).

As discussed in Chapter Five, ethnic minority clients often prefer a clinician from the same ethnic background (Atkinson & Lowe, 1995). It could be expected that, if cultural differences or communication barriers lead to differences in medication prescribing or compliance for ethnic minority clients, ethnic matching of clients with primary case managers may lessen these differences.

Client satisfaction and cultural sensitivity

Client ratings of satisfaction with services have become an important part of outcome evaluation for health services over the last 15 years. Although clients' views about, and satisfaction with, mental health services are regarded as important, there is considerable debate about how best to assess these.

Several measures of client satisfaction have been used in community mental health services. These include the Client Satisfaction Questionnaire (CSQ8) (Larsen, Attkisson, Hargreaves & Nguyen, 1979; Nguyen, Attkisson & Stegner, 1983), the Service Satisfaction Scale (Greenfield & Attkisson, 1989), the Client Satisfaction Survey (Damkot, Pandiani & Gordon, 1983), and the Verona Service Satisfaction Scale (Ruggeri & Dall'Agnola, 1993; Ruggeri, Dall'Agnola, Agostini & Bisoffi, 1994). The Victorian Department of Health and Community Services, Psychiatric Services Division, also developed a scale to be used across the State (Department of Health and Community Services, 1995; Thomas and Associates, 1996).

Studies using quantitative measures invariably find very high rates of satisfaction, and there is some question about whether these ratings truly reflect client opinion, or whether instruments are simply insensitive to dissatisfaction (Nguyen, Attkisson &

Stegner, 1983). Some studies suggest that qualitative methods may better tap dissatisfaction (Perreault, Leichner, Sabourin et al., 1993), especially if explicit questions about dissatisfaction are included. One limitation of qualitative approaches, though, is that they make comparisons across groups more difficult, and some authors suggest a combination of both approaches (Ruggeri, 1994; Ruggeri & Dall'Agnola, 1993).

For the purpose of this evaluation, a brief quantitative satisfaction rating scale was required as it was important that qualitative questions also be included in the interview, and it was necessary to explore cultural sensitivity in some depth. The most widely used satisfaction questionnaire in health and mental health is the Client Satisfaction Questionnaire (CSQ8), which consists of 8 items requiring a response on a four-point scale (Larsen, Attkisson, Hargreaves et al., 1979; Nguyen, Attkisson & Stegner, 1983). It has been shown to have good psychometric properties (Attkisson & Zwick, 1982; Nguyen, Attkisson & Stegner, 1983) and its developers conclude that it may be 'especially useful as a brief global measure of client satisfaction.' (Nguyen, Attkisson & Stegner, 1983, p. 307).

Using translated versions of the CSQ8 was initially considered but this proved to be unworkable due to the administrative and copyright requirements of the authors of that scale. Instead a brief scale was developed based on the content of a number of satisfaction instruments.

Most studies of client satisfaction have found high rates of satisfaction. For one study of the CSQ8, the mean score was 27.1 compared with scale maximum of 32 (i.e. mean satisfaction rating of 84.7 percent of maximum possible) and with individual item means ranged from 77.5 percent to 89.5 percent of the scale maximum. Versions of the same instrument translated into languages other than English have shown good psychometric properties, and similarly high rates of satisfaction. A French version used in a Canadian study found mean rating of 28.4 (88.8 percent of maximum) (Perreault, Leichner, Sabourin et al., 1993), a translation into Dutch (de Brey, 1983) found mean rating of 3.25 for each item (81.3 percent) and a Spanish version found a mean total of 26.4 (82.5 percent) (Roberts & Attkisson, 1983).

Both unidimensional and multidimensional constructs of satisfaction have been postulated. An inspection of the correlation matrix of the first client satisfaction survey conducted by the Psychiatric Services Branch, Department of Health and Community Services (unpublished data supplied by the Branch) showed high correlations between most items and the total satisfaction score. These data suggest that the instrument tapped an overall satisfaction factor rather than discrete dimensions. Previous research findings on this issue have varied. Lebow concluded that satisfaction has been found to be multidimensional more often than unidimensional, but that a general factor is usually found supplemented by some specific factors. Greenfield and Attkisson found two consistent factors – practitioner manner and skill, and satisfaction with perceived outcome (by clients), and a less consistent factor associated with access and office procedures (Greenfield & Attkisson, 1989).

The Verona Service Satisfaction Scale (VSSS) is based on the Service Satisfaction Scale with some modifications. It combines ratings of satisfaction on a 5-point Likert scale with spontaneous answers to open ended questions, and has been administered by an interviewer reading out the questions. In one study, it took around 45 minutes to complete (Ruggeri & Dall'Agnola, 1993; Ruggeri, Dall'Agnola, Agostini et al., 1994). The mean satisfaction rating varied by dimension from a low of 3.72 (74.4 percent of maximum possible) for type of intervention to 4.09 (81.8 percent) for overall satisfaction, and the test-retest reliability (Cohen's Kappa) varied from 0.22 to 0.56.

Perreault, Leichner, Sabourin et al. (1993) compared quantitative and qualitative methods of assessing client satisfaction in a study in Montreal. They used the French version of the CSQ8 and the SHARP-V to measure quantitative satisfaction and four open-ended questions to assess qualitative satisfaction (they considered taping the interviews but found this interfered with the expression of responses). All of those interviewed (252) gave an answer to open ended question on aspects for which they were satisfied whereas only 149 mentioned anything when asked about aspects they were dissatisfied with. They concluded that oral administration is more appropriate method for people with psychiatric disabilities, and that the qualitative method allowed people to express dissatisfaction, when asked specifically about this.

As part of this evaluation, it was also thought important to understand and assess clients' views about the cultural sensitivity of services they used. The development of culturally sensitive services was a central goal of the policy statement developed by the Psychiatric Services Branch of the Department of Human Services:

'Mental health services will enhance the outcomes for people of NESB by delivering services which demonstrate an awareness and respect for the client's cultural framework'. (Department of Human Services, 1996, p.19)

There is a large body of literature concerned with the concept of cross-cultural sensitivity in mental health services, much of it from the counselling area. According to this literature, staff require skills in cross-cultural psychiatric assessment, diagnosis and treatment, and knowledge of cultural influences on explanatory models of illness, the expression of psychological distress, expectations of health practitioners, and the helping relationship. There is consensus that staff should consider, among other things, dimensions of culture and the way in which they influence behaviour, the client's world view, the client's migration and settlement history, religious and spiritual beliefs, ethnic identity, acculturation, English language ability, and working with interpreters (American Psychological Association, 1993; Bhugra, 1993; Bhugra, 1997; Bhugra & Bhui, 1997a; Bhugra & Bhui, 1997b; D'Andrea, Daniels & Heck, 1991; Hardy & Laszloffy, 1992; Ho, 1991; LaFromboise & Coleman, 1991; Lloyd & Bhugra, 1993; Phillips, Leff, Kaniasty, Carter, Paret, Conley & Sharma, 1999; Ponterotto, Rieger, Barrett & Sparks, 1994; Pope-Davis & Dings, 1995; Sabnani & Ponterotto, 1992; Sue, Arredondo & McDavis, 1992; Sodowsky, Taffe, Gutkin & Wise, 1994).

Several scales have been devised to measure the cross-cultural sensitivity of mental health staff, counsellors or mental health services (Phillips, Leff, Kaniasty et al., 1999). These include the Cross Cultural Counseling Inventory-Revised (LaFromboise & Coleman, 1991), the Multicultural Counseling Inventory (Sodowsky, Taffe, Gutkin et al., 1994) and the Multicultural Counseling Awareness Scale (Ponterotto, Rieger, Barrett et al., 1994). These scales have been developed from theoretical literature describing cross-cultural counselling competence, and by combining the views of experienced multicultural practitioners. They have generally been designed for self-rating by clinicians (e.g by self-completed questionnaires) or for rating of counsellors

behaviour by trained observers. They have not been designed for clients to be able to rate the cross-cultural sensitivity of staff.

One difficulty with existing scales is that they are often very abstract and are oriented towards professionals' perspectives of the counselling/helping process. For example some scales require a rating of the extent to which the counsellor understands the 'client's worldview'. It was felt that it would be difficult for many clients to understand and interpret the language and concepts used in these instruments. In addition, no instruments could be found which investigated or explicitly included clients' views of cultural sensitivity. It may be that clients view cross-cultural sensitivity in similar ways to professionals, but this cannot be taken for granted.

Hence an important task for this evaluation (and as it emerged, a time-consuming and difficult one) was to develop a method to examine clients' views of cross-cultural sensitivity. This process was combined with the process of assessing client satisfaction with services as it was intended to interview clients about both areas during the one interview.

Service utilisation

Service use, particularly hospital admission and length of stay, has long been used as an indicator of outcomes from mental health services (Draine, 1997; Srebnik, Hendryx, Stevenson, Caverly, Dyck & Cauce, 1997), and for assessing the impact of ethnic matching (Flaskerud & Liu, 1991; Flaskerud & Hu, 1994; Fujino, Okazaki & Young, 1994; Jerrell, 1995; Sue, Fujino, Hu et al., 1991; Yeh, Eastman & Cheung, 1994; Ying & Hu, 1994). Hospital admission is a proxy measure of relapse, and clients with fewer relapses would have fewer admissions, or less time spent in hospital. For those with psychotic disorders, it might be expected that earlier intervention may lead to fewer involuntary admissions.

The introduction of Crisis Assessment and Treatment Teams (CATTs) in Victoria in recent years means that some clients who need intensive treatment and would

previously have been hospitalised are now managed by CATTs. Therefore the amount of client contact with CATTs can also be taken as an indication of outcome.

This study explored hospital admission and CATT team contact for NESB clients. It would be expected that if ethnic matching improved client functioning or led to fewer relapses, these clients would have fewer CATT contacts or admissions. An analysis of contacts with the Continuing Care Team was also included because previous studies had shown that this was likely to increase as a result of ethnic matching (Flaskerud & Hu, 1994; Flaskerud & Liu, 1991; Sue, Fujino, Hu et al., 1991; Fujino, Okazaki & Young, 1994; Jerrell, 1995; Yeh, Eastman & Cheung, 1994; Ying & Hu, 1994). If BCM staff spent more time with their NESB clients than other staff did, this may in itself have had an impact on relapse, early intervention and consequently on CATT contacts and hospital use. To examine whether ethnic matching itself led to reduction in hospital and CATT use, it was necessary to account and control for any differences in 'inputs'.

Social functioning

There has been substantial interest in recent years in developing and using valid and reliable measures of outcome for community mental health services (Dickerson, 1997; Srebnik, Hendryx, Stevenson et al., 1997). Srebnik and colleagues argued that social functioning is one of the four major domains of outcome from community mental health services – the others being client satisfaction, quality of life and clinical status. Social functioning has been conceptualised as 'clients' social and vocational role performance and their ability to perform activities of daily living' (Srebnik, Hendryx, Stevenson et al., 1997, p.904). It is concerned with the ability to function in community settings. Less attention has been paid to social functioning than to other areas, principally measures of symptomatology or hospitalisation. Flaskerud suggested that as service utilisation was an indirect measure of outcome, future research into ethnic matching should also investigate measures of clinical and social functioning, including ratings by therapists (Flaskerud, 1986).

There are several existing scales which measure social functioning (Andrews, Peters & Teeson, 1994). The Global Assessment Scale (GAS) (Endicott, Spitzer, Fleiss & Cohen, 1976) has been used in several previous studies of ethnic matching (Flaskerud & Hu, 1994; Flaskerud & Liu, 1991; Fujino, Okazaki & Young, 1994; Takeuchi, Sue & Yeh, 1995; Ying & Hu, 1994) perhaps because it was routinely used in county mental health systems in California where these studies were conducted. However, there have been some questions about the usefulness of the GAS as an outcome measure. One criticism has been that the GAS combines both symptom and social functioning items, and it is not possible to rate these separately, yet they may vary independently (Dickerson, 1997; Goldmann, Skodol & Lave, 1992). Sue has also suggested that the GAS may not be sensitive enough to measure changes in outcomes (Sue, 1998) and that this could have been why some studies have not detected an effect of ethnic match on outcomes measured by this scale.

In this thesis, it was decided that a multidimensional measure of outcome should be used, ideally one developed specifically for use in community mental health services. The Multnomah Community Ability Scale (Barker, Barron, McFarland & Bigelow, 1994a; Barker, Barron, McFarland & Bigelow, 1994b; Barker, Barron, McFarland, Bigelow & Carnahan, 1994) was chosen as it had been developed in community mental health services, has been shown to have good psychometric properties and predictive validity, and has been used in a variety of community mental health service evaluation projects (Barker, Barron, McFarland et al., 1994a; Barker, Barron, McFarland et al., 1994b; Bhui, Puffet & Strathdee, 1997; Trauer, in press; Zani, McFarland, Wachal, Barker & Barron, 1999).

AIMS

Case management effectiveness

This study aimed to investigate whether case management is effective compared to standard community care without case management, by conducting a meta-analysis of the results of controlled studies of case management effectiveness. A second aim was to compare outcomes for assertive community treatment to clinical case management.

Implementation of the program

The aims in examining the implementation of the BCM program were to investigate:

- What changes to roles and/or program model were there upon implementation?
- What were the caseloads for bilingual staff, including size and composition?
- What types of activities were being undertaken by bilingual case managers (e.g., assessment, counselling, referral)?
- What were the relationships between BCM staff and other staff and services?
- How were the roles of bilingual case-management staff seen by the agency?
- What did the bilingual staff think about their positions?
- Do any aspects of the program need to be changed in order for it to operate more effectively?

Medication management

The aims for this study were to investigate whether NESB clients matched to a case manager of the same background differed from NESB clients with another case manager on: mean neuroleptic dose; method of administration; use of atypical anti-psychotic medication; and perceived compliance with medication.

Client satisfaction and cultural sensitivity

This study aimed to investigate clients' satisfaction with, and views about the cultural sensitivity of, mental health services by using both structured and open-ended approaches. A second aim was to investigate whether NESB clients had a preference for a case manager of the same background. The third aim was to investigate whether clients matched to a case manager of the same background were more satisfied with the mental health service, and the cross-cultural sensitivity of service providers, than NESB clients with another case manager.

Service utilisation

This study aimed to investigate whether NESB clients matched to a case manager of the same background differed from NESB clients with another case manager on: frequency and duration of Continuing Care Team community contacts; frequency and duration of Crisis Assessment and Treatment Teams (CATT) contacts; and frequency, legal status and total duration of hospital admissions.

Social functioning

The aim for this study was to investigate whether NESB clients matched to a case manager of the same background had a greater improvement in social functioning over time than NESB clients with another case manager.

METHOD

Case management effectiveness

Design and sampling strategy

The present analysis included studies of outcomes of case management in mental health services, published between 1980-1998 in refereed journals. Studies were included if:

1. Their focus was on the treatment of adults.
2. Subjects had a serious mental illness (e.g. psychosis, affective disorder, personality disorder or anxiety disorder). Studies where subjects had a diagnosis of substance abuse were included if it occurred with another psychiatric diagnosis, but not if it was the sole or primary diagnosis.
3. Outcomes for a group receiving case management were compared with a group who received standard community care but not case management, or outcomes for a group

receiving ACT were compared with a group receiving another form of case management.

4. Dependent variables were measures of outcome for clients (e.g. hospitalisation, quality of life, client satisfaction, level of community functioning etc.).

The first sampling strategy was to examine studies cited by previous reviews of case management in mental health services which met the criteria outlined above. Second, Medline and PsychLit searches were conducted using the terms ('case management' or 'care management' or 'care programming' or 'assertive community treatment') and ('mental health' or 'psychiatric' or 'psychiatry') and ('evaluation' or 'outcome' or 'comparison' or 'effect').

The combination of these two methods yielded approximately 180 articles in English language journals. Some articles reported comparison of two or more different types of case management with control groups and the results of some studies were reported in several different articles. Where possible, each comparison was coded and included as a separate study, but studies for which different outcomes were reported in more than one article were included only once. Studies comparing ACT to another model of case management were included and analysed separately.

Measures

Each study was coded for client characteristics as well as aspects of study design, including sample size, study period, number of outcome measures used, attrition rates and group allocation method. Each study was categorised by an estimate of research quality following similar criteria to those used by Glass, McGaw & Smith (1981). These categories were: random assignment to conditions, with attrition less than 20 percent (highest rating); random assignment with attrition greater than 20 percent or differing between groups; well-designed matching studies or analysis for covariance; and weak or non-existent matching procedures (lowest).

Measures of outcome were calculated for each of twelve domains; (i) improvement in symptoms (excluding the Global Assessment of Functioning and Global Assessment

scales which include both symptoms and level of social functioning), (ii) number of admissions to hospital, (iii) length of hospital stay, (iv) proportion of clients admitted, (v) contacts with mental health services, (vi) contacts with other services, (vii) drop-out rates from mental health services, (viii) level of social functioning (quality of life rated by clinicians and clients, level of social functioning, and improvement in housing situation), (ix) client satisfaction, (x) family satisfaction, (xi) family burden of care and (xii) cost of services.

Statistical analysis

Two methods were used to calculate a standardised statistic for each outcome variable; the Pearson product-moment correlation coefficient (r) and the one-tailed level of significance (p). While there are a number of measures of effect size, r was regarded as being a more well known and interpretable statistic than other effect size measures. Correlation coefficients can be derived from other statistics such as t -values, means and standard deviations, or one-factor F -values (Rosenthal, 1984): the META computer program (Kenny, 1997) was used to calculate r from reported statistics.

When possible, the one-tailed p -value was also calculated for each outcome measure independently of whether the actual r could be calculated. One-tailed p values were obtained by halving the reported two-tailed probability if it favoured case management, and by subtracting the halved two-tail value from one if it favoured the control group (so for example, a two-tailed p of 0.05 in favour of case management was coded as 0.025, and in favour of the control group was coded as 0.975). If studies simply reported the result as 'not significant', p was coded as 0.5 (Rosenthal, 1984).

Where a study reported more than one result in domains which were combined (such as two different symptom measures), the mean p or r was calculated (Rosenthal, 1984). All r and p values were calculated by the author, and after all studies had been coded, each r or p value was recalculated and any inconsistencies resolved. For relevant outcome domains a record was made of whether the measure used in the original study had previously been reported in peer-reviewed journals or not. Missing data was not included in the analysis.

The weighted mean r for each outcome domain was calculated by converting each r to a standard normal deviate (Fisher's z) and weighting each z by the study's sample size and research quality (Cooper, 1989; Hedges & Olkin, 1985; Rosenthal, 1984). The 95 percent confidence interval was calculated for each weighted mean r (Cooper, 1989). As a separate analysis, the combined p value was calculated for each outcome measure by calculating the standard normal deviate for each p reported, and weighting by sample size and research quality (Rosenthal, 1984).

To investigate the impact of possible publication bias, Rosenthal's fail safe N was calculated for each combined p (Rosenthal, 1984), and Egger et al's regression asymmetry test for publication bias was calculated (Egger, Davey Smith, Schneider & Minder, 1997; Steichen, 1998). The fail safe N is an estimate of the number of studies with non-significant results which would have to be added to the sample in order to change the combined p from a significant one (at 0.05) to non-significant. Egger et al's asymmetry test is a formal statistical test using relative effect size and sample size from each study to detect whether effect sizes are biased.

Homogeneity analysis techniques devised by Hedges and Olkin (1985) were used to compare the effect sizes between groups. This technique, which is based on effect sizes, determines whether variance within and between groups is significantly greater than would be expected by chance. Q values can be calculated for the heterogeneity within (Q_{within}) and between groups (Q_{between}). If there is a real difference in outcomes between groups, Q_{between} will be significant based on the chi-square distribution (Hedges & Olkin, 1985). In order to compare outcomes between ACT and generic or clinical case management, two techniques were used. First, the combined p and weighted mean effect size were calculated for those studies directly comparing these programs. As the number of such studies was small (nine), a separate strategy was used to compare ACT with clinical case management: all studies comparing case management to a control group were included and Q_{between} was calculated to compare differences on outcomes for ACT compared with clinical case management.

Implementation of the program

Design and sampling strategy

A combination of qualitative and quantitative approaches were used. A key informants approach was used in selecting staff to be interviewed. It was assumed that the BCM staff, their discipline supervisors and team managers would have the most direct knowledge about the positions, and any difficulties which had been encountered in establishing the program. Semi-structured interviews were conducted in October and November 1997 with staff in the BCM positions (10 at that time), clinical supervisors (8), Continuing Care Team managers (4) and Area Managers (4). These interviews were repeated during late 1999 and early 2000 with bilingual staff (13 including two who left in early 1999), Continuing Care Team managers (5) and clinical supervisors (6) in order to monitor changes in the program over time. A list of staff interviewed is attached in Appendix I.

Measures

Face-to-face interviews were conducted using a semi-structured interview schedule (Appendix II). This included questions about the perceived aims of the program, roles of bilingual staff and work within each role, relationships with other staff, organisational impediments to the program, cultural issues in case management, mental state assessment and needs assessment, previous experience of the bilingual staff, training received since starting in the position, role of the VTPU in providing coordination and support, positive and negative aspects of the positions, and ideas about any changes necessary. The BCM's were also asked about their caseloads, both individually and as a group, at different points of time after the implementation of the program. Information was collected about the number of clients and their ethnic backgrounds, and the average caseload of other case managers at each clinic. This was verified from CCT managers.

Procedure

Most interviews were audio-taped with the permission of the interviewees (one person did not wish to be recorded, and technical difficulties prevented some interviews being taped), and detailed notes of the discussion were also kept. The audio-tapes were transcribed, where necessary with reference to notes. Another source of data was the fortnightly meetings of BCM held at the VTPU. Notes were made at each meeting of the major issues discussed. Finally, the author was also involved in the process of developing the proposal with area managers, in recruiting at some centres, and in discussions with Continuing Care Team managers throughout the project. This provided a participant observation perspective during the program design phase. The implementation evaluation is based mostly on data obtained during the BCM group meetings, and from the interviews with staff, supervisors and managers.

Analysis

The interviews were coded using NUD*IST computer software (Qualitative Solutions and Research, 1997), according to a pre-set coding framework which was changed slightly after joint coding of one interview by the two coders (Stephen Ziguras and Jo Pennella). The final coding frame used is attached (Appendix III). The results were analysed by first compiling all comments coded under the same category, listed by type of position (BCM, supervisor or manager), and then recording the major themes or issues emerging for each category (Miles & Huberman, 1994) . Where it seemed relevant, the frequency of comments is presented in the text, but for the most part, this was not calculated.

Medication management

Design and sampling strategy

Medication information was collected over the period November to December 1997. The aim was to include as many clients as possible at each service who were born overseas and spoke Croatian, Greek, Italian, Macedonian, Turkish or Vietnamese as their first language (the six languages spoken by the BCM staff). A random sample of Australian born clients was included from the same services (these were chosen by case managers from their own caseloads) to match with the NESB population. At this time, the clients who had an ethnic match with case managers would have seen their current case manager for between 6-12 months. It was not possible to examine change in medication management over time, because it was only possible to collect medication information once due to limited resources. The design for this study was therefore a cross-sectional survey. In order to control for possible differences due to diagnosis, only clients diagnosed with a psychosis, and prescribed anti-psychotic drug were included in this analysis.

Measures

Case managers were asked to provide details of the three main prescribed psychotropic medications, dose and frequency. Case managers also rated the level of social functioning for each client using the Multnomah Community Ability Scale (MCAS) which was used to assess change in social functioning. The MCAS is a 17-item scale developed by clinicians, managers and researchers in Oregon USA, with the intention of measuring outcomes of mental health services. It has been shown to have good reliability and predictive validity (Barker, Barron, McFarland et al., 1994a; Barker, Barron, McFarland et al., 1994b). One item of the MCAS measures case managers' perceptions of client's compliance with prescribed medication on a five-point scale, and this item was used as a measure of medication compliance. Demographic data, including date of birth, country of birth, preferred language, and gender was obtained from the services' computerised databases. Case managers also provided an estimate of

the client's fluency in English, and whether they spoke a language other than English (LOTE).

Procedure

The author contacted managers of the CCTs during mid-1997, and presented an overview of the evaluation at staff meetings at each centre. A list of case managers for all clients was obtained from CCT managers. Case managers of the clients selected for the study were approached by letter, and asked to collect the data described above. A follow-up letter was sent if there had been no response after 4 weeks, and telephone contact was made with case managers who had not responded 2 weeks after the second letter was sent.

Statistical analysis

In order to contrast various doses of medications, oral and depot antipsychotic doses were converted to equivalent average daily doses of chlorpromazine (CPZe). Equivalences were calculated from a range suggested in the literature (Bazire, 1998; Galletly & Tsourtos, 1997; Herz, Zarin & McIntyre, 1997) and from clinical experience (A/Prof Tim Lambert calculated the CPZe doses for this part of the study). For the analysis of dose size, one case with an average dose of 4000 mg/day CPZe was excluded as an outlier, as the next highest dose was 1500 mg/day. As the data for dose sizes were positively skewed, natural logarithm of dose size was used to conduct analyses.

Differences on sociodemographic variables were investigated using t-tests. For route of administration, the proportion of NESB-born clients receiving a depot injection was compared with the proportion of Australian-born clients using the chi-square test. Mean medication dose for each group was compared using analysis of co-variance (F-test). Proportions of each group receiving atypical antipsychotics were compared initially using the chi-square test. Further analysis was conducted by choosing a subset of clients matched for age and medication compliance, and using logistic regression to compare proportions receiving an atypical antipsychotic.

Logistic regression analysis was used to examine the predictors of route of administration (oral versus depot). Thirteen independent variables were included; ethnic/linguistic matching with a case manager, country of birth (NESB versus Australia) and sex, (entered as dichotomous variables) and age, impairment of thought processes, mood abnormality, ability to manage money, acceptance of illness (insight), alcohol and drug use, compliance with medication, impulse control, medication dose, and cooperation with staff. The variables 'ability to manage money', 'insight', alcohol and drug use', 'impulse control', 'medication dose', 'cooperation' and 'compliance' showed skewed distributions, so appropriate transformations were carried out before the regression analysis.

Multiple regression analysis was used to examine the predictors of medication compliance. Thirteen independent variables were included; ethnic/linguistic matching with a case manager, medication administration route (depot versus oral), and sex, (all entered as dichotomous variables) and age, impairment of thought processes, mood abnormality, ability to manage money, acceptance of illness (insight), social network size, alcohol and drug use, impulse control, medication dose, and cooperation with staff. Two outliers in the solution identified through examination of the residuals scatterplot ($z > 3.0$) were excluded from the analysis (Tabachnick & Fidell, 1996).

For the analyses by country of birth, the sample was split into those born in Australia (54) or the United Kingdom (4 patients) and those born in a non-English speaking country (110). The NESB group was further categorised according to whether they were born in a European country or an Asian country (Vietnam was the only Asian country included) for the analyses where this distinction was relevant.

For analyses by language the sample was split into those speaking English, and those who preferred to speak a language other than English, and where relevant, this latter group was divided into those speaking a European language or Vietnamese.

As it became evident that country of birth was confounded with age (those born in a non-English speaking country were older), a separate analysis was conducted for a subset of the total sample. Each client born in Australia was matched with a client born

in a NES country by age and medication compliance (based on the commonly used measure of Euclidean distance). For the 110 patients born in a NES country, 35 (31.8 percent) saw a case manager from the same ethno-linguistic background and 75 (68.1 percent) did not.

Client satisfaction and cultural sensitivity

Design and sampling strategy

The initial design was a cross-sectional case-control study, comparing NESB clients with a bilingual case manager of the same background with NESB clients with another case manager. It was intended to match NESB clients with a BCM with NESB clients from the rest of the service on the basis of age, sex, diagnosis, centre and country of birth. To control for possible effects of differences between the BCMs and other staff (other than fluency in another language), it was decided to include a group of Australian-born clients of BCMs and another group of Australian-born clients without a BCM. This group was interviewed about their satisfaction with services, but not about cultural sensitivity. A total of 200 clients was identified from client records provided by the services, approximately 50 in each group (NESB with a BCM, NESB with another case manager, Australian born with a BCM, Australian born with another case manager). During the process of recruitment, case managers reported that a substantial number of these clients had been discharged in the 3 months between the client lists being provided and the interviews commencing. As far as possible, these clients were replaced with clients from the same backgrounds.

Measures

The interview schedule to assess client satisfaction and views about cultural sensitivity was developed jointly by Stephen Ziguras and Steven Klimidis from the VTPU, and Yvonne Stolk, Ethnic Mental Health Consultant for the Western region. As mentioned above, it was felt that both quantitative and qualitative methods should be used to

explore client satisfaction. For this purpose a brief satisfaction rating scale was needed as cross-cultural sensitivity was to be covered in the same interview. Short measures of client satisfaction have been shown to have good psychometric properties; for example, the CSQ8 has an alpha coefficient (a measure of internal consistency of the scale) of 0.93 (Larsen, Attkisson, Hargreaves et al., 1979; Nguyen, Attkisson & Stegner, 1983), and has been shown to have high split half reliability (Attkisson & Zwick, 1982). This suggests that a brief scale could function as a reasonable measure of satisfaction.

As previous research had shown that there was a general satisfaction factor, a brief satisfaction scale was developed by adapting questions from the Psychiatric Services questionnaire, and from previously published scales. The first such scale included six questions concerning satisfaction with information provided, promptness of treatment, staff, treatment received, staff acknowledgment of the client's views, and client's ability to influence treatment. After pilot testing, the staff question was split into two, to assess clients views about their doctor and case manager separately, and the two questions on the ability to influence treatment and staff listening were combined into a general satisfaction question.

Following Ruggeri et al. and Perreault et al., a number of open-ended questions about clients' experiences and opinions about the service were included. These questions asked clients what happened when they attended the clinic, about doctor and case manager activities, the most helpful and least helpful things about the service, and whether there was anything else which would help. Interviewers rated their impression of the client's general attitude to the service, and their impression of the degree of difficulty clients had in understanding the questions. The satisfaction questions were included in the cross-cultural satisfaction questionnaire used to conduct interviews with clients born overseas in a non-English speaking country. Clients born in Australia were only asked questions about service satisfaction, information received, and family involvement.

After reviewing the cross-cultural counselling literature, an initial list of domains of cross-cultural sensitivity was developed based on both theoretical descriptions and the content of other measures. Focus groups were conducted with three groups to assess their views of cross-cultural sensitivity: a group of Greek carers attending a family

education and support group run by the Australian Greek Welfare Society; a group of Vietnamese clients who attended two community mental health services in the West of Melbourne; and a group of three interpreters (one Greek, one Italian and one Vietnamese) with extensive experience in the mental health field. The project was also discussed with a consumer-consultant from the Western region.

From these focus groups, a draft interview schedule was developed which incorporated the domains of migration and settlement experience, acculturation, English proficiency and need for an interpreter, preference for ethnic background of case manager, religious beliefs, information received, and family involvement. It was thought that a face-to-face interview using a structured interview schedule was preferable to a self-completed questionnaire as some clients may have difficulty completing a written questionnaire, and because interviews allow for clarification of both questions and answers, where these are unclear. The schedule attempted to avoid the use of psychiatric terminology, and the initial version consisted mostly of Likert-scale type questions.

The interview schedule (which combined questions on cross-cultural sensitivity and client satisfaction) was trialled in November 1998 with five NESB clients (born overseas in a non-English speaking country) who were regarded, by their case managers, as having a good grasp of English. It became apparent that the questions were too abstract and that clients had difficulty understanding them. There was also insufficient space for more general questions and comments. The schedule was redrafted, the language simplified, and more open-ended questions added to allow a more naturalistic conversation to occur. It was trialled again in February 1999 with another four English speaking NESB clients. The questionnaire appeared to be better understood and more relevant to the experience of clients, and some minor changes to format and wording were made after this. The final version of the interview schedule is included in Appendix VI.

Procedure

The English version was translated into six languages: Croatian, Greek, Italian, Macedonian, Turkish and Vietnamese by the Victorian Interpreting and Translating

Service (VITS). Eleven bilingual interviewers were recruited. These staff were experienced in client interviewing, and most had worked as bilingual professionals in the health and welfare field, although experience in mental health varied. Interviewers were asked to check that the translated version included all questions, pages or statements covered in the English version (i.e. that nothing was missing), that it reflected the meaning of questions in the English version as far as possible, and that questions were clear and expressed in reasonably simple language.

Where changes were required, the translation was returned to VITS with a request to amend the translation, sometimes with a suggested alternative provided by the interviewer. The final versions were checked and passed by all the interviewers, although one of the two Vietnamese interviewers believed that the register of language in the Vietnamese version was still too formal and may need to be rephrased for some clients. However, lack of time prevented another revision.

Interviewers attended two half-day training sessions. These included information about mental health services, skills in interviewing clients with a mental illness, client and interviewer safety and confidentiality, and an overview of the interview schedule. Part of the sessions involved a simulated interview to practice using the interview schedule. Once interviewing began, interviewers attended monthly meetings to discuss the progress of the project and any questions or difficulties which had arisen during interviews.

During May 1999, the author attended staff meetings at two clinics to discuss the client interviews. Written information was distributed to the other three services as it was not possible to attend meetings before the project started. Ethics committee approval was obtained from the University of Melbourne. The Director of Clinical Services for the four services at the start of the evaluation project indicated that separate ethics committee approval from the Health Care Network which managed the services would not be required as it had already been obtained from the University of Melbourne.

The case manager for each client included in the sample was identified from data provided by the services. In August 1999, a letter was sent to each case manager explaining the project and asking if she or he would discuss with project with the clients

listed. Information about the project in the client's preferred language was included (Appendix VII). Case managers were requested to pass the information to clients and to ask if they were interested in being interviewed. Clients who agreed to be interviewed were asked to sign a consent form (Appendix VIII) giving permission for their contact details to be passed on to the VTPU. Clients were informed that they would be reimbursed \$20 for participating. In September 1999, a second letter was sent to case managers who had not responded to the first. Phone calls were also made to all case managers who had not responded. Interviewers made contact directly with clients who agreed to participate and arranged a time and place for the interview. Most interviews took place at the clinic usually attended by the client, with a small number being conducted at the person's home if they requested this.

The process of recruitment was a lengthy and difficult one. Some case managers discussed the project with clients immediately and informed the researchers about the clients decision soon after. However many case managers did not respond, even after the second letter and attempts to contact them by phone. When contacted, they said they had been too busy to approach clients about the project, or that they had not seen the person since the first letter had been sent. A greater than expected number of clients either refused or were unable to participate (mostly because they had been discharged or they were regarded as too ill by their case manager). Some managers also reported that there had been many research projects conducted at their centres recently, and that staff were suffering 'research fatigue'. It was the impression of the researchers that most staff were extremely busy, and many saw the task of discussing the project with clients as a low priority. Due to time constraints, most effort was concentrated on recruiting clients of NESB, and less effort was expended on following up Australian-born clients.

Analysis

Qualitative data from open-ended questions were analysed using NUD*IST computer software (Qualitative Solutions and Research, 1997). Responses were coded under each question (i.e. responses to the same question for all clients received the same code). The results were analysed by first compiling all comments coded under the same question, listed by country of birth and whether clients were matched with a case manager of the

same background. The major themes or issues emerging for each category were described, but the frequencies of these were generally not calculated. For the analysis of the questions about the advantages and disadvantages of a case manager of the same background or of a different background (Questions 50-53) the responses were coded into separate categories and the frequencies of these categories listed. The categories are described in the results. Comments from clients were quoted in the results to illustrate common themes.

Quantitative data from questions with dichotomous or Likert-scale type responses were initially presented in the form of frequencies of response categories. In order to compare satisfaction by country of birth, and by matching with case manager, a 'total satisfaction score' was calculated for each client by summing the five general satisfaction items; satisfaction with doctor, satisfaction with case manager, satisfaction with promptness of help, satisfaction with treatment, and general satisfaction with the service. Each item was scored from 1 very dissatisfied to 7 very satisfied, giving a range of possible total scores of between 5 and 35. Missing data was replaced with the mean of the non-missing items for that person.

A 'cultural sensitivity rating score' for each client was calculated based on the responses to questions about individual aspects of culture; ('satisfaction with understanding of migration', 'satisfaction with understanding of religion', 'satisfaction with family involvement with treatment', 'satisfaction with information received', and 'rating of respect shown by staff for language and culture'). A total cultural sensitivity score was calculated by summing the standardised (normal deviates) scores of each question to overcome the fact that three items were rated on a seven-point scale and one (staff respect for culture and language) was rated on a four-point scale. Satisfaction with religion was not included in the final scale due to the large amount of missing data. Missing data for the other items was replaced with the mean of the non-missing items for that person. This rating scale was then transformed so that the maximum score was set at ten, and the minimum at zero.

Comparisons between groups were made using the Mann-Whitney U test and Fisher's exact test or other non-parametric statistics due to the small sample size obtained.

Service utilisation

Design and sampling strategy

This study used a quasi-experimental design to examine mental health service utilisation data for the period 1 July 1997 to 30 June 1999. Data were obtained from the Psychiatric Records Information Systems Manager (PRISM) database for all clients from one of the six ethnic backgrounds covered by the BCM program, and all Australian-born clients. Data for NESB clients from ethnic backgrounds not covered by the BCM program were excluded from the analysis. Data was collected for Continuing Care Team community contacts, CATT contacts, inpatient admissions and legal status, and client demographic details. Bilingual case managers were allocated specific sub-centre codes when they first started recording PRISM contact details (Appendix IV), and these were used to distinguish between contacts with a BCM and other staff. Inspection of the data during the evaluation period showed that these codes were being used.

Measures

For Continuing Care Team community contacts, information was collected on duration of contact, contact type (direct versus telephone), sub-centre code, country of birth, date of contact and research code, client age, sex and diagnosis. Contact duration in PRISM was originally recorded as a range for each contact, for example 'less than 15 minutes). To calculate average contact duration the duration of each contact was recoded to the mid-point of the range: 'less than 15 minutes' was re-coded to 7.5 minutes; '15 ≤ 30 minutes' to 22.5 minutes, '30 ≤ 60 minutes' to 45 minutes, '1 ≤ 2 hours' to 90 minutes, '2 ≤ 4 hours' to 180 minutes, and 'greater than 4 hours' to 4 hours. The data was aggregated to provide the number and total duration of direct and telephone contacts with a BCM, and the number and total duration of direct and telephone contacts with another case manager.

For CATT contacts, information was collected on duration of contact, contact type (direct versus telephone), sub-centre code, country of birth, date of contact and research

code, client age, sex and diagnosis. Measures were calculated in the same manner as for contacts with the community clinic.

For hospital admission, admission date, discharge date, admission legal status, CTO agency and CTO expiration date was collected. Length of stay in inpatient care was defined as the time between admission and discharge. Each admission could have more than one admission legal status code. To simplify results, involuntary admissions were defined as any admission which had at least one of the involuntary codes, while voluntary admissions were defined as the absence of an involuntary code for a given admission. Length of stay was calculated for both voluntary and involuntary admissions. The data were aggregated over admission date to provide the number of voluntary and involuntary admissions per client.

For the analysis of service use by existing clients, some clients had been in contact with services for less time than others, meaning that the raw number of contacts for each client could not be used as a measure of outcome. For example, clients who were discharged from the services before June 30 1999 would have had contacts over a shorter time period than clients who were in contact with the services for the entire 2 years. To control for these differences, the frequency of contact per year and total duration of contact per year (telephone and direct) with CCTs were calculated, as were the frequency of contact per year and total duration of contact per year (telephone and direct) for CATTs, and the frequency of admissions per year and total length of time in hospital per year.

Frequency of contact was calculated by dividing the number of contacts by the time available for contacts. The time available was defined as the total time in contact with the service minus the time spent in inpatient care during that time. The frequency of admission was defined as the number of admissions divided by the time the person had spent in contact with any of the four area mental health services over the two year period.

Procedure

Initially, four categories were used to identify client/case manager ethnic match.

- NESB client / Bilingual Case manager of same background
- ESB client / Bilingual Case Manager
- NESB client /other Case Manager
- ESB client /other Case Manager

As PRISM data included all contacts (including those with doctors, attendance at depot clinics etc.) most clients who had a BCM also had contacts with other staff. Also, some clients were transferred to a BCM during the two years so some contacts occurred with another case manager before the transfer date. It was not possible to find the allocation dates for clients in this situation, so instead the total proportion of contacts with a BCM was calculated and used as the independent variable (i.e. it became a continuous rather than a categorical variable).

The final analysis examined the relationship between the proportion of contacts with BCM for NESB clients (of the same background) and the outcome variables described above. The proportion of contact with BCM for Australian born clients was included as a covariate to control for possible group differences between BCM and other staff, apart from ethnic match with clients (for example because other staff included doctors who would be expected to have fewer contacts with clients than case managers).

For some analyses (e.g. comparison of median contact rates) this variable was recoded into a dichotomous variable; 'No BCM involvement' (proportion of contacts with a BCM=0), and 'Some BCM involvement' (proportion of contacts with a BCM greater than 0).

Statistical analysis

Most of the service utilisation variables were positively skewed. The Stata software program (Stata Corporation, 1997) was used to calculate transformation equations which would normalise the data. 'Frequency of direct contact' was transformed using

the equation $\ln((\text{frequency of direct contact}+1)-.9811728))$; this produced a normal distribution. All other variables were transformed using the natural logarithm function, and the Kolmogorov-Smirnov test (Siegel & Castellan, 1988) was used to check that the transformed variables did not significantly depart from normality.

Median contact frequency and duration, length of stay and hospital admissions were calculated from the untransformed data trimmed of the top five percent of cases due to skewness.

Multiple regressions were conducted to examine the impact of ethnic matching on each outcome variable. It was expected that if there was an effect from matching clients and case managers on the basis of ethnicity, this would lead to differences between NESB clients matched to a BCM and other NESB clients. However it was not expected that Australian born clients would have different outcomes from being matched to a BCM. It was therefore postulated that there may be an interaction effect of ethnic matching with country of birth.

To allow for this possibility, an interaction variable was calculated by recoding country of birth as -1 for English speaking country and $+1$ for a non-English speaking country, and multiplying this variable by proportion of contacts with a BCM. Increasing positive values for this variable therefore indicate increasing contact with a BCM for clients of the same background, and larger negative values indicated increasing contact with a BCM for clients of English speaking backgrounds. This allowed an analysis of whether BCM contacts had a different effect on matched NESB clients compared to Australian born clients.

In other words it was expected that all clients of BCM may have different frequencies of contact (eg with CCTs etc.) compared to clients of other staff because of differences between the two groups of staff, but including the interaction term allowed an analysis of whether this difference was greater for NESB matched clients compared to Australian clients.

For the analysis of contacts with Continuing Care Teams, the independent variables included country of birth (clients born in an English speaking country =1, clients born in

a non-English speaking country=2), gender (male=1, female=2), and diagnosis (psychosis=1, other diagnosis=2) which were coded as dichotomous, and proportion of contacts with a BCM, the interaction term described above, and age, coded as continuous variables. If the proportion of contacts with BCM was statistically significant in the regression, this would indicate differences between the group of BCM staff and other staff, and if the interaction term was significant, this would indicate that the impact of the BCM's on matched NESB clients was different to the effect for Australian born clients.

The regression equations for the outcome variables (contacts with Crisis Assessment and Treatment Teams, and hospitalisation) included the same variables as above, and also included the four variables measuring contact with CCT (frequency of telephone and direct contacts, and total duration of telephone and direct contact). These were added to control for possible differences in outcomes due to differences in inputs, i.e. time spent with the client by the case manager.

Social functioning

Design and sampling strategy

A quasi-experimental design was used to compare outcomes for NESB clients with a BCM to NESB clients who did not have a matched case manager. As mentioned above, it was thought possible that the BCM as a group may have had a differential effect on outcomes for their clients compared to other staff. For example, the BCM were generally less experienced, raising the possibility that their clients may have had less favourable outcomes. On the other hand, they were also seen as more enthusiastic and committed, possibly leading to better outcomes for their clients overall. To allow for possible differences between staff, a sample of Australian born clients of the BCM and Australian-born clients of other case managers was included, and scores for these Australian-born clients used to control for general differences between the groups.

The aim was to include as many clients as possible at each service who were born overseas and spoke Croatian, Greek, Italian, Macedonian, Turkish or Vietnamese as their first language (the six languages spoken by the BCM staff). A random sample of Australian born clients was included from the same services (these were chosen by case managers from their own caseloads) to match with the NESB population.

Measures

The Multnomah Community Ability Scale (MCAS) was used to assess social functioning of clients. The MCAS is a 17-item instrument which measures the level of functioning of people with chronic mental illness, and which was designed to be completed by case managers (Barker, Barron, McFarland et al., 1994a; Barker, Barron, McFarland et al., 1994b; Barker, Barron, McFarland et al., 1994c). The scale was designed to provide an objective measure of the disability of chronic mental illness for persons in the community. The authors developed an initial scale based on items suggested by 43 community mental health clinicians, and then pilot tested it with 180 clients selected at random from community mental health services. The scale was expanded from 13 to 17 items, and trialled in another test with 150 people for whom case managers also provided global ratings of overall ability (from 1 to 10), number of hospitalisations and demographic data.

Inter-rater and test-retest reliability of the MCAS have also been investigated by having forty-three clients rated by two different clinicians, and repeating this process after two to four weeks. The inter-rater reliability was 0.85, and test-retest reliability was 0.83 (correlation between first and second rating), and Cronbach's alpha was 0.90. The validity of the scale was examined by comparing MCAS scores for 240 clients of community support services with subsequent hospitalisation. Those with higher MCAS scores (better functioning) were less likely to be hospitalised (Barker, Barron, McFarland et al., 1994a; Barker, Barron, McFarland et al., 1994b; Barker, Barron, McFarland et al., 1994c). These results were also replicated with a larger sample (Zani, McFarland, Wachal et al., 1999). It can be concluded that the MCAS is a reliable, valid scale for assessing client level of general social functioning.

Procedure

The author contacted managers of the CCTs during mid-1997, and presented an overview of the evaluation at staff meetings at each centre. A list of case managers for all clients was obtained from CCT managers. Case managers of the clients selected for the study were approached by letter, and asked to collect the data described above. A follow-up letter was sent if there had been no response after 4 weeks, and telephone contact was made with case managers who had not responded 2 weeks after the second letter was sent.

This process was repeated in March 1998, where staff were asked to provide another MCAS rating for those clients they had rated 6 months previously. Some new clients were also rated for the first time. Case managers were asked to complete a follow-up rating at the end of 1998 and the end of 1999 for the same clients. There were thus four rating time points; Sep-Nov 1997, March-April 1998, Sep-Nov 1998, and Sep-Nov 1999. Many clients were discharged or transferred to other services over this period, making it difficult to complete MCAS for all clients at all time intervals. Information was collected about the discharge destination (i.e. other mental health service, general practitioner) for as many of the discharged clients as possible.

Statistical analysis

Change in social functioning over time was calculated for those with more than one MCAS rating. The number of MCAS ratings per person varied from 2 to 4 and the time between the first and last ratings also varied (from 6 to 24 months). In addition there was considerable missing data (for example for people who had a rating at time 1 and time 3 but none at time 2 or time 4). This meant that it was not possible to use traditional MANOVA techniques for the analysis as this does not adequately deal with missing data (Everitt 1998).

Instead, the MLwiN program for multilevel or hierarchical linear modelling (Goldstein, 1995; Rabbash, Browne, Healy, Cameron & Charlton, 1999) was used to calculate slopes for each person, controlling for time between ratings. This gave a regression slope, representing change in functioning per time period, for each person. The intercept for each person was also calculated – this represented an estimate of the MCAS score for each person at time zero based on the regression slope. The individual slopes were then analysed using ANCOVA in order to examine the effect of country of birth (ESB versus NESB), case manager (BCM versus other case manager) on the change in social functioning over time. The intercept was entered as a covariate to control for the ‘starting MCAS score’ for each person, as it could be expected that the degree of change may depend on a person’s initial level of functioning.

Clients who had changed from a BCM to another case manager or vice versa from one rating to another were excluded, as the change of case manager would have confounded the effect of ethnic matching.

CONCLUSIONS

From the description provided above, it can be seen that there were six separate studies in this thesis. First, it included an investigation of the effectiveness of case management by conducting a meta-analysis of previous studies. Second, it considered the implementation of the BCM in order to see whether it was implemented as planned. The study also investigated the impact of matching clients with a case manager of the same ethnic background on four outcome domains: medication management; satisfaction with services and their cultural sensitivity; service utilisation; and improvement in social functioning. The next chapter describes the results of each of these investigations in turn.

8. RESULTS

INTRODUCTION

This chapter describes the results of the six main areas of investigation of the thesis. First, it describes the results of meta-analysis of the effectiveness of case management. Next it describes the implementation of the BCM program and compares the proposed program with that which resulted. The four areas of investigation of the impact of matching clients with a case manager of the same ethnic background are then described: medication management; service utilisation; satisfaction with services and their cultural sensitivity; and improvement in social functioning. Each section concludes with a brief summary of the results, which are discussed further in the following chapter.

CASE MANAGEMENT EFFECTIVENESS

Selection of studies

Thirty-five comparisons of either ACT or another model of case management with usual treatment were found which met the criteria for inclusion (Table 8.1). Some articles appear more than once because they report the results of separate comparisons. Another nine studies were found which directly compared ACT with clinical case management (included in Table 8.1 as ACT v CCM).

Six studies which met the inclusion criteria were not used in this analysis: one used criminal justice contacts as the only outcome measure and this was not included as a domain in this study (Wilson, Tien & Eaves, 1995); in another the case management and control groups received services for differing amounts of time (Cutler, Tatum & Shore, 1987); and in the other studies (Aberg-Wistedt, Cressell, Lidberg, Liljenberg & Osby, 1995; Dincin, 1990; Mueller & Hopp, 1987; Mueser, Bond, Drake et al., 1998; Solomon & Draine, 1994; Solomon & Draine, 1995; Solomon, Draine & Meyerson, 1994), neither effect sizes nor p values could be retrieved.

The type of case management was recorded according to the definition used by the authors of the report. Initially Solomon's typology (Solomon, 1992) of (i) 'assertive community treatment', (ii) 'strengths', (iii) 'rehabilitation' and (iv) 'generalist' models was used to record types of case management. Nineteen studies compared ACT with usual treatment, and sixteen studies compared another model of case management (one 'strengths' program, one 'rehabilitation' program, one 'generalist' program and thirteen others which could not be further classified) with usual treatment.

These other models have all been designated 'clinical case management' (CCM) in this thesis as they all included a single person responsible for conducting needs assessment, developing individual plans, coordinating access to needed services, and monitoring mental state and social functioning. In addition, most emphasised the importance of the case manager establishing a therapeutic relationship and providing ongoing care (rather acting merely as an administrative service broker), and so corresponded to Kanter's description of clinical case management (Kanter, 1989). This group also seem to share features of the 'clinical case management', 'strengths' and 'rehabilitation' models described by Mueser and colleagues (Mueser, Bond, Drake et al., 1998).

ACT programs provided intensive support and many of the case management functions listed above, but differed in that they operated with teams of two or more responsible for each client, had lower caseloads, and often (but not always) provided more needed services from within the program rather than referring to other services. In seventy-one percent of the 19 ACT programs, case managers had caseloads of between 10 and 19 clients, and the other twenty-nine percent had less than 10 clients per case manager. Fifty-six percent of the 16 clinical case management programs had caseloads between 10 and 19, and the remainder had caseloads greater than 20 per case manager. Usual treatment was generally provided via outpatient visits to a community mental health facility.

Client characteristics

A total of 6 365 clients were included in the 35 studies comparing case management with usual treatment. Eighty-three percent (5 283) were single (including categories 'never married', 'widowed' and 'divorced'). Fifty-six percent (3 564) of subjects were male, the mean age was thirty-seven , and subjects had an average 6.6 (S.D. 2.0) previous admissions. In those studies which reported DSM Axis I diagnoses for all clients (19 studies), 62 percent of clients were diagnosed with schizophrenia, 7.8 percent with bipolar affective disorder, 9.0 percent with another psychotic disorder, 13.1 percent with depression, 2.2 percent with neurosis, and 7.8 percent with another diagnosis.

There were no statistically significant differences between case management and control groups on any of these demographic variables or diagnosis. However information on previous admission was unavailable from twenty-five studies (71 percent) because such admissions were reported in a format which did not allow comparisons across studies.

Study characteristics

Of the 35 studies comparing case management with usual treatment, eighty-three percent (29) employed random allocation of clients to intervention and control groups, and the others were matched designs (non-random allocation to groups). The mean study period (defined as length of time during which the two groups received different services until the final measure for comparison was recorded) was 16.5 months (S.D. 6.7). The mean attrition rate was 15.9 percent (S.D. 9.3) for case management group and 23.4 percent (S.D. 10.9) for control groups. Median study sample size varied considerably across outcome measures from a maximum of 121 for proportion of group hospitalised, to a minimum of 32 for family satisfaction.

Table 8.1 Studies and outcome domains included

Authors ¹	Year	Model ²	Study quality ³	Sample size ⁴	SY ⁵	AD	DY	PR	CMH	CO	DR	SF	CS	FS	FB	CT
Stein & Test ¹⁻⁵	1980	ACT	H	121	X		X	X				X				X
Hoult et al ^{6,7}	1983	ACT	H	115	X	X	X	X				X	X	X	X	
Santiago et al ⁸	1985	CCM	MH	159								X				
Franklin et al ⁹	1987	CCM	MH	340				X				X				
Bond, Miller et al ¹⁰	1988	ACT	MH	64			X	X				X				
Bond, Miller et al ¹⁰	1988	ACT	MH	64			X	X				X				
Bond, Miller et al ¹⁰	1988	ACT	MH	42			X	X				X				
Goering et al ^{11,12}	1988	CCM	ML	164		X	X	X		X		X				
Jerrell & Hu ¹³	1989	ACT v CCM	MH	35	X				X			X				X
Bond, Witheridge et al ¹⁴	1990	ACT	MH	82		X	X	X			X	X	X			
Bush et al ¹⁵	1990	ACT v CCM	H	28			X					X				
Bigelow & Young ¹⁶	1991	CCM	ML	68		X	X	X	X	X		X				
Bond, McDonel et al ¹⁷	1991	ACT	ML	74		X					X	X	X			
Bond, Pensec et al ¹⁸	1991	ACT v CCM	L	31		X	X	X								
Test et al ^{19,20}	1991	ACT	MH	113			X	X				X				
Champney & Dzurec ²¹	1992	ACT v CCM	L	77									X			
Curtis et al ^{22,23}	1992	CCM	H	292		X		X				X				
Curtis et al ^{22,23}	1992	CCM	H	288		X		X								
Morse et al ^{24,25}	1992	ACT	MH	72	X				X	X	X	X	X			
Rössler et al ²⁶	1992	CCM	ML	324				X								
Burns et al ²⁷⁻²⁹	1993	CCM	MH	172	X		X	X	X			X	X		X	X
Hornstra et al ³⁰	1993	CCM	ML	224		X	X	X	X							
Audini et al ³¹	1994	ACT	H	66	X			X				X	X	X		
Macias et al ³²	1994	CCM	H	37	X			X				X	X		X	
Marks et al ^{33,34}	1994	ACT	MH	189	X		X	X				X	X	X		X
Muijen et al ³⁵⁻³⁹	1994	CCM	MH	82	X	X	X		X			X	X	X		X

Table 8.1 (cont) Studies and outcome domains included

Authors ¹	Year	Model ²	Study quality ³	Sample size ⁴	SY ⁵	AD	DY	PR	CMH	CO	DR	SF	CS	FS	FB	CT
Wood & Anderson ⁴⁰	1994	ACT	ML	118			X	X								
Ford, Beadsmore et al ⁴¹	1995	CCM	MH	77	X			X	X		X	X				
Marshall et al ⁴²	1995	CCM	MH	61	X		X					X				
Quinlivan et al ⁴³	1995	ACT	H	60			X		X							X
Quinlivan et al ⁴³	1995	CCM	H	60			X		X							X
Quinlivan et al ⁴³	1995	ACT v CCM	H	60			X		X							X
Chandler et al ⁴⁴	1996	ACT v CCM	H	439	X		X				X	X				
Ford, Ryan et al ⁴⁵	1996	CCM	ML	90	X							X				
Lafave et al ⁴⁶	1996	ACT	MH	65			X	X				X	X			
Herinckx et al ⁴⁷	1997	ACT	MH	163							X					
Lehman et al ⁴⁸	1997	ACT	MH	152	X		X		X			X				
Morse et al ^{49,50}	1997	ACT v CCM	H	90	X				X			X	X			
Mowbray et al ⁵¹	1997	ACT	MH	121			X					X				
Drake et al ⁵²	1998	ACT v CCM	MH	173	X		X					X				
Essock et al ^{53,54}	1998	ACT v CCM	H	252	X		X	X				X			X	X
Fekete, Bond et al ^{55,56}	1998	ACT	H	128	X	X	X					X				
Holloway & Carson ⁵⁷	1998	CCM	MH	60	X	X	X	X			X	X	X			
Rosenheck & Neale ⁵⁸⁻⁶⁰	1998	ACT	MH	873	X		X		X			X	X			X

Notes

- References are included below
- Model: ACT = comparison of assertive community treatment with standard care without case management; CCM = comparison of clinical case management with standard care without case management; ACT v CCM = comparison of assertive community treatment with clinical case management
- Study quality: H - High (random assignment to conditions with attrition < 20 percent); MH - medium high (random assignment with attrition ≥ 20 percent); ML - medium low (well-designed matching studies or analysis for covariance); L - low (weak designs for matching or no analysis for co-variance).
- Sample sizes varied by outcome domain, the figures included here represent the largest sample size.
- Outcome domains: SY - Symptoms; AD - Number of admissions; DY - Hospital days used; PR - Proportion of group hospitalised; CMH - Contacts with mental health services; CO - contacts with other services; DR - Drop-out rates from mh services; SF - Social functioning; CS - Client satisfaction with services; FS - Family satisfaction with services; FB - Family burden of care; CT - Total cost of care. X indicates that data was used in this analysis

Studies included in the meta-analysis

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Does case management improve outcomes?

The results of the comparison of case management with standard care are presented in Table 8.2, which shows each outcome domain by the number of studies contributing p-values, the combined one-tailed p, Rosenthal's fail safe N, the number of studies contributing r values, and the weighted mean r and its associated 95 percent confidence interval. Case management programs were more effective than control interventions for most types of outcome measured both by combined $p \leq 0.05$, and by the probability that r is significantly greater than zero at the 95 percent confidence level.

Specifically, case management was associated with greater improvement in symptoms, less days spent in hospital, a smaller proportion of clients hospitalised, increased contacts with both mental health and other services, reduced drop-out rates from mental health services, greater improvements in level of social functioning, greater client and family satisfaction with care, less family burden of care and reduced total costs of care, compared to standard services. Conversely, clients of case management services were admitted to hospital more frequently than those of the comparison services.

Publication bias

Although most of the relationships were highly statistically significant, it is possible that, due to publication bias, studies finding non-significant results were not published and hence not included in this analysis. Rosenthal's fail safe N is shown in Table 8.2. There are no objective criteria by which to judge when the N is large enough to be confident of the validity of the results, but (Rosenthal, 1984) suggests that when there is a fail safe N greater than or equal to 5 times the number of comparisons plus 10, the results could be considered 'robust'. By this criterion, the domains of decrease in hospital days used, decreased proportion of clients hospitalised, increased contacts with mental health services, decreased drop-out rates, improvement in social functioning and increased client satisfaction could be considered to be robust against publication bias on the basis of reported p values.

Egger's test for publication bias was calculated for each outcome domain except contacts with other services, family burden of care and family satisfaction which had sample sizes too small to plot. Three of the remaining nine domains showed some evidence of publication bias - proportion of clients admitted to hospital ($p=0.015$), contacts with mental health services ($p=0.017$) and client satisfaction ($p=0.05$). These results differ slightly from those for the fail-safe N as these are based on effect sizes rather than p values.

The impact of study quality

The Q_{total} values and associated level of significance are shown in the two right-hand columns in Table 8.2. Nine domains had variance greater than that which would be expected by chance. To test whether quality of research design was associated with different outcomes for these measures, the four categories for research quality were collapsed into one 'high' and one 'low' category and the weighted mean r for these two groups was compared.

Four of these nine measures showed significant differences in outcomes by study quality - number of admissions ($Q_{between}=14.7$, $p<0.001$), days in hospital ($Q_{between}=4.6$, $p=0.03$), contacts with mental health services ($Q_{between}=12.2$, $p<0.001$), and level of social functioning ($Q_{between}=4.8$, $p=0.028$). However the weighted mean r values for the 'high' quality group were almost the same as those calculated for the sample as a whole: for number of admissions the high quality group weighted mean r was -0.14 compared to -0.10 for the total sample; for days in hospital, 0.26 compared to 0.24 ; for contacts with mental health services, 0.21 compared to 0.24 ; and for level of social functioning, 0.14 compared with 0.15 . Taken together, these results suggest that including matched-control studies and weighting for study quality increased the power of the analysis while effectively limiting the impact of lower quality studies on the overall estimates of effect size.

Table 8.2 Outcome domains by significance level and effect sizes

Outcome type	Significance levels (p)			Effect sizes (r)				
	N (p)	Combined p (one-tail) ¹	Fail safe N	N (r)	Weighted mean r ²	95% CI for r	Q _{total}	p for Q _{total}
Symptoms	13	<0.001	47	11	0.16	(0.11, 0.21)	4.9	0.900
Number of admissions	10	0.999	-	8	-0.10	(-0.16, -0.05)	39.2	<0.001
Hospital days used	21	<0.001	427	17	0.24	(0.21, 0.28)	127.1	<0.001
Proportion of group hospitalised	17	<0.001	215	19	0.10	(0.06, 0.14)	200.5	<0.001
Contacts with mental health services	8	<0.001	130	10	0.24	(0.19, 0.28)	129.8	<0.001
Contacts with other services	3	<0.001	16	3	0.33	(0.22, 0.43)	3.7	0.157
Drop-out rates from mental health services	6	<0.001	70	5	0.33	(0.25, 0.41)	29.8	<0.001
Social functioning	28	0.007	167	20	0.15	(0.11, 0.19)	34.4	0.016
Client satisfaction with services	12	0.028	72	8	0.23	(0.17, 0.29)	43.4	<0.001
Family satisfaction with services	4	<0.001	18	4	0.42	(0.29, 0.53)	7.7	0.054
Family burden of care	4	0.007	6	2	0.43	(0.23, 0.60)	0.2	0.649
Total cost of care	5	0.043	1	5	0.13	(0.07, 0.19)	13.9	0.008

Notes

1. Combined $p \leq 0.05$ indicates that outcomes for the case management group were significantly better than for the control group, $p \geq 0.95$ indicates superiority of control group over case management.
2. Weighted mean $r > 0$ indicates that outcomes for the case management group were superior to the control group, $r < 0$ indicates the superiority of control group over case management.

The impact of using measurement instruments which had or had not been previously reported in peer-reviewed journals was also examined, as this was one of the criteria used by Marshall and colleagues to exclude some outcome domains. The weighted mean r value for those studies using previously reported measures was compared with those which used measures which had not been reported. Only two domains had sufficient studies using both reported and non-reported measures to enable a comparison. For both, previously reported measures showed significantly higher mean weighted effect sizes compared to non-reported measures - level of social functioning (r for reported measures=0.18, r for non-reported measures=0.13, $Q_{\text{between}}=4.41$, $p=0.036$), and client satisfaction (r for reported measures=0.38, r for non-reported measures=0.19, $Q_{\text{between}}=8.54$, $p=0.003$). Assuming that instruments not previously reported have lower reliability rates, these results support the *a priori* assumption that these measures may tend to under-estimate effect sizes.

A key difference between this study and that of Marshall's' (Marshall, Gray, Lockwood et al., 1998; Marshall & Lockwood, 1998) was that this one used somewhat broader inclusion criteria - matched studies (rather than just randomly controlled studies) were included and all measures (rather than just those previously reported in a peer reviewed journal). The results from the analyses in this section show that these broader inclusion criteria have not biased the results in favour of case management.

Effectiveness of assertive community treatment compared to clinical case management

First, studies were examined which directly compared ACT programs with clinical case management programs. There were no differences between programs in terms of previous admissions, age, percent with psychosis, sex ratio, or percent single. All but two domains had less than four studies contributing effect sizes - too few to draw any firm conclusions. ACT was superior to clinical case management in improving social functioning ($n=5$, $r=0.18$), and marginally superior in reducing total number of days in hospital ($n=5$, $r=0.08$), although the small number of studies limit confidence in these findings.

In order to investigate this issue further outcomes for controlled ACT studies were compared with outcomes for controlled studies of clinical case management. Clients in the ACT studies had more previous admissions than those in the clinical case management studies (mean 7.4 c/f. 4.7, $t(8)=2.35$, $p=0.047$) but data were available for only 9 studies. There were no significant differences in age, percent with psychosis, sex ratios or percent single.

The Q_{total} scores and associated level of significance in Table 8.2 show that there was no significant heterogeneity in outcomes for improvement in symptoms, contacts with other services and family burden of care. This suggests that, on these measures, case management was effective but that there were no differences between ACT and clinical case management (although only two studies assessed family burden of care). The remaining nine domains were analysed further by comparing outcome effect sizes for ACT against clinical case management (Table 8.3).

For number of admissions, effect sizes could only be calculated for two studies in the ACT group, making comparisons using $Q_{between}$ impossible. However, enough studies reported p values for this domain to show that ACT was effective in reducing the number of admissions whereas clinical case management increased the number of admissions (the combined p being significant in the opposite direction).

For days spent in hospital, the ACT studies showed a significant positive effect according to both combined p and weighted mean r, but clinical case management showed a significant positive effect for weighted mean r only. The weighted mean effect size for days in hospital was significantly greater for ACT compared with clinical case management.

Table 8.3 Outcomes of ACT studies versus clinical case management studies

Outcome type	ACT (n=19)					Clinical CM (n=16)					Difference in mean r^1
	Significance levels		Effect sizes			Significance levels		Effect sizes			
	N	p	N	Mean r	95% CI	N	p	N	Mean r	95% CI	
No. of admissions	4	0.005	2	0.07	(-0.06, 0.21)	6	0.999	6	-0.14	(-0.20, -0.08)	*
Length of stay	14	<0.001	11	0.28	(0.24, 0.32)	7	0.19	6	0.11	(0.03, 0.18)	p<0.001
Proportion hospitalised	9	<0.001	10	0.35	(0.30, 0.41)	8	0.25	9	-0.07	(-0.12, -0.02)	p<0.001
Contacts with mh services	3	<0.001	4	0.18	(0.12, 0.23)	5	0.003	6	0.38	(0.30, 0.45)	p<0.001
Drop-out rates	4	<0.001	3	0.37	(0.27, 0.46)	2	0.001	2	0.24	(0.07, 0.40)	*
Social functioning	16	0.035	10	0.15	(0.10, 0.20)	12	0.043	10	0.14	(0.08, 0.21)	p=0.99
Client satisfaction	8	0.032	6	0.23	(0.17, 0.28)	4	0.317	2	0.27	(0.04, 0.47)	*
Family satisfaction	3	<0.001	3	0.46	(0.33, 0.58)	1	0.500	1	-0.03	(-0.42, 0.37)	*
Cost of care	2	0.002	3	0.12	(0.06, 0.18)	3	0.448	2	0.20	(0.15, 0.36)	*

Notes

1 p values in these two columns indicates the statistical significance (two-tailed) of the difference in the weighted mean effect size for ACT compared to CCM, but does not indicate the direction of the difference.

*Number of r values in one or both groups too small to make comparison using Q_{between}

For the proportion of clients admitted, ACT studies showed a significant positive effect according to both combined p and weighted mean r , suggesting that ACT reduced the proportion of clients admitted compared with standard care. Clinical case management showed non-significant weighted mean r and combined p values, suggesting that it did not differ with standard care. ACT was significantly better than clinical case management in reducing the proportion of clients admitted.

Both ACT and clinical case management were associated with an increased frequency of contact with mental health services according to both weighted mean r and combined p , but the increase in contacts with mental health services was significantly greater for clients of clinical case management programs compared to clients of ACT programs.

Both ACT and clinical case management increased clients' level of social functioning, decreased drop-out rates from mental health services, increased client satisfaction, and decreased total cost of care based on weighted mean effect sizes. There was no difference between the two types of programs in terms of the increase in client's social functioning, but for the last three domains, and family satisfaction with care, the number of studies was too small to allow comparison using Q_{between} .

Summary of findings

The results of this study showed that ACT reduced the total number of admissions and the proportion of clients hospitalised whereas clinical case management increased both, both ACT and clinical case management reduced hospital days used, but ACT was significantly more effective, ACT and clinical case management were equally effective in reducing symptoms, increasing contacts with services, reducing drop-out rates from mental health services, improving social functioning, and increasing client satisfaction with services. Both ACT and clinical case management lower the family burden of care and improve family satisfaction with services. The total cost of care was reduced by both types of case management, but different methods of costing limit confidence in this finding.

IMPLEMENTATION

Funding

The program was developed in conjunction with area managers and the Western Sector Ethnic Issues Group. When the implementation of the program was discussed with area managers in June 1996, they felt that creating and advertising all ten positions together would be difficult due to budgetary constraints. After discussions with the management of the Western region of the Department of Human Services, the Department agreed to fund the establishment of the program by providing additional funding of \$300 000 for one year (the equivalent of 5 full-time positions), on the condition that the services establish a total of 10 positions and that after the first year, they continue as permanent positions funded from the core budget.

Recruiting period

Positions descriptions (Appendix IV) were developed during the last half of 1996 and the positions advertised in December 1996. At that time, a Vietnamese worker was working half-time at South West AMHS, and she agreed to take on one of the positions on a full-time basis. South West originally had three out of ten positions allocated but Mid West actually had a greater number of NESB people in its catchment area, so it was decided that three positions should be based at Mid West instead of South West. South West AMHS decided to create an extra position so that they could employ one of the applicants who would not otherwise have been employed, leading to a total of 11 positions across the four Area Mental Health Services. Six staff had been employed by March 1997. These were three Greek-speaking, two Vietnamese-speaking, and one Turkish-speaking. The remaining positions were readvertised in April and all but one position was filled by July 1997. The number of positions filled over time during 1997 is shown in Figure 8.1. It can be seen that all eleven positions were not filled until November 1997.

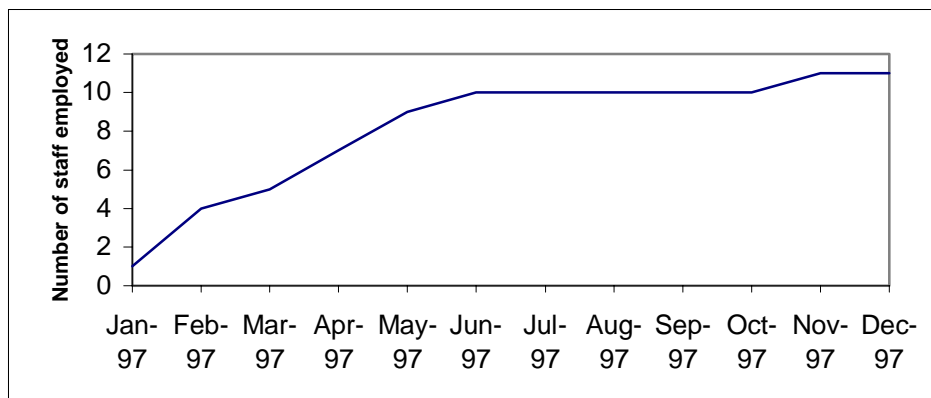


Figure 8.1 Total number of staff employed by month

Languages selected

For some languages (Chinese and Arabic) few applications were received from people with the desired qualifications and experience. A substantial number applied with related qualifications such as community development, general counselling, but these were not considered adequate to work as a case manager in mental health.

An issue which emerged during the selection process was how to verify the fluency of applicants in the language other than English. The National Accreditation Authority for Translators and Interpreters (NAATI) runs occasional tests at the para-professional level which would have been about the level of expected fluency, however these were too infrequent to require applicants to sit (every few months). Some applicants were born overseas, or had grown up overseas: it was felt that these staff could be assumed to be fluent in the language required. For those born and raised in Australia, it was suggested that one informal way of checking communication ability in the LOTE was to co-opt an interpreter or ethnic community worker experienced in the mental health field onto the interview process, and to conduct part of the interview in the LOTE. This was done with some interviews, but not all.

For some interviews, AMHS's recruited the assistance of outside staff as, for example, a member of Croatian Community Services interviewed Croatian-speaking applicants. The Ethnic Mental Health Consultant for the North West Health Care Network participated in some interviews, and the author of this thesis participated in one.

Qualifications

Another issue which emerged during the recruitment process was the question of minimum qualifications necessary to work in clinical mental health services. This was a particular issue for psychology, as senior psychologists insisted that the minimum necessary qualification was a Masters Degree in Clinical Psychology. Most managers believed that if the position consisted of case management and not advanced psychotherapy, then an undergraduate degree with some experience was adequate. These views appeared to vary within the psychology profession itself and also between services. Some services employed psychology graduates without a clinical masters for the bilingual program while others would not consider these applicants. Where they were employed, the expectation was that these staff would be expected to pursue Clinical Masters qualifications, but this was not made a condition of employment. One person in one of the positions who held a Clinical Masters dropped out of the program.

Staff employed

By December 1997, eleven bilingual staff were employed. The languages spoken are shown in Table 8.4. Three staff spoke Vietnamese, three Italian, two Greek, one Macedonian and Croatian, one Croatian and one Turkish. Four had professional backgrounds in social work, three in psychology (undergraduate degree), three in psychiatric nursing, and one in occupational therapy. The Italian-speaking worker at North West AMHS took maternity leave in January 1998 and was replaced with another Italian-speaking worker for 4 days per week.

Table 8.4 Number of staff and languages spoken

Service	No.	Languages spoken
South West AMHS	3	Croatian, Greek, Vietnamese
Mid West AMHS	3	Italian, Macedonian (& Croatian)*, Vietnamese
Inner West AMHS	2	Italian, Vietnamese
North West AMHS (Moreland)	2	Greek, Italian
North West AMHS(Broadmeadows)	1	Turkish

**One staff member at Mid West AMHS spoke both Macedonian and Croatian.*

In February 1998 the Vietnamese staff member at Mid West AMHS resigned. The position was advertised once, but no suitable applicants were found, and the position remained vacant for some months. It was readvertised and eventually was filled by a nurse who was completing her post-graduate training in mental health. In early 1999, both the Italian and Vietnamese speaking case managers at Inner West AMHS resigned. They were advertised and new Italian and Vietnamese speaking staff were employed.

Previous experience

Three out of the 10 staff had worked in clinical mental health services before starting in the BCM position (for 6 months, one and two years respectively), and two had experience in non-government psychiatric disability services (for 6 months and 3 years). Seven staff had some experience in another area of health or welfare (including vocational rehabilitation, residential youth services, sexual abuse, family support, ethnic agencies, nursing homes and various counselling agencies). Overall the group had a mean of 3.1 years of full-time experience in the workforce with a mean of 8 months in mental health. For this purpose, part-time work was translated into the equivalent full-time (e.g., one year half-time was treated as 6 months full-time experience).

Program support and coordination

Group supervision and coordination meetings

A review of a similar model for the employment of bilingual staff found that staff in these positions could become isolated and had recommended that services enable bilingual counsellors to meet regularly as a group (Mitchell, Malak & Small, 1998). Consequently it was agreed that the VTPU should provide a forum for bilingual case managers to meet regularly.

It also became apparent that quite a few of the staff selected had limited experience in the mental health system and managers felt that some additional group supervision should be provided to support them. The aims of the VTPU meetings were to:

- enable program staff to meet to discuss issues of mutual concern, including the development of their positions and roles;
- coordinate the program and ensure consistency between services;
- facilitate the program evaluation;
- provide additional group supervision;
- provide specific educational sessions regarding aspects of their work.

This process was jointly run by the Ethnic Mental Health Consultant for the North West Health Care Network, who provided clinical supervision, and the Service Development Coordinator at the VTPU (the author), who focused on implementation, administrative and evaluation activities.

The first of these meetings took place on 20 March 1997. After the second meeting in April, staff requested that they occur more frequently as they felt there was too much to cover in one meeting per month. It was agreed that the meetings take place fortnightly until the end of 1997, alternating between clinical supervision sessions one meeting and more general program issues at the other.

Topics covered in the supervision sessions included DSM IV diagnoses, mental state assessment, cultural variations in expression of symptomatology, cultural issues in mental state assessment, case examples presented by the bilingual staff, cross-cultural counselling, and others. BCM's also presented information on community work they were involved in, and the issues surrounding this work. Guest speakers provided sessions on cross-cultural assessment, family work, cross-cultural counselling, community development, PTSD and others.

Meetings with clinical supervisors

Two meetings were held between clinical supervisors and the VTPU to discuss the program and their respective roles. The first presented an overview of the model and the role of the VTPU and the EMHC in providing ongoing support and group supervision. One issue which emerged at this meeting was that the bilingual staff were being asked to interpret for other staff; supervisors felt that the staff should not be asked to interpret,

and that this would distract from their ability to conduct their clinical work. This point was also raised in interviews with bilingual staff, and managers. The other major concern was that the caseloads of the staff would need to be limited and monitored in order for them to be able to carry out the other community development and education activities. An informal guideline was established that caseloads for bilingual staff would be two-thirds that of other staff (this is in accordance with the nominal caseload figure of 20 described in the original proposal to establish the program). Supervisors were to monitor this. By late 1999, the expectation that BCM's act as interpreters had dissipated.

Another concern was that staff have adequate access to education and staff development opportunities and not be limited by the 5 days per year limit which was used at some services. Supervisors also believed that referral procedures would need to be tightened because some staff were being referred clients directly rather than through the usual procedures and this meant that they could quickly become overloaded. More recent interview data revealed that two of the bilingual staff members had clients contacting them directly rather than through the usual procedure. Supervisors also expressed concerns about 'boundary issues', such as those clients who rang with non mental health concerns and had heard about this particular case manager within the community.

Aims of the program

Interviewees were asked what they thought were the aims of the program. The responses are summarised in Figure 8.2. The most common aims were thought to be, educating and supporting other staff in working with NESB clients, delivering clinical services in clients' language, improving the accessibility of mental health services to NESB people (or people from the specific language group), providing better services to NESB clients, and educating ethnic communities about mental illness and mental health services.

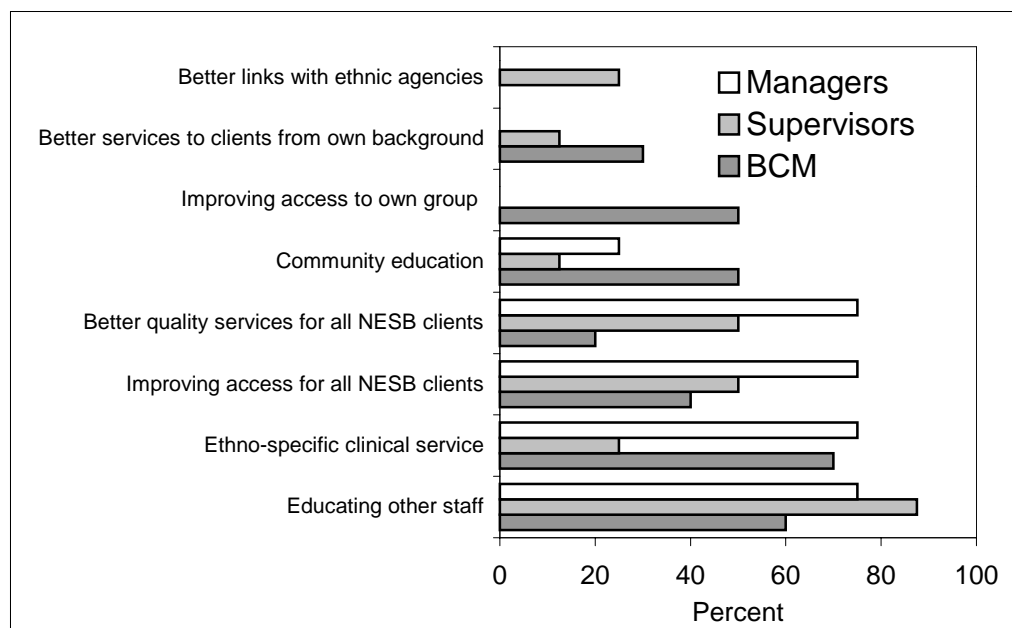


Figure 8.2 Program aims as seen by managers, supervisors and BCM's

The main difference between the aims as seen by BCM's on the one hand, and managers and supervisors on the other, were that BCM's were more likely to mention a specific ethnic group as the focus of their work whereas the other two groups were more likely to talk about NESB people as a whole. However this may have been because BCM interpreted this question as being about the aims of their own positions as well as the program overall. Some were asked for example 'What do you see as the aims of the bilingual case management program and your positions?' BCM were also more likely to mention educating ethnic communities as an aim.

One supervisor said that he thought the bilingual staff saw their positions as having an ethno-specific focus whereas he saw it as having an impact on the accessibility of the service to NESB people overall, not just those languages which were spoken by staff. He thought that the presence of staff who were conscious of ethnic issues, and who would raise these within the clinic as part of their mandate would also have an impact on how other staff thought about their work with NESB clients in general. Certainly, most of those interviewed placed a great deal of importance on working with other staff as an integral approach of the program.

All interviewees were also asked whether they thought that other staff in the organisation saw the aims of the program in the same way as they did. Most thought

that there were common understanding of the aims of the program, although half of the BCM said they did not know what other staff saw as the aims, and three said they did not know the managers views. There was a perception amongst some BCM staff and supervisors that other staff in the service saw the program primarily as a vehicle for delivering case management in the language of the client, and did not see or understand the other roles of BCM such as providing cultural information and working jointly with staff, or community education. A number of BCM had been asked to interpret for other staff and it was suggested that initially, other staff thought that BCM should act as interpreters.

The second round of interviews showed that confusion about the BCM roles had diminished and that there was greater acceptance of the positions. An indication of this change in perception was an increase in requests for secondary consultation from other staff, although this remained a small part of their work.

As well as the stated aims of the program, some participants had less obvious goals tied to the BCM program, which appeared to represent conflict between management and professional perspectives. One manager discussed the requirement that psychologists have a Clinical Masters to work in mental health as being an example of professional elitism and that this level of qualification was not necessary for the 'core business of the service' i.e. case management. S/he saw the BCM program as an opportunity to start to break down this 'professionally created barrier' to the employment of psychologists without clinical masters.

Another supervisor stated that s/he was very pleased that the BCM program had placed a great deal of emphasis on discipline-specific supervision because the need for such supervision had previously been questioned by management, and the supervisor believed that the BCM had strengthened his argument for this to remain.

Several supervisors applauded the emphasis on community development in the program and that staff had reduced caseloads in order to work on this. They felt that community work was not supported by services to the extent it should be because direct clinical work always took precedence and staff did not have time left over to work on community-oriented projects.

Roles of bilingual case management staff

This section reports on the major roles undertaken by staff: sole case management, joint case management, secondary consultation, and community development. As these were the major areas of work proposed, they are examined in some detail, both in terms of work being done, and opinions of staff about them. Interpreting is included, because most staff were asked to do interpreting even though this was not intended.

Sole case management

Allocation process

Some centres developed referral forms for staff to complete if they wanted the BCM to take on a client or to be involved in some way, but these were generally not used by other staff. Supervisors believed that staff were already inundated with paperwork and that referral forms were seen as imposing yet more 'bureaucracy'. Most referrals happened more informally: through discussion in the hallway or in the tea-room, or as one bilingual worker put it, 'corridor referrals'. Initially, BCM staff were allocated clients directly from other staff as a way of building up their case-load, but generally, after a few months, allocation occurred through the same process as for other staff at each centre.

Some BCM's quickly became overloaded with referrals of clients from their specific language group from staff with existing clients. For others, though, staff did not transfer existing clients. Staff interviewed believed there were several reasons for this. First, it was not necessary for NESB clients to be allocated always to a case manager who spoke their first language as for many people it was perceived that ethnicity or culture was not an issue. Second, some staff and clients already had a good working relationship which would be disrupted by allocating a new case manager. Third some supervisors and managers believed that occasionally staff became comfortable with clients that they knew and were reluctant to 'let them go' whether or not this would have been for the client's benefit.

In some cases, BCM's continued to be approached directly by other staff or the Crisis Assessment and Treatment Team (CATT) outside the normal allocation process in order to take on a new (or existing) client. Other BCM's received referrals from outside their area mental health service such as from GP's and other non government organisations. This often placed considerable pressure on the staff to agree to take a new client immediately. Supervisors attempted to manage this by arguing that all allocations should go through the normal procedures.

A related issue was how to handle phone calls from members of ethnic communities who had heard that there was a bilingual staff member available at the clinic. While it was not the role of bilingual staff to act as a duty worker for all inquiries from NESB people, there was some concern that these calls were often only made because the person wanted to talk to some-one in their own language and that passing such calls to the duty worker to be handled with the telephone interpreter service would maintain existing barriers to access. An arrangement which appeared to be working reasonably well was that the bilingual staff member would take the call and liaise with the duty worker about the case and whether a follow-up interview should be arranged. Where this was indicated, an interpreter was booked, and sometimes but not always the bilingual staff member would join in the assessment process.

Caseload size and composition

At most centres the bilingual staff were given a period of time to gradually increase their caseloads. There was one exception where the person's caseload increased rapidly, but this was later dealt with so that the case-load was adjusted. The main reasons for this gradual increase were to allow staff to learn how the system operates, and the process of mental health case management given that this was the first time most of them had worked in this role. Staff felt that this process had been handled very well by their services and were appreciative of the sensitivity shown. Supervisors stressed the importance of this but felt that there were also other advantages for both the BCM and the clinic:

‘because their caseloads have grown a bit more slowly than other staff, this has given them more scope to fill in on duty and intake, work that no-one particularly enjoys doing, and that has given them a lot of credit in the eyes of other staff’

One difficulty in managing the allocation process was the need for BCM to take on clients when they came up at allocation meetings as clients from their specific language groups were referred relatively infrequently. As one BCM stated:

‘There’s a dilemma in taking on too many non-_____ clients because if more _____ clients come in I might not be able to take them.’

On the other hand, some staff and supervisors felt they were getting too many ethno-specific clients, and that their roles were seen by other staff as being there to see clients who speak the same language. For example the assumption from other staff was that if a Greek client comes in they should go to the Greek case manager. Most supervisors raised this issue. One BCM expressed this by saying: ‘If a _____ name comes up they all look at me.’ The second round of interviews indicated that this was still an issue for some BCM’s, although some felt they had more say over the clients that were allocated to them.

Because many BCM’s reported seeing clients born in Australia from the same ethnic background as themselves, these data were collected separately at the end of March 1998 and in April 2000 (PRISM does not record ethnic background or parents country of birth). These data are presented in Figures 8.2 and 8.3, divided into clients from the same ethnic background born overseas or in Australia, from a different NESB background born overseas and in Australia, and from English-speaking backgrounds, born overseas and in Australia.

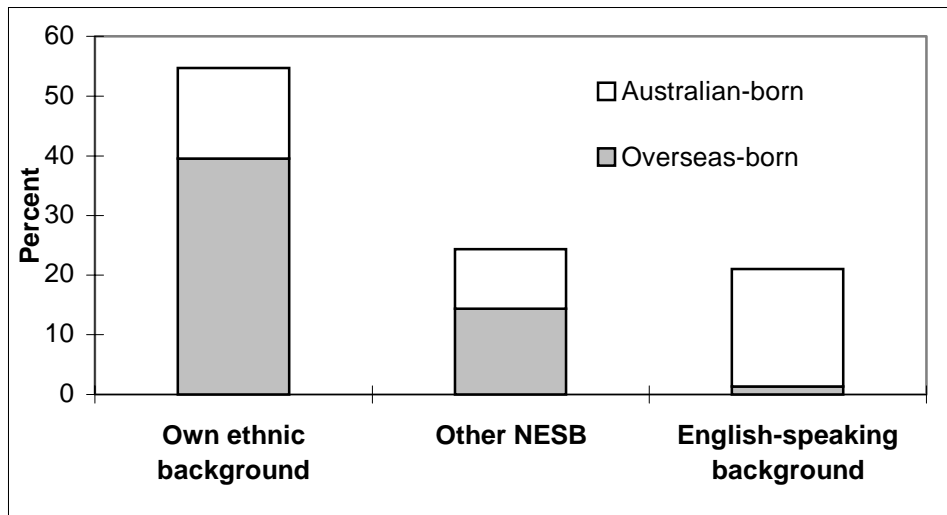


Figure 8.3 Caseload by ethnic background - March 1998

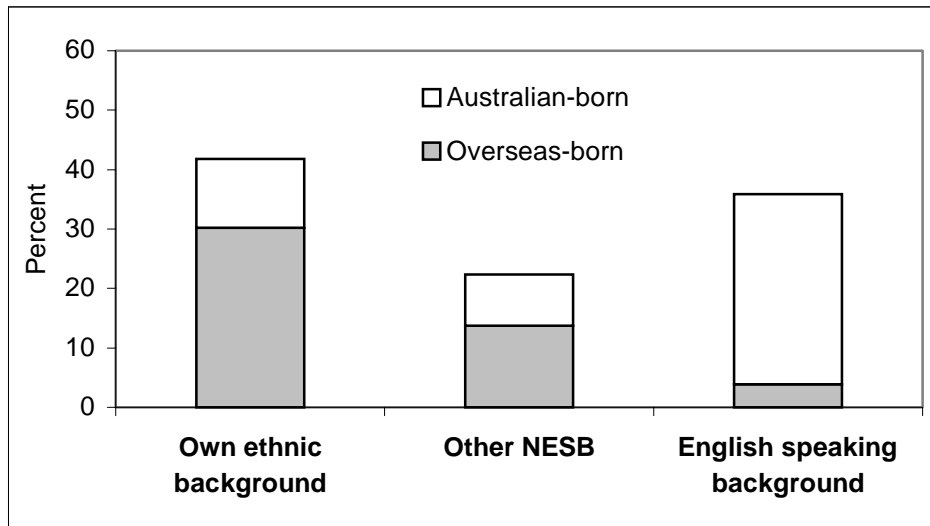


Figure 8.4 Caseload by ethnic background - April 2000

It can be seen that the proportion of BCM caseload of people from the same background (both overseas-born and Australian-born) decreased from about 55 percent in March 1998 to just over 40 percent in April 2000. On the other hand, clients of ESB comprised 20 percent of the BCM caseload in March 1998 but closer to 40 percent in April 2000. Figure 8.5 shows that there was a large increase in the number of ESB clients seen by the BCM over this two year period, and a smaller increase in NESB clients.

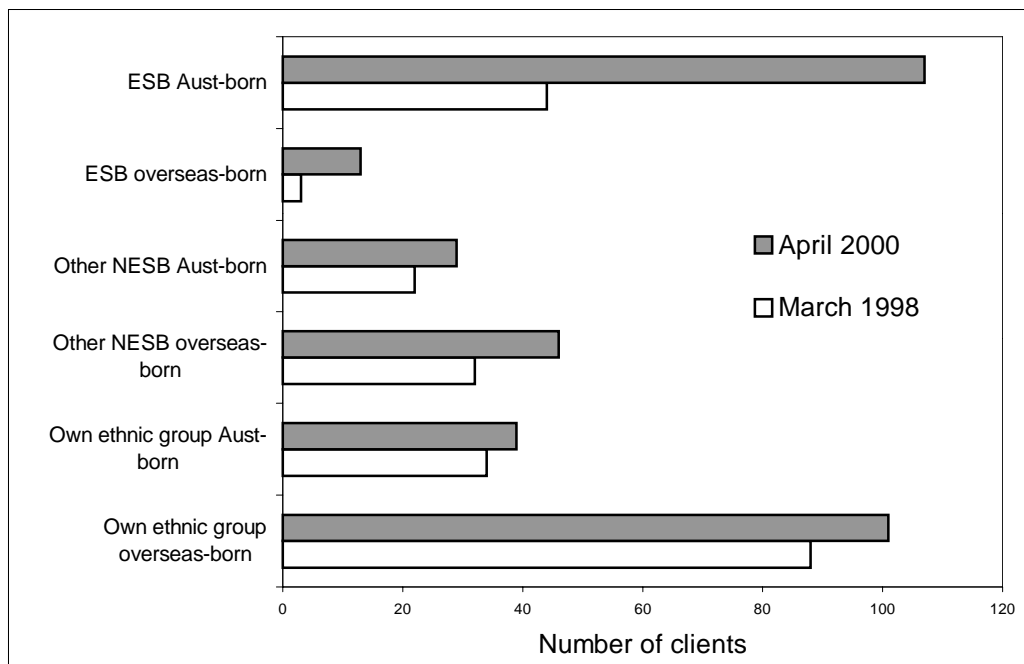


Figure 8.5 BCM caseloads March 1998 and April 2000

In March 1998, there were a total of 223 clients seen by the ten bilingual staff employed at this time, with an average of 22 clients per BCM. Caseload sizes in CCTs at this time averaged about 35, suggesting that the target of BCM having caseloads two-thirds those of other staff was being met by the program in March 1998.

However by April 2000, this situation had changed dramatically. The average caseload for the BCM's was 32, while those for other staff were still around 35. It can be seen from Figure 8.6 that the caseloads for BCM's increased substantially but those for other staff were fairly stable. From the data provided in Figure 8.5, it can be seen that the increase in caseload was mainly in clients of ESB born in Australia.

Caseload size had become a major concern for all the BCM. Most believed that services were under-staffed, possibly due to lack of funding, and that they were obliged to take on new clients as they were referred. Managers also spoke of these pressures.

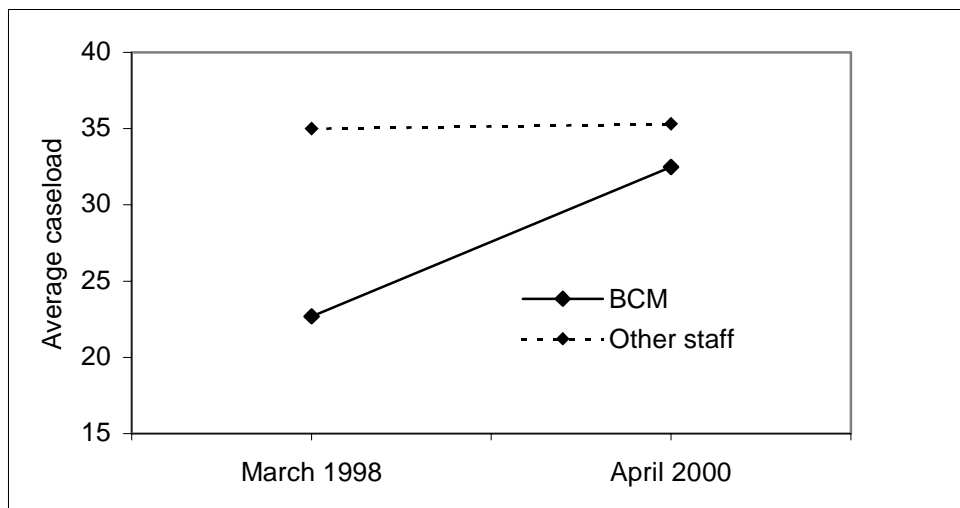


Figure 8.6 Average caseloads of BCM and other staff March 1998 – April 2000

The program proposal suggested that bilingual staff would take on clients from the same language group when ‘there appear to be significant cultural issues in presentation of symptoms which make assessment difficult, or the client has not successfully engaged with other clinic staff.’ The main considerations mentioned about who the BCM would adopt were first, current caseload size and composition, and second, the ethnic background of the clients being allocated. BCM staff and supervisors mentioned that there were other factors such as whether there were specific cultural issues which a BCM could deal with more effectively than other staff. However there did not seem to be any consistent view regarding what these issues were and when it was more appropriate for a BCM to deal with these.

When interviewed again in 1999 about reasons for deciding which clients the BCM should see, the only consistent issues mentioned by BCM’s, managers and supervisors were the client’s ethnic background and English ability.

Professional background and specialisation

Each of the bilingual staff were asked whether they undertook any specific work or worked in a particular way because of their professional background. While the core work of case management was similar for all staff, there were also some areas which each professional group tended to concentrate on. Nursing staff spoke about depot injection clinics and psycho-education, psychologists mentioned counselling, family

therapy, psychotherapy (when time permitted) and specific psychological tests (such as IQ testing), social workers mentioned counselling, family work and community development, and occupational therapy was concerned with practical issues such as daily living skills. The second round of interviews indicated that areas of specialisation often reflected personal interests in working with particular clients or engaging in certain activities (e.g. working with families, working with sexually abused clients, community education).

Joint case management

Joint case management did not feature as a large part of the work of the BCMs. Of the ten BCMs interviewed, one had no joint case-managed clients, one BCM had one client, four BCMs had two clients, three BCMs had three clients, and one BCM had eleven. The staff member with eleven joint clients had been working in the service for almost two years, which may account for the relatively high number, but this position had also been nominated when the worker was first employed to conduct mainly joint work.

BCM were asked what work they did when joint case managing a client. The most common response (seven out of nine staff) was working with families - family education, support and counselling. Other types of involvement included: assisting with assessment, either on duty or a needs assessment in the clients own language; dealing with practical follow-up issues such as liaison with other services, referrals, settlement issues (including English language training) acting as temporary case manager for either a client being transferred from another case manager with a period of joint case management to facilitate the transfer or filling in for another case manager away on holidays; working with clients with high needs such as frequent (daily) contacts; and assisting in interpreting cultural issues or behaviour. Sometimes the other case manager had a specialist role such as conducting psychotherapy. For some staff, joint case management was seen as a way for the new BCM to learn the job with another more experienced case manager and with the BCM gradually taking over sole client care. Bilingual staff felt that this was an effective way to 'learn the ropes'.

Joint case management was seen to have a number of advantages by managers; it allowed clients to get to know more than one person in clinic so that if their case manager left or went on holidays, clients would still know a staff member, and that it was an important way to help other staff learn about cultural issues. Although joint case management was reasonably infrequent, there were some examples of the positive impact it could have. One BCM reported that a client confided to her some concerns which had not been communicated to his other case manager because he felt more able to discuss these concerns with her in his own language. Another felt that being part of both cultures enabled her to interpret each culture to the members of the other (i.e., Australian customs and culture to Vietnamese clients and Vietnamese culture to Australian professionals), and that this was particularly helpful for clients.

It appears that many other staff (according to those interviewed) did not see joint case management as a way to learn about cultural issues from the BCM. Some supervisors reported that they did this and found the process very useful, but felt that other staff generally did not take up this opportunity. There was a tendency for some staff to assume that the BCM should work with someone from their own background as a sole case manager rather than as joint case manager. One BCM said when staff approach her to take on clients she offered to work with them (the other staff member) as joint case manager - some were happy with this arrangement but others were not keen to enter into this sort of conjoint work.

Bilingual case managers were sometimes not clear about what was expected of them, nor about where responsibility lay for action with or for clients. For example, one said that:

'its a lot of work, you have to always follow-up with the other case manager to see what is happening and what you need to do next.'

Some supervisors believed that BCM's were left to do follow-up or routine work as they were junior staff and this often happened with other joint arrangements. Occasionally, BCM's were asked to act as interpreters for the family as well as case manager for the client; this has been tried a few times, but the feeling amongst most was that it was not possible to do both tasks at the same time. In such situations, staff booked interpreters

instead and while family members were reluctant about this for a while, they generally came to accept it.

The situation changed little between 1997 and 1999, with BCM staff reporting that they had virtually no clients who received joint case management. Traditionally, joint case management in the CCTs has been used only for clients with high needs (such as someone who needs very frequent contacts with the clinic) as a way of sharing the load of this work and also for staff to support each other. Some managers, although keen to promote joint case management also thought that it seemed like a luxury to have two staff involved with the one client, especially when the service was understaffed. Another factor mitigating against joint work was the emphasis in policy documents and in everyday practice of individual responsibility for a client, at least in the CCTs. Mobile Support Teams tend to stress group case management far more and may have more experience in how to deal with this approach in practice.

A final question was whether other staff saw a need for the involvement of bilingual staff as case managers. At meetings with staff during the design and implementation of the program, a number of people expressed the view that employing bilingual staff was insulting to them because it implied that they were not working adequately with NESB clients. While this may be a minority view, there is certainly a question about whether other staff believe that bilingual staff are needed or could contribute anything to the clinical encounter. One manager felt that:

'The incentive for joint case management, the incentive for them (other staff) keeping the case and consulting I suspect would come more from the BCM themselves.'

Some supervisors felt that staff were more likely to see bilingual staff as being necessary and useful for newer or 'more culturally-different' language groups such as Turkish and Vietnamese.

Secondary consultation

Secondary consultation can be thought of as short-term limited contact with another staff member around a specific question problem or issue for a client, rather than ongoing involvement as would occur in joint case management. Most BCM staff and supervisors reported that they received some requests, but they tended to be informal and ad hoc. For example BCM's reported being asked about cultural issues facing a client when passing another worker in the hallway, or during lunch. An exception to this was the Vietnamese case manager at South West who had been employed there for almost two years (the first part-time) when the first interviews were conducted. Supervisors and managers believed she was used a good deal in this role. She also had the highest number of joint case managed clients (10). Second round interviews also indicated that other staff were considered to have more difficulties in dealing with clients from a Vietnamese culture rather than clients from European ethnic backgrounds.

The main areas which staff were asked about were whether unusual or unfamiliar beliefs were culturally normal or may have been delusional/ psychotic, and also about family values and behaviour. Bilingual workers reported that when they were requested to provide some advice or information about possible cultural issues, they preferred to meet the client and family themselves in order to make an assessment as this was difficult to do from second-hand information.

Another issue raised, mostly by the bilingual staff themselves as well as their supervisors, was the degree to which one can be expert or 'know' one's culture. Staff said that they felt they had a good understanding about their own cultural groups but that they did not know everything, nor was it possible to know this, given the complexity and diversity of all ethnic/ cultural groups. Some supervisors felt that this would be more of an issue for those bilingual staff born in Australia, both in terms of their knowledge about cultural issues, and in terms of the credibility. The need to recognise the limits of one's own knowledge and experience was a recurring theme and most bilingual staff expressed the desire to continue learning about ethnic issues.

Supervisors also felt this was important, but as one said 'they might not know everything, but they know more than I do'.

There were two other factors mentioned which may impact on the secondary consultation role. First, several supervisors and managers argued that requesting information from another staff member required staff to admit that they needed help and that for some staff this may be seen as undermining to their self-confidence or degree of professional competence.

Second, the limited mental health experience of BCM may have made them seem less 'credible' as a source of clinically relevant information. Supervisors reported that staff at their level of experience would not usually be in a position to consult to more experienced staff which meant that the BCM may not be entirely confident in this role, or not be seen as competent by other staff. However, by the end of 1999, most the BCM were no longer regarded as inexperienced or junior staff. The second round of interviews indicated that the BCM program had had an impact on staff attitudes - there was heightened awareness and sensitivity to cultural issues, and a greater propensity for staff to ask questions about cultural issues than in the past. The BCM's cultural knowledge was seen as being relevant because of the high number of NESB clients frequenting area mental health services and the need to ensure quality of care to this group.

Community development

The term 'community development' is used loosely in this thesis to refer to a range of activities such as community education, establishing family information sessions or groups, liaison with community agencies, and project work. The main organising principle for this term is around activities not directly related to individual clients, and which are intended to have some impact on service provision indirectly.

All staff were involved to some extent in similar activities: making contact with local ethnic agencies, collecting material in languages other than English, and collecting and

compiling materials about ethnic communities. For the first year of the program there was an emphasis from managers and supervisors on direct clinical work until the staff became established in their positions. Over time, numerous community-oriented projects were undertaken. These are described below by language group.

Italian

In 1997, two Italian information sessions were run for the general community, one during mental health week at CO.AS.IT. (the major Italian welfare agency), and one at a psychiatric disability support service in Carlton. The Italian workers reported on their first forum:

'at the Yarra education session, only one person came. There was not much advertising on radio or the newspaper. Especially the older group they all listen to the radio. The second one was with CO.AS.IT. and North West service in mental health week. This was attended by 65 people, mainly carers of a person with a mental illness. It was advertised through Il Globo two weeks in a row and the Italian radio station. I did a short interview and also went on SBS radio a few times. They had us talking about the session in a promo and they played this a few times. We also advertised through the VTPU newsletter, the mental health week brochure, and to mainstream services such as the community health centres, Schizophrenia Fellowship. I think most people who came heard it on the radio or through the newspaper.'

'There were many questions around depression, a number of people talked about people they were caring for and how they hadn't got better, medication, non-compliance, how do you treat people when they don't want any treatment and how to deal with this.'

In 1998, a second Italian forum with CO.AS.IT. during mental health week was arranged, the Italian workers adopting similar advertising and promoting strategies to the previous year. The forum proved successful, with 80-100 people attending from

both inner and outer parts of Melbourne including a busload of people from the Peninsula areas, Frankston and Rosebud.

In August 1999, the third annual Italian forum was conducted. In an attempt to organise and generate ideas for this forum, the Italian workers met with members from CO.AS.IT. and reviewed the outcomes of the prior two forums. The Italian workers arranged meeting times with various community services including CO.AS.IT, Centrelink, the Association of Relatives and Friends of the Mentally Ill (ARAFEMI), Action on Disability within Ethnic Communities (ADEC) and the three Area Mental Health services, Inner West, Mid West and North West, to solicit their participation. Advertising for this forum was done through specific forms of the Italian media, such as RETE, an Italian specific radio station and the Italian newspaper, 'Il Globo'. Flyers advertising the forum were sent to a broad cross-section of the public and professional community, including clients, carers, private Psychiatrists, GP's, counsellors and psychiatric disability services. Entertainment and catering for the forum was arranged, the Italian workers successful in securing the well known Italian choir- La Voce Della Luna to perform on the night and the Italian specific biscuit company 'Unibic' to provide catering.

On the night, presenters included an Italian speaking psychiatrist, who spoke about the medical and psychosocial aspects of mental illness, and a client talking about his personal experiences. A worker from Centrelink (social security) spoke about carer pension and disability support pensions and a worker from CO.AS.IT. presented information about their services. The three Italian bilingual case managers informed the audience about Area Mental Health Services and talked about their roles as bilingual case managers.

Approximately 20 people attended the forum, including both clients and carers, ranging from 26-46 years of age. Evaluation forms indicated that overall the audience regarded the forum both important and informative but in future would like to see more information on topics about 'guardianship, early warning signs and alternatives to medication'. The Italian workers identified some possible reasons for the reduction in numbers compared to the previous two years, attributable to the timing of the forum, the late notice due to problems with advertising and the need to present information in a

different format In future, the Italian workers would like to ‘take the show on the road’ presenting information to specific Italian services and groups such as Italian social/community groups and to people residing in Italian specific accommodation.

In addition to the Italian forums, a carers group was facilitated by the Italian worker at MidWest, and an in-service for Italian workers at CO.AS.IT. was provided by one of the Italian workers from Inner West, in a response to their request for more information on how to conduct mental state examinations.

Greek

From the commencement of their positions the Greek bilingual workers liaised with the Australian Greek Welfare Society (AGWS), and in 1999, both the bilingual workers and the AGWS, presented a public forum for the Greek community. The forum was held during mental health week, the aims of which were to provide language specific and culturally relevant information on mental illness, mental well-being and mental health services. Advertising of the forum was widespread, including interviews with SBS Greek radio, and announcements broadcast on 3XY and 3ZZZ. The print media was also used, with community announcements made in Greek newspaper editions. Posters and flyers were sent to Greek speaking GP’s, various mental health professionals and a broad section of the Greek speaking community

On the day, information kits were distributed and presentations were made by the Greek workers on schizophrenia and major depression. A personal speech was delivered by a Greek carer, relaying her own experiences as mother and carer of her son who had been suffering from schizophrenia for 14 years. The forum was attended by 75 people from a diverse range of professional and personal backgrounds and qualitative feedback indicated that the forum was extremely successful Some of the comments included:

Well done, congratulations, that was excellent it was very informative and it would be very important to run sessions like this more regularly as this was the first time anything like this has ever been done.

There is a lot of need for information like this to be presented in Greek as we are very isolated in our community and don't have access to this kind of information.

The Greek workers had been involved in a number of other activities. They made attempts to establish links with the Greek Orthodox church and open a dialogue on mental health issues concerning the Greek community. The Greek workers believed that the 'spiritual fathers' were often the first point of contact for a large majority of the Greek speaking community in times of distress and need and that it was important to strengthen the links between mental health services and the church.

The Greek worker from North West conducted a number of interviews over three Greek specific radio stations, 3XY, 3ZZZ and 3EA to inform the Greek community about mental illness. In 1998, a carers information night was also organised with one other Greek worker, at North West Area Mental Health Service and was open to all workers from CCT, CATT and MSTT. The worker from South West wrote a number of articles to be published in Greek specific newspapers and magazines.

Vietnamese

The Vietnamese bilingual workers were involved in many community development activities, often in conjunction with other Vietnamese workers from two psychiatric disability services (Western Region Outreach Service or WROS, and Macaulay Community Support Association). A forum about mental health services and mental illness was held for Vietnamese workers during mental health week in 1997. In October 1999, the Vietnamese workers were involved in the planning of a Vietnamese education forum. This was a joint project with ADEC and the Ethnic Mental Health Consultants from the Western and Eastern regions.

An ongoing aspect of community development for Vietnamese workers was the establishment and management of a women's group, comprising of 17 women from WROS, Macaulay and South West, MidWest and Inner West. In light of the increasing number of women involved in the group, a 'kids' group was initiated, to provide support to children who had a parent with a mental illness. The kids group was held at

South West and facilitated by the Vietnamese workers from WROS, South West and Macaulay, and two other volunteers. A men's group was also organised by WROS and Macaulay. A number of activities to augment family cohesiveness have also been organised, such as the preparing of a family meal once a month and a camp that is arranged annually to provide respite to Vietnamese family groups, funded by the Western Respite Service of the Richmond Fellowship.

Other community development activities included the development of glossary of mental health terms in Vietnamese, which has been valuable in demonstrating the many different ways that one mental health term in English such as 'depression' can be translated in up to five different terms in Vietnamese. The Vietnamese workers also delivered talks over the Vietnamese radio and published articles in the Vietnamese health magazine. Also, the Vietnamese worker from Inner West was involved in the Vietnamese version of the multiple family group, based on the model developed in the USA being trialled by Inner West in partnership with Macaulay Community Support Association.

Turkish

The Turkish worker initiated a number of community development activities. In 1999, she was primarily responsible for the genesis of a Turkish mental health network, comprising five mental health professionals and one client. The group met once a month and aimed to devise strategies to educate the Turkish community about mental illness, and mental health professionals about Turkish culture. The Turkish worker was also involved running a support group for women who were clients of the local mental health services.

Other community development activities included presentations on Turkish family dynamics to staff at other community mental health services, and some inpatient units, and to postgraduate psychology students. The Turkish worker was also proactive in visiting GP's in the Broadmeadows region to inform them of her role as a bilingual case manager and more recently to inform them of the Turkish Mental Health Network. She also established links with a hodja (lay healer) at the Turkish mosque in Broadmeadows, the first point of contact for many people with mental health problems.

Following the devastating earthquake in Turkey in mid-1999, she was involved in providing debriefing, and establishing support groups, for Turkish clients and members of the Turkish community.

Croatian

The Croatian worker had established informal links with Croatian Community Services (the major Croatian ethnic welfare agency), maintaining weekly or fortnightly meetings with them. Croatian Community Services workers frequently made contact with the Croatian worker to seek advice and assistance for their own clients, and they also jointly provided a range of social and support activities to clients of South West and other mental health services. The Croatian worker was also involved in running a number of information sessions for the Croatian community and conducted a staff presentation on aspects of Croatian culture at South West Mental Health Service.

Macedonian

The Macedonian worker conducted several information sessions for the general Macedonian community, and established links with various Macedonian welfare workers and networks. In 1999-2000, the worker began planning a series of six information and support sessions for Macedonian carers. These were planned in conjunction with staff from the VTPU and were intended to begin in late May 2000.

Benefits and constraints of community development

All the BCM staff were enthusiastic about community development activities and saw this area of work as important and interesting part of their work. The value of this work was affirmed by both supervisors and managers. As one supervisor put it 'on a broader level, I don't think you can ever do enough community work. Every bit they do is fantastic.'

Outreach to ethnic agencies and programs in their local areas was seen as especially important. One BCM suggested that people of NESB were much more likely to approach an ethnic welfare agency when experiencing some sort of difficulty, but that

staff at these services did not necessarily know how and when they could call on or refer to specialist mental health services. She suggested that a regular outreach session at such services could help overcome difficulties in referral processes, help to educate staff about mental illness and mental health services, particularly about the criteria for acceptance by community mental health services, which was not well understood by ethnic agencies. Similarly, it was felt that links with bilingual general practitioners (GP's) were also important. One worker felt that there had been an increase in referrals to the centre from GP's who had heard that she was working at the clinic.

There were a number of factors which either limited the amount or scope of community work. The nature of this work was somewhat different to direct clinical work; it was seen as relatively less structured and expectations were generally less clear. This provided a good deal of autonomy for staff, but also made it difficult to deal with such a broad area alone. Those staff where there was more than one person who spoke the same language (Greek, Italian and Vietnamese) found it easier to undertake community work because they were able to work as a team or at least discuss common strategies. As one said 'working with other people is really important.'

The priority given to clinical work, (which all interviewees agreed with) meant that community work had to be fitted into times around clinical duties. Staff talked about cancelling planning meetings for community activities in order to respond to a client crisis or to fill in for duty. This was seen by supervisors and managers as an issue for community work done by all staff in community mental health services, not just for the bilingual case managers.

Community work was also seen as invisible to the rest of the clinic. Many of those interviewed felt that most staff did not know what types of community work the bilingual staff were doing (including some managers). One supervisor said that he encouraged staff to report on these activities at every opportunity so that they did not get 'lost'. While community development was seen as important by managers, some supervisors argued that it was seen as the 'frilly bits, the icing on the cake, but this is always seen as diversion from the main game', which made it even more necessary to keep highlighting what was being done.

One aspect which most bilingual staff were interested in or had started working on was general community education using the ethnic media. Ethnic communities were seen to have less access to information about mental illness and mental health services, and to have very negative views about mental illness. The ethnic media were important in advertising events and distributing information about mental health services.

The most common ethnic media used were ethnic newspapers and radio. However both these covered the entire state (sometimes even the country) so providing contact details for staff would reach people outside the catchment area of the clinics where staff were employed. This posed a difficulty for staff because although having a contact person was important for members of the community to get more information, many of these contacts did not relate to the immediate catchment area, and had to be referred elsewhere. The Vietnamese worker at South West reported regularly receiving phone calls from members of the Vietnamese community throughout Melbourne, as word spread about her position.

A cautionary note was sounded by two managers who felt that there was some danger that community work with ethnic groups would come to be seen as the responsibility solely of the bilingual staff. They thought this work should be taken on by the clinic as a whole and shared by other staff as well: 'And I guess the criticism of that is that we can't just leave it to BCMs and we need to work very much with them.' Along the same lines, some concern was expressed that links between bilingual staff and ethnic agencies or GP's needed to be extended to the rest of the clinic as a whole. A suggestion made by several people was that contacts with individuals be documented in a resource file and that other staff be included in this process of outreach in some way. Some services for example have established 'portfolios' for each staff member to make personal contact with ethnic agencies, compile information and so on, so that this task is shared and also includes more than the major communities covered by the BCM program.

Interpreting

An early issue raised in the VTPU meetings was that some staff were being asked to act as interpreters. There was some debate about whether this was an appropriate role for

bilingual staff, with most staff arguing that it was not. Attempts to interpret during family interviews, while at the same time acting as case manager, proved to be too difficult. It was decided that bilingual case management staff should not interpret for a number of reasons, including:

- bilingual staff are employed as clinicians, and asking them to interpret means that time is diverted away from clinical work; bilingual staff cannot be expected to be 'on-call' to interpret,
- interpreters require specific skills and training which bilingual staff do not necessarily have,
- bilingual staff are often asked to be involved in joint assessment or joint case management, and it is not possible to perform these roles and interpret at the same time.

However it was felt that it would be appropriate for staff to interpret in emergencies, and with duty phone calls where the caller could not speak English. These suggestions were written up and circulated to Continuing Care Team managers and discipline supervisors.

Most of the BCM mentioned this issue during interviews. The consensus seemed to be that this issue had initially been a problem at all services but managers and supervisors had discussed the difficulties with staff and that it did not now pose a significant problem, although in some circumstances BCM were still being asked to interpret, for example on some assessments by CATTs.

Cultural issues in clinical practice

The interaction of ethnicity, culture, mental illness, and treatment was central to the work of bilingual case managers, as it was to other clinicians working with people from varied ethnic backgrounds. This section summarises some of the main points made by interviewees regarding mental state examination and diagnosis, case management and the clinical relationship, although it is beyond the scope of this thesis to explore these questions in detail.

Mental state examination

The most common issue mentioned by bilingual staff was the influence of culturally-influenced explanatory models on the process of diagnosis. Staff thought that beliefs about black magic, curses, spirits, fortune telling, fate and destiny were common in some groups but were sometimes interpreted as delusional.

For example, one BCM staff member spoke about a client who believed in black magic and that she was at the mercy of people who placed spells on her - a belief which could be seen as culturally normal. However this seemed to be part of a larger paranoid and delusional belief system, and the worker felt that it was often not clear whether this was still 'currently normal' or not. Some bilingual staff reported that in such situations, clients expected them to agree with their magical thinking because they were from the same culture, and that emphasising cultural issues could conflict with accepted medical explanations about illness and causation, and place the BCM in position of conflicting loyalties.

Another issue was cultural differences in emotional expression and how these were interpreted. The Turkish worker argued for example that 'Turkish women keep their feelings bottled up and then when they finally express them it can seem very emotional - they cry a lot, can't breathe, sometimes fall on the floor, they get really hyped up and it comes out like a torrent'. This behaviour could be interpreted as mania or a panic attack, but the worker felt that this was a common mode of expression of grief for women in Turkey, particularly outside the major metropolitan centres.

Staff mentioned a number of other examples: Vietnamese people may be less willing than English-speaking background Australians to express negative feelings easily or openly which means that symptoms of depression can be missed while Southern Europeans may be more expressive or animated, leading to being labelled manic. Similarly, the emphasis on family responsibility and involvement for many ethnic communities could be interpreted as 'over-involvement or over-protectiveness'.

Dress was mentioned by staff from several different backgrounds; they believed that people from their cultural backgrounds tended to dress well most of the time,

particularly going to a clinic, so that dress was not necessarily an indication of mental state.

Another issue raised by about half the bilingual staff was a cultural difference in orientation regarding mental health more generally. These staff felt that their communities and families placed a much greater emphasis on outward indications of welfare or well-being, such as dress, owning a car or house and so on, whereas Australian society, or at least mental health practitioners, tended to emphasise internal psychological states such as self-esteem, acceptance of illness, self-worth.

Case management issues

Most interviewees thought that the case management process was generally the same for clients regardless of ethnic background but there were some specific issues that arose for NESB people.

The shame of having mental illness, and stigma within ethnic communities was seen as being more problematic and having a greater impact on clients. Part of this related to confidentiality being very important and some staff said they made a point of discussing confidentiality in much more depth for NESB clients than they would for Australian born people.

Perhaps related to this, a number of BCM said they thought that NESB people had less insight into their illness or were less prepared to accept having an illness. This made it more difficult to educate NESB clients and families, and often meant accepting that they would refuse to see their condition as an illness.

Many staff thought that more time was needed with NESB clients, because they did not know about how services operated, and it took longer to explain things. This seemed to be related to migrant status rather than just English ability and many BCM thought that they spent relatively more with their NESB clients compared with Australian born clients.

Two BCM talked about issues facing NESB women, both as clients and carers. One issue was domestic violence and one worker said s/he thought this was very common in her community so she always gave women a chance to meet with her when their husbands were not present. Another BCM thought that women from her culture found it difficult to discuss some issues in front of their husbands so she also made a point of allowing time by themselves to discuss particular concerns or questions.

One worker described concentrating on practical issues such as dealing with government departments, translating letters, because most of her clients did not speak English and there were few other workers around who could do this, and also because of a lack of familiarity with the system. Several staff thought that there were less services available to those who don't speak English so it was harder to refer or discharge them to another service. They felt that they had to take on more of a service delivery role than they would for clients who spoke English.

The impact of migration was seen to be an important issue generally, both in terms of practical issues such as acquiring a new language, establishing social networks and finding work, or learning about a new system but also in terms of psychological aspects such as homesickness, loneliness, ambivalence about leaving the old country and the experience of being culturally different.

Clinical relationship

As well as influencing some of the content of case management, cultural issues were also seen to be relevant to the relationship between clinician and client. NESB people were thought to have less of an understanding of professional roles especially for allied health disciplines. Some BCM and supervisors thought that people born in a NESB country often saw professionals more as friends or members of their extended family and could not understand some of the boundaries professionals imposed on the relationship (such as limiting personal information or attending social or family gatherings).

A counterpoint to this was that most staff interviewed believed that clients generally felt more comfortable seeing a worker from the same ethnic background. There were three distinct, but often overlapping aspects. First, being able to speak the same language made clients feel that they could express themselves more easily and confidently, and believe that there was less chance of being misunderstood. Bilingual staff felt that communicating in the client's preferred language enabled them to get a better sense of the person and conduct more accurate assessments than working through an interpreter.

Second, regardless of language of the encounter, many staff believed that sharing a similar ethnic background helped to establish a link between worker and client, and also contributed to clients feeling that they were more likely to be understood. As one case manager quoted a client saying to him 'it's not the same, no matter what we do, no matter how long we live here, we are still different.'

Third, those staff who had themselves been migrants said that they could identify with clients who had also migrated and they felt they had a better understanding of the process of migration and settlement, and associated issues such as homesickness, learning English etc. One said that she used her experience in settling and acculturating to help clients understand ways in which they could respond to Australian society.

Because of these, supervisors and bilingual staff believed that a shared ethnic background led to quicker engagement and establishment of trust.

However, there were also some negative aspects of having a shared ethnic background. Some staff said that clients expected them to agree with traditional values or beliefs about the cause of their illness. This posed a dilemma; for example, one person said 'I don't want to agree with them but I don't want to tell them they are wrong'. Because of confidentiality issues, and the fear of information about their illness being passed on to community members, some NESB people may prefer to see someone not from their own background - this had been experienced by one BCM, but a number of supervisors raised this possibility.

Other BCM's spoke of the greater expectations (such as a closer personal relationship or a greater advocacy role on their behalf) that clients had of them because they were 'one

of us'. Generational and gender issues were also important, young women especially could be regarded as 'too young' to be able to help older clients, and gender issues for some clients could be far more important in their preference for a case manager, either because of cultural reasons, or their own experiences (such as sexual abuse).

Organisational and management issues

Bilingual staff reported that they generally did not have much contact with Mobile Support and Treatment Teams, but most had had some contact with CATTs, mainly requests to sit in on assessments or sometimes, to interpret. Contact with inpatient units varied – three BCM staff went regularly to meet with clients or staff at their hospital settings while others had no contact. Most interviewees did not think there were any particular barriers to working with other teams or services.

As far as attitudes and working relationships within their own teams, the picture was somewhat mixed. At two services, staff felt that they were well accepted and that there was a strong commitment to ethnic issues. At two others, the views were ambivalent. One BCM said for example that s/he thought about half of the staff were positive and the other half did not think that bilingual workers were needed. Another BCM at the same service felt that the service was generally very Anglo-Saxon in orientation and did not cater well to the needs of NESB people.

Many of the BCM said that they thought other staff only saw them 'as someone who speaks _____ and can work with _____ clients'. It was felt that other staff generally were not aware of either the other skills and experience that BCM had nor of their other roles and work in the BCM, particularly the community development and secondary consultation roles. One person said the part of the job s/he liked least was 'dealing with some doctors who don't listen to other staff.' As discussed above, there was some confusion about roles when BCM first started with other staff thinking they should also interpret in some situations. However in the second round of interviews there was a general consensus that a good understanding and acceptance of the BCM program and roles had developed over time.

At two centres, supervisors reported that there was some concern expressed initially by a few staff about the lack of clinical experience of the BCM. This tended to come from staff who had worked in the clinic for many years, but the feeling was that this has fairly quickly dissipated once the BCM showed that they were keen to learn, enthusiastic and competent.

The main organisational issue appeared to be with CATTs which initially called on BCM to interpret. However a number of positive examples of working with CATTs were also described. Some managers and supervisors described CATTs as having a different culture and approach to the rest of the service and one stated that s/he thought CATTs were 'very good at protecting their boundaries and not taking on anything they don't want to.' BCM generally reported positive relationships with the CATTs and the rest of staff.

Management was also seen by the BCM as supportive. Specific examples of this included being open to ideas put forward about new projects, and allowing the BCM to build their caseloads up gradually, although pressures on the clinics led to increasing caseloads for the BCM from 1997-1999. BCM also felt that managers were supportive in not expecting them to interpret although some felt that managers could do more to get this message across to other staff and CATTs.

At three services, the BCM met with the CCT manager on a regular basis to discuss how the positions were progressing and any difficulties they were experiencing, and this was seen as very useful. Also mentioned was support for training. Supervisors also felt that management was supportive, or in one or two cases, generally not involved in either a positive or negative manner. Managers did not think that the BCM posed any specific management difficulties and that it had added a great deal of energy and enthusiasm to the services. One supervisor raised the issue of how to keep new staff informed about the BCM given the high turnover of staff at the clinic. As discussed elsewhere, both supervisors and BCM (and some managers themselves) felt that managers should promote the positions and their roles more within the service and externally.

Changes in the cultural sensitivity of services

Several managers said they believed that their services had become more culturally sensitive, or at least more aware of cultural issues, because of the BCM. One way in which this occurred was that BCM's often raised questions about language, culture, religion and migration at clinical review meetings, prompting other staff to consider these where they may not have in the past.

Changes suggested

Bilingual staff

Generally, the staff felt that their positions were interesting and challenging. A few felt that the services where they worked needed to ensure that working with NESB people was not just seen as the province of bilingual case managers but that all staff and management saw this as a responsibility - this echoes comments made by some managers and supervisors. One person thought the positions were funded for only a limited period of time and felt that they should be permanent. There were mixed feelings about the title 'Bilingual Case Manager' as discussed above, and some staff wanted this to be abandoned. Others thought that it was important to have their specific roles and responsibilities recognised in their positions or they would end up doing exactly the same work as everyone else.

The most common issue of concern, mentioned by all the BCM staff, was the size of the caseloads they were expected to carry, and that this prevented any real focus on other aspects of their work. Many felt frustrated that they could not undertake community work to the extent they wished or felt was needed, and there was a perception that services paid lip-service to this aspect of their work. Some suggestions about future changes or changes which should be taken into account in implementing similar positions elsewhere included:

- reducing caseloads to enable more time for community work;
- having more than one staff member speaking same language to enable joint work on community projects;
- more publicity about the program by management, both within the service and externally;
- better orientation to service and clearer description of position and expectations;
- at meetings of BCM, more time on cultural issues in assessment and treatment/ counselling;
- finding ways to work more with other staff as joint case manager or in secondary consultation;
- training in running staff development sessions;
- more involvement in assessment when clients are first referred.

Supervisors

Supervisors raised similar issues to those expressed above by the bilingual staff, but there were some additional comments. One thought that being able to provide psychotherapy in the first language of clients was a major advantage for the service, and that staff should be encouraged to develop their skills in this area. Suggestions included:

- Cross-cultural training for BCM but also for staff generally;
- More BCM in other services across Victoria (as the BCM at this service frequently received requests for help or information from other mental health services);
- Bilingual staff to be employed in more senior positions;
- Better orientation;
- Feedback from evaluation of the program.

Managers

Managers were also generally happy with the program. Many acknowledged that they could do more to promote the program, but were also keen to protect staff from being exposed to too many expectations. Cross-area work was discussed more with managers

than with other staff. Managers thought that the idea of providing case management or secondary consultation for clients outside the catchment area was not possible because the staff were busy enough as it was, although some saw this as possibility if there was an exchange of resources across areas (e.g., in staff time). Most would have liked to see more secondary consultation and joint case management within their own service.

Specific suggestions included:

- More consultancy and joint case management work;
- Need more feedback about the program before considering changes;
- For BCM with psychology qualifications to gain Clinical Masters;
- Checklist for BCM involvement with clients;
- Feedback from evaluation;
- Providing education to all staff if the program is introduced at another service.

Summary of findings

Additional funding was provided for the first year by the Western Region Office of the Department of Human Services, and then all the positions were incorporated into the services' core budgets. This 'seed' funding was very important in enabling the program to be established. The staff who were employed had limited experience in mental health. However, managers felt that they were extremely enthusiastic, eager to learn and dedicated to their work. After a few months, they had gained credibility within the services and from other staff.

Support for staff, clinical supervision and access to training were provided in the first twelve months as the staff were relatively inexperienced, and the positions somewhat unusual. The supervision provided by individual clinical supervisors and Yvonne Stolk, Ethnic Mental Health Consultant, were seen by staff to be very useful and important.

During the establishment of the program, there had been some discussion with managers about the criteria to be used to select ethnic groups to be covered by the program. These criteria included the size of the group within the catchment area, the proportion of people from each group who spoke English poorly or not at all, the amount of other resources available to each community (for example ethnic community

agencies), recency of arrival, and the distribution of ethnic groups across the region generally (as opposed to individual catchment areas). Managers made the final decisions about these criteria, and in the end, the languages targeted were those with the largest populations in each catchment area.

About half the clients seen by the BCM came from the same ethnic background, as proposed initially. The size of caseloads for BCM increased from 23 (around two-thirds of other staff) in 1998 to 32 (90 percent of those of other staff) in 2000, while those for other staff remained fairly constant at about 35 clients per case manager. Secondary consultation increased over time, but formal joint case management was rare.

Community work covered family education, community education, liaison with ethnic agencies, and organising support groups, but the extent of community work was limited by increasing caseloads. Community work was more feasible for staff where more than one per ethnic group was employed (Greek, Italian and Vietnamese) compared to the other BCM's (who spoke Croatian, Macedonian and Turkish).

Managers felt that the BCM's had raised the awareness, and discussion, of cultural issues (for example at clinical review meetings), and had made a major contribution towards making their services more culturally sensitive.

BCM's believed that their NESB clients needed more time from staff because they had less access to other social support services due to language and cultural barriers, and most staff interviewed felt that clients from the same ethnic background expected more from BCM's because of shared ethnicity

Most BCM's, supervisors and managers believed that a shared ethnic background between client and case manager would lead to a better therapeutic engagement, because clients felt more comfortable being able to speak in their first language, particularly about difficult emotional issues, and that an ethnic match enabled trust to be established more quickly.

MEDICATION MANAGEMENT

Sample

Medication data were provided for 241 clients. Seventy one percent were diagnosed with a psychosis, 10.3 percent with bipolar disorder, 2.6 percent with a personality disorder, and diagnosis was missing for 9.5 percent. One hundred and sixty-eight (69.7 percent of the total) received anti-psychotic medication, and the analyses in this study are restricted to this group.

The major countries of birth were Australia (31.2 percent), Vietnam (20.7 percent), Italy (16.5 percent), Greece (11.4 percent), the Former Yugoslav republic of Macedonia (6.3 percent), Turkey (5.5 percent) and Croatia (3.4 percent). Preferred languages of patients were English (59.0 percent), Vietnamese (17.9 percent), Italian (7.3 percent), Greek (6.4 percent), Turkish (5.1 percent), Macedonian (1.7 percent) and Croatian (1.2 percent).

The mean age of the group was 40.7 (s.d. 12.0), and 56 percent were male. There was no difference in the gender breakdown by birthplace or preferred language, but there was a significant difference for age. The overseas born group were older (mean age 43.3) than the Australian born (mean age 35.5, $t(157)=4.06$, $p<0.001$), and those speaking a European language (mean age 46.4) were older than English speakers (mean age 38.4) and Vietnamese-speakers (mean age 34.4, $F(2,160)=13.0$, $p<0.001$). For the 110 clients born in a non-English speaking country, 35 (31.8%) saw a case manager from the same ethno-linguistic background and 75 (68.1%) did not.

Route of administration

Table 8.5 shows route of administration by birthplace and preferred language. Of the sample, 39.9 percent received a depot only and 55.3 percent received an oral neuroleptic only. Interestingly, only 8 people (4.8 percent) received both oral and depot medication, and 7 of these were born in a NES country.

Table 8.5 Route of administration by birthplace and preferred language.

Administration Route	Birthplace				
	Aust & UK (56)	Europe (83)	Vietnam (27)	NES total (110)	Total (168)
Depot only (%)	32.1	42.2	48.1	42.7	39.9
Oral only (%)	66.0	50.6	48.1	50.0	55.3
Both (%)	1.8	7.2	3.8	7.3	4.8

The results of the regression model are shown in Table 8.6. The model was a significant predictor of receipt of depot injection (Chi-Square=37.7, df=12, $p<0.001$). There were three significant predictors of receipt of depot medication; cooperation with treatment, medication dose, and ethnic match.

Clients of NESB matched with a case manager of the same background were less likely to receive depot medication than other NESB clients (Figure 8.7), and clients who were regarded as less cooperative and on higher doses of medication were more likely to receive depot medication.

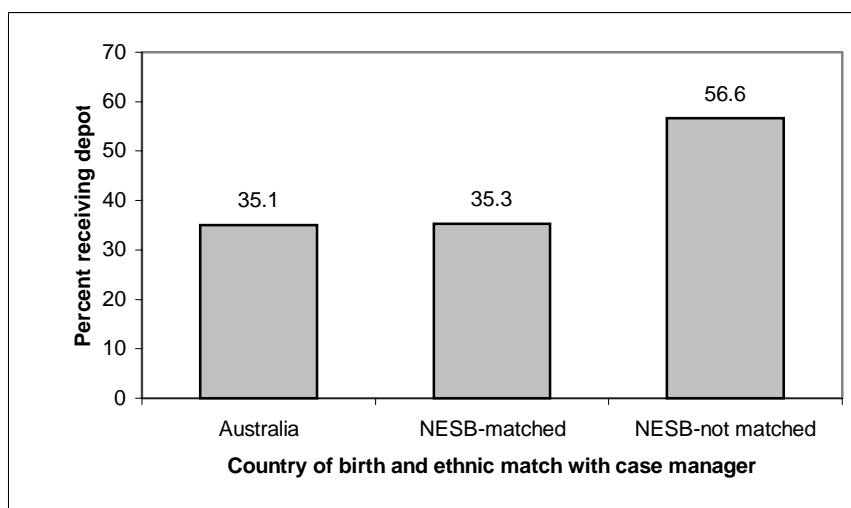
**Figure 8.7 Receipt of depot medication by birthplace and ethnic match**

Table 8.6 Predictors for depot medication

Variable	B	p	R
Sex	.141	.715	.000
Age	.018	.299	.000
Thought disorder	.050	.788	.000
Insight	-.236	.179	.000
Medication compliance	1.971	.360	.000
Cooperation	-1.865	.033	-.106
Drug/alcohol abuse	-.292	.613	.000
Impulse control	-.943	.187	.000
Medication dose	.907	.001	.195
Ability to manage finances	.283	.112	.048
Ethnic match	.943	.048	.092
Country of birth	-.355	.496	.000
Constant	-5.514	.007	

Average daily antipsychotic dose

The mean dose was calculated for each birthplace and language group, and is shown in Table 8.7 by administration route. There was a significant relationship between total dose and both age ($r=-0.23$, $p=0.003$) and gender ($t(136)=2.59$, $p=0.01$), with younger patients and males having higher doses.

As it might be expected from previous research that patients of Asian backgrounds would receive smaller doses, average doses for those born in Vietnam were compared with the rest of the sample, after controlling for age and gender. This analysis showed that the Vietnamese born received a significantly lower total dose (Vietnamese mean dose 244 mg/day, all others mean dose 342 mg/day, $F(1, 156)=2.5$, $p=0.03$) although this difference was not significant for oral or depot doses (perhaps due to the smaller number included in these analyses).

That Asian people require smaller doses of psychotropic medication is presumably due to genetic or average body size differences between regional population groups, rather than ethnic identity, cultural difference or communication barriers. In order to explore the effects on dose size of cultural differences between groups, Asian-born patients were excluded and average dose was then analysed by birthplace and preferred language. After controlling for age and gender, there was no difference in oral, depot or total dose size by country of birth or preferred language. There was also no effect when considering whether patients were matched to a case manager of the same ethnic background.

Table 8.7 Mean dose by birthplace and administration route

Administration route	Birthplace				Total (167)
	Aust & UK (56)	Europe (82)	Vietnam (27)	NES total (109)	
Mean oral dose (mg)	313	277	203	260	280
Mean depot dose (mg)	513	302	268	294	352
Mean total dose (mg)	390	310	244*	293	326

* p<0.01 for Vietnamese-born vs all others

Atypical antipsychotics

Table 8.8 shows the percent of each birthplace and language group receiving an atypical antipsychotic (clozapine, olanzapine or risperidone). Forty five (27.1 percent) were on a novel drug (risperidone 14.5 percent, clozapine 10.2 percent and Olanzapine 2.4 percent) with the rest (72.9 percent) on a traditional ('typical') neuroleptic.

Table 8.8 Percent receiving atypical antipsychotics by birthplace

Medication type	Birthplace				Total (168)
	Aust & UK (56)	Europe (83)	Vietnam (27)	NES total (110)	
Clozapine (%)	14.3	9.6	3.7	8.2	10.1
Olanzapine (%)	7.1	0.0	0.0	0.0	2.4
Risperidone (%)	14.3	13.3	18.5	14.5	14.3
Total new (%)	35.7	22.9	22.2	22.7	26.8

The proportion of English-speakers receiving an atypical medication was no different to the proportion of those preferring a language other than English (LOTE) ($\chi^2(1)=0.29$, $p=0.59$). However, there was a trend for a greater proportion of those born in Australia to receive atypical medications when compared to those born in a NESB country ($\chi^2(1)=3.68$, $p=0.055$). Those born overseas were less likely to be on a novel drug. There was also a strong effect for age, with those receiving an atypical medication being significantly younger ($t(159)=2.18$, $p=0.03$). However, age and birthplace were confounded, with NESB people being older than the Australian-born group.

In order to investigate this relationship further, patients were matched for age and medication compliance so that all 54 patients born in Australia were matched with the

same number born in a NES country. Logistic regression was conducted with sex, age, and medication compliance as covariates. This analysis showed a significant effect for age ($p < 0.01$) but no effect for birthplace, gender or compliance rating. Patients matched with a case manager of the same ethnic background were no more likely to receive an atypical drug than NESB patients with non-matched case managers.

Perceived compliance with medication

Case managers rated the compliance of patients with medication on a five-point scale which comprised one of the seventeen items of the Multnomah Community Ability Scale. Higher scores indicated greater perceived compliance. Initial bivariate analysis showed no difference in perceived compliance with medication either by birthplace, preferred language, or gender. There was a small correlation of age with compliance ($r = 0.19$, $p = 0.017$), with greater compliance exhibited by older patients.

Table 8.9 shows the thirteen predictor variables entered into the regression equation, bivariate correlation with medication compliance, the standardised regression coefficient (beta), t-value and the statistical significance of beta. Bivariate analysis (column 2 in Table 8.9) showed that several variables were significantly correlated with poor medication compliance: lack of cooperation with staff ($r = 0.78$, $p < 0.01$), poor insight ($r = 0.50$, $p < 0.01$), problems with impulse control ($r = 0.40$, $p < 0.01$), drug or alcohol abuse ($r = 0.37$, $p < 0.01$), mood abnormality ($r = 0.21$, $p < 0.01$), and younger age ($r = 0.18$, $p < 0.05$), but matching with an ethnically similar case manager was not significantly correlated with compliance ($r = -0.06$, $p = 0.24$).

Table 8.9 Predictors of medication compliance

Predictors	Bivariate r	Beta coefficients	T	p
Cooperation with staff	0.78**	.532	7.74	.000
Insight	0.50**	.218	3.13	.002
Ethnic match	0.06	.139	2.33	.019
Impulse control	0.40**	.172	2.37	.019
Ability to manage finances	0.07	-.152	-2.36	.020
Age	0.18*	.108	1.79	.075
Receipt of depot medication	-0.15	.061	1.03	.306
Sex	0.04	-.048	-.82	.416
Mood	0.21**	.049	.75	.457
Social network	0.03	-.042	-.72	.473
Drug or alcohol abuse	-0.37**	-.042	-.69	.491
Medication dose	0.12	.033	.52	.606
Thought disorder	0.14	-.015	-.21	.835
(Constant)			-.37	.709

* $p \leq 0.05$, ** $p \leq 0.01$ (2-tailed)

Using multiple regression, five variables were found to have a statistically significant relationship with medication compliance. Greater cooperation with staff ($\beta=0.53$, $p < 0.001$), better insight ($\beta=0.21$, $p=0.002$), matching clients with a case manager from the same ethnic background ($\beta=0.14$, $p=0.019$), fewer problems with impulse control ($\beta=0.17$, $p=0.019$), and less ability to manage finances ($\beta=0.15$, $p=0.020$) were associated with greater compliance. This prediction model was statistically significant ($F=15.4$, $p < 0.0001$) accounting for 54 percent of the variance in medication compliance ratings (Adjusted $R^2=0.54$).

The fact that ethnic matching was not directly correlated with compliance but showed a significant relationship in the regression model suggests that the effect of ethnic match was moderated by a variable in the regression model. To explore this, variables were successively removed from the regression model until the effect of ethnic match failed to reach significance. With 'cooperation' removed from the regression, ethnic match failed to reach significance ($\beta=0.09$, $p=0.21$), but when cooperation was entered, ethnic match was statistically significant ($\beta=0.14$, $p=0.019$). Thus it can be said that, in the original regression model, once differences in cooperation had been accounted for, ethnic matching did show a significant independent relationship with medication compliance. Ethnic minority clients were more likely to comply with medication if they were matched to a case manager of their own ethnic background.

In order to investigate the possibility that bilingual case managers were generally allocated clients who were more likely to comply with their medication regime, mean compliance ratings for clients for bilingual staff (these included clients from both the same ethnic background and other backgrounds) were compared to clients for all other staff. This analysis showed no difference in mean ratings of compliance between these two groups of staff ($t(61)=-0.31, p=0.76$). Entering this variable into the regression equation also showed no significant relationship with compliance.

Summary of findings

The results showed that there was no effect of ethnic match on medication dose and receipt of an atypical medication: matched clients had the same average medication dose and were just as likely to receive an atypical neuroleptic, as unmatched clients. However, clients of non-English speaking background who had a case manager of the same ethnic background, were less likely to receive depot medication, and more likely to comply with medication, than other NESB clients of the service.

CLIENT SATISFACTION AND CROSS-CULTURAL SENSITIVITY

Sample

Of the 200 clients originally identified, fifty-two agreed to be interviewed, an overall response rate of 26 percent. Sixty-two clients refused, and another 55 were not able to be interviewed (12 were too ill, 3 due to safety concerns, 27 had been discharged, and 13 for other reasons). For the other 31 clients, the case manager never responded to letters or phone calls.

Clients interviewed had a mean age of 41.6 years (S.D.11.2), had been going to the current clinic for mean of 4.0 years (S.D. 2.6 years), and 69.2 percent were female. Figure 8.8 shows that most clients attended the clinic monthly (48.7 percent) or

fortnightly (28.2 percent). Country of birth and mean length of time in Australia are shown in Table 8.10, and preferred language is shown in Table 8.11.

Thirty-nine NESB clients were interviewed about their satisfaction with services and the cultural sensitivity of the services they attended. The thirteen Australian-born clients were interviewed about their satisfaction with services, but not about cultural sensitivity.

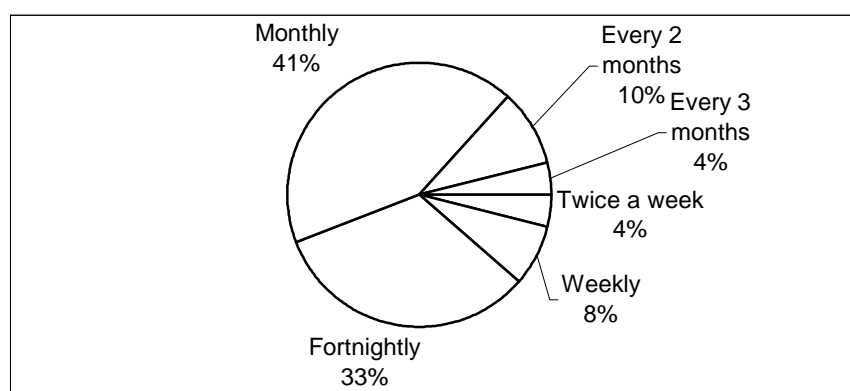


Figure 8.8 Frequency of attendance at the clinic

Table 8.10 Country of birth and number of years in Australia

	Number	Percent	Mean years in Australia
Australia	13	25.0	-
Croatia	2	3.8	20
Greece	7	13.5	36
Italy	2	3.8	36
Macedonia	3	5.8	26
Turkey	7	13.5	20
Vietnam	18	34.6	13
Total	52	100.0	21

Table 8.11 Language spoken at the clinic

	Number	Percent
English	22	42.3
Greek	5	9.6
Italian	2	3.8
Macedonian	2	3.8
Turkish	4	7.7
Vietnamese	17	32.7
Total	52	100.0

How do staff help?

Clients were asked (both NESB and ESB) what took place when they went to the clinic and how staff helped them. Forty-eight people saw a doctor at the clinic but thirteen of these did not know the doctors name, either because they could not remember or because their doctor had recently changed. Fifty people saw a case manager, but only one of these did not know their case managers name. Thirty-three clients saw one of the bilingual case managers and the rest saw another case manager.

Almost all clients said that doctors helped them by asking questions about symptoms and sometimes about other aspects of their lives, and by prescribing and monitoring medication. When asked how doctors helped them, some of the responses included:

Asks me questions, how I go with the medicine, how I pass my time when I am away from the clinic, prescribes medicine.

The doctor observes my illness condition by asking me about my feelings and thoughts, and about my current life situation, then he writes out a prescription.

Talks to me. She gives me medication. She talks to me about changing my tablets, she regulates my medication, asks me questions about how I am going with the tablets.

He helps me. How? (interviewer) He listens to me and I feel I am understood by somebody, it gives me a feeling that I am not alone on the world.

The main ways in which case managers were seen to help were by helping with practical problems such as writing letters, dealing with government services, referral to other services, talking about problems and listening and problem solving, providing emotional and moral support, ensuring they attend medical appointments, and monitoring medication.

She helps me when I experience difficulties e.g. housing, lack of household contents. I confide to her when I feel sad.

My case manager helps me with things concerning my mental health e.g. family problems. I confide to her when I feel down and she helps me to get back to normal life. Besides, she organises group outings, cooking and flower arrangement classes.

He is a good person, we go out for walks and trips and for coffee. I had depression. _____ has helped me economically (by giving me money for petrol to go and see my brother). Generally we speak and he gives me support.

Clients were asked if they saw anyone else in the clinic who helped them, apart from their doctor and case manager. Fourteen people named someone else, including nurses, crisis team workers, receptionists, interpreters, and other staff, and ways in which these staff helped included making appointments, visiting at home, and being available to talk to when their case manager was not around.

Satisfaction with services

Open-ended questions were asked about the treatment received for the condition, how quickly help was received when needed, and general satisfaction with services.

Most comments about treatment, both positive and negative, concerned medication.

I get better now. I sleep well. With my situation if I didn't take my pills I don't know how I would be.

I am very satisfied. I feel very good each time I see the doctor, and feel better after taking medications.

Medication is now very good. I used to take a couple of different ones before, but they changed them till they found something suitable.

The main areas of dissatisfaction concerned the turnover of doctors, and that the medication was unhelpful:

As I have said earlier, doctor asks lots of questions about my illness. I'm not happy with the changeover of doctors. They only see you once or twice, just to get to know you and your experiences of having a mental illness and then I have to see a different doctor. I personally feel that they do not follow up properly.

Now I'm back on my old one (medication). I'm very satisfied. The other one was driving me mental, but none of the doctors would believe me. They wouldn't!

The doctors change very often and they all give me different medications. For example, the last one told me that the medication the other doctor gave me weren't good.

Few people mentioned culture or language when expressing their views about satisfaction with the service. The exceptions concerned medication, and ability to converse in the first language:

Doctor changes happen every three or six months, and each time I have to repeat again and again about my illness condition to the new doctor, and my medication doses instructed by my present doctor are too strong for me because such doses are supposed for Australian people, but I am Asian, smaller than them, therefore it results in so many side effects.

In terms of promptness of treatment, most clients felt they received help when they needed it. The main negative comments were about being kept waiting for appointments, or being kept waiting on the phone by receptionists:

I am very satisfied. They are quick and very efficient.

When ever I need help I can get it

When I ring up the clinic the secretaries there make me wait too long and sometimes the phone would even get hung up. They have no idea of whether the doctor is in or not and so they are not very helpful.

The following questions investigated NESB clients' settlement experience, maintenance of culture, English ability, interpreter use, preference for the ethnicity of their case manager, family involvement, information received, and views about the cultural sensitivity of the service.

Migration and settlement

Clients were asked about their experience of migrating to Australia, about the positive aspects of their settlement experience and about settlement difficulties.

Common responses about the benefits of living in Australia were:

- there were many services available compared to their country of origin,
- legal and human rights and freedom from persecution,
- the lifestyle was comfortable,
- there were more educational opportunities for their children,
- work was generally available (this mostly from the Europeans),
- and there were established ethnic communities in Melbourne.

The most common difficulties mentioned included:

- lack of English ability,
- separation from family and friends,
- financial problems,
- lack of respect for elders (e.g. teachers),
- cultural differences,
- and difficulty finding work (this mostly from the Vietnamese).

Two-thirds of clients said they thought staff should understand their migration and settlement experiences, another 19 percent thought staff did not need to understand these, another 14 percent were undecided. Clients were asked if staff did understand their migration experience; responses are shown in Figure 8.9.

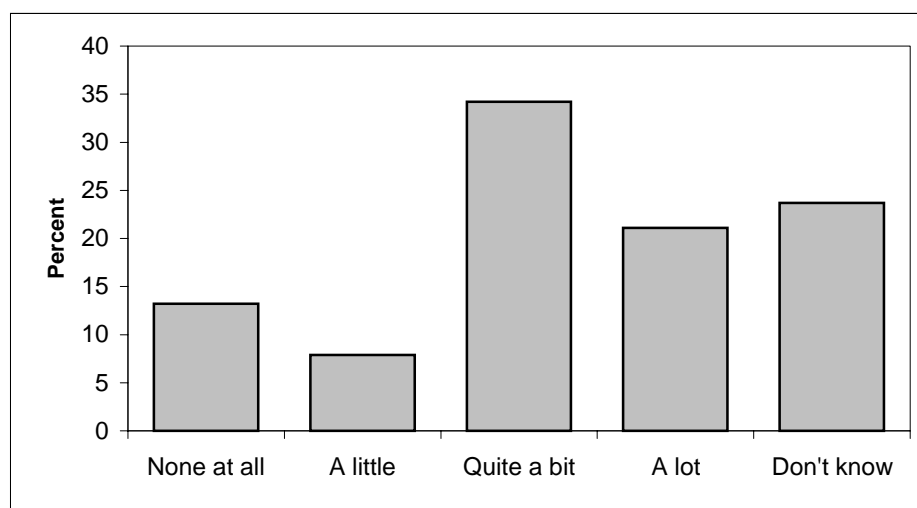


Figure 8.9 Staff understanding of migration experience

While a majority thought that staff had quite a bit or a lot of understanding, a significant minority (21.1 percent) thought that staff had only a little or no understanding.

Comments on this question included:

Their understanding is perhaps quite high because they have asked me a lot about my opinions about Australia and my own experience in settling in this country

I think they don't know about my experience because it isn't necessary unless for those who suffer the problem shortly after their arrival.

However, they have never asked me about such things (this person said that staff had 'quite a bit' of understanding of his/her migration experience, and was 'very satisfied' with staff knowledge of it).

Having a good understanding of my experience by staff might help them in providing counselling or advice to other patients.

My case manager has a better understanding about it. My doctor is just aware of my illness condition only.

Only five people reported that that staff had misunderstood some aspect of their migration and settlement experience, but another eight said they didn't know. When asked to describe the nature of the misunderstanding, the responses were fairly general:

They have no understanding about the culture and the family life of migrant people. For instance, when they help me with my family problems, instead of helping my wife and myself get back together, they unconsciously make the situation worse i.e. they'd rather encourage my wife to leave the family.

They don't know anything about it and because they don't want to know, they don't ask any questions.

Ratings of staff satisfaction with understanding of migration and settlement issues is shown in Table 8.12. There was no difference in satisfaction with staff understanding of migration according to whether or not clients were matched with a bilingual case manager, (Mann-Whitney $U=130.0$, $p=.37$), but those who reported an experience of staff misunderstanding were less satisfied (Mann-Whitney $U=88.5$, $p=0.02$).

Table 8.12 Satisfaction with staff understanding of migration

	Number	Percent
Very dissatisfied	1	2.7
Generally dissatisfied	1	2.7
A little dissatisfied	0	0
Neither satisfied nor dissatisfied	2	5.4
A little satisfied	9	24.3
Generally satisfied	5	13.5
Very satisfied	19	51.4
Total	37	100.0

The main findings from this section are that the most common settlement difficulty for immigrants was lack of English, a majority (67 percent) thought staff should understand migration, and about half thought staff had quite a bit or a lot of understanding. There was a high level of satisfaction with staff understanding, but a small number had experienced a misunderstanding of their migration experience and this group were less satisfied. There was no difference in satisfaction with migration understanding by ethnic match. These results suggest that knowledge of clients' immigration and settlement experience is an important component of cultural sensitivity.

Culture

Clients were asked how much they had taken up Australian ways of doing things, and how much they maintained traditional cultural practices (Figure 8.10).

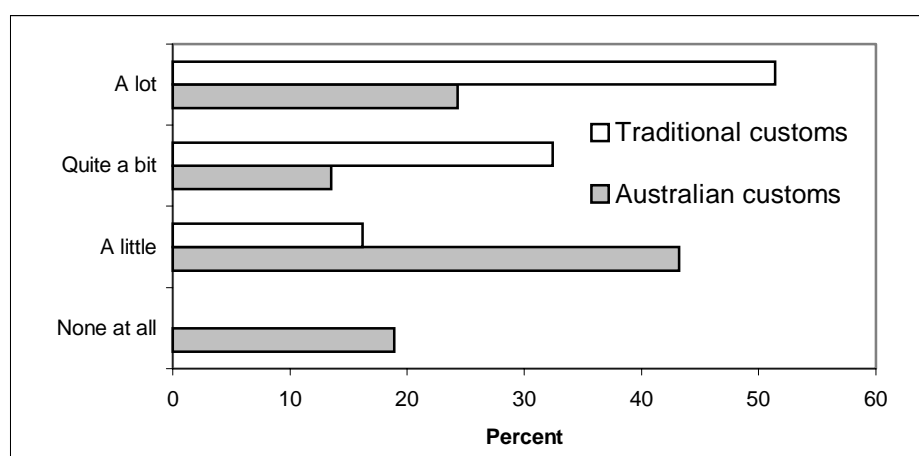


Figure 8.10 Adoption of Australian customs and maintenance of traditional customs

Those interviewed tended to maintain their traditional practices (83.8 percent said they maintained traditional ways 'quite a bit' or 'a lot') more than they adopted Australian ways (37.8 percent said they adopted Australian ways 'quite a bit' or 'a lot'). A difficulty with this question was defining 'culture' in a way which was comprehensible in very few items. In the introduction to the question, culture was defined as 'things like, the sort of food you generally eat, what you believe in, which language you mostly use, what sort of music you listen to.'

Comments in relation to this question showed that people generally identified culture with these behavioural practices:

At home, we speak Macedonian, we eat Macedonian food, I listen to and love Macedonian music. Also, we practise all the Macedonian customs and celebrate all the religious holidays.

I came to Australia at the age of 29 so Vietnamese culture is my life and keeping the culture is very important to me. I am willing to learn and adapt to the new environment but at home I still prefer doing things in Vietnamese ways such as listening to Vietnamese music, eating Vietnamese meals, and encouraging my kid to respect elder generation and ancestors, etc.

Others are part of Greek organisations and clubs but we (my husband and I) don't have any contact with them. I have stopped contact with the organisations and clubs. I think I would feel more 'Greek' if I did have contact with Greek organisations/clubs because I would be dealing only with Greeks.

Few people mentioned cultural identity in terms of belonging to ethnic organisations or mixing with people of the same ethnic background. This may have been because the question did not refer specifically to social networks, or this may reflect reduced social contact because of the mental illness.

Surprisingly, there was no correlation between the length of time in Australia and adoption of Australian practices ($r=-0.03$, $p=0.84$), or maintenance of traditional practices ($r=-0.1$, $p=0.55$). However, clients who adopted Australian practices were less likely to maintain traditional practices ($r=-0.33$, $p=0.045$). Those born in Vietnam adopted Australian practices slightly less and maintained traditional practices more than others, but this difference was not statistically significant.

The main results from this section were that clients showed a high level of maintenance of traditional culture, adopted Australian customs less, and that clients who adopted Australian practices were less likely to maintain traditional practices. 'Cultural

practices' were defined in behavioural terms such as music, dress, food, celebrating religious holidays and language spoken.

English proficiency

The next section asked clients about their English proficiency. Figure 8.11 shows interviewees' ratings of their understanding of English, and their ability to express themselves in English. This table shows that 64.8 percent said they found understanding staff who spoke in English 'a little bit' or 'not at all hard' whereas 54 percent said they found expressing themselves 'a little bit hard' or 'not at all hard'. Qualitative data showed that many interviewees may not have distinguished between understanding and expression with these two questions, because they referred to difficulties in understanding staff when asked about their ability to express themselves.

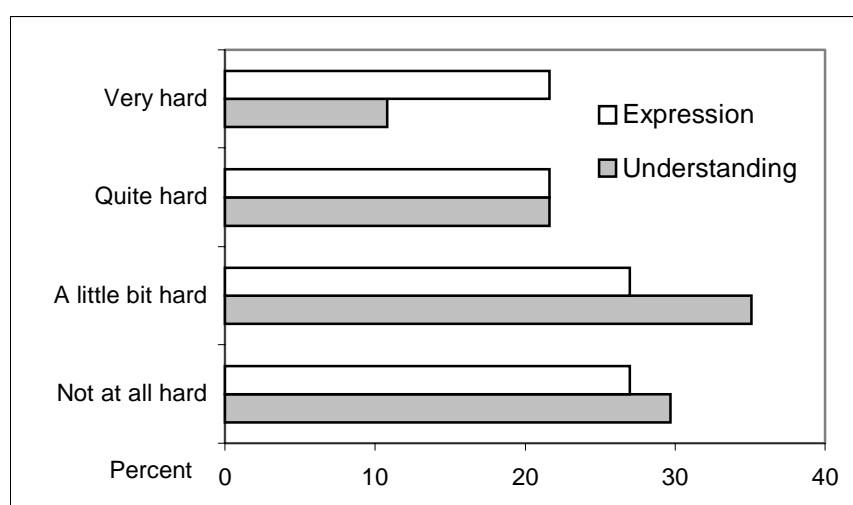


Figure 8.11 Difficulty with expression and understanding of English

Sixty-five percent said there were some things they did not understand when staff spoke in English, and 81 percent said they found it hard to say some things in English. Clients found medical terminology the most difficult area to understand – this included discussions of their symptoms, medication, and side-effects. Some people also referred to staff speaking too quickly or having a non-Australian accent (e.g with a doctor from England) which made it difficult to understand. In terms of difficulty with expression, the most common areas mentioned were discussing the illness, and expressing feelings and problems.

I did not go to school - I avoided school and I did not learn. I find it difficult speaking about my medication in English - I find it difficult to bring up and open a topic to discuss. It is difficult to express myself in general in English

A key finding from this section was that in spite of the fact that the people interviewed had spent an average of 20 years in Australia, a substantial number still experienced difficulties with English. About one third had some difficulty in understanding English and almost half had difficulty expressing themselves in English. Areas of most difficulty were understanding medical terminology about symptoms and medication, and being able to express feelings and problems.

Interpreting

Clients were asked how often they needed an interpreter, and how often one was present (Table 8.13). It can be seen that the frequency of interpreter provision roughly corresponded to the need expressed by interviewees.

Table 8.13 Need for and provision of interpreting

	How often interpreter is needed		How often interpreter is present	
	Number	Percent	Number	Percent
Never	8	22.2	6	17.1
Only sometimes	12	33.3	9	25.7
Quite often	1	2.8	3	8.6
Always	15	41.7	14	40.0
Don't know			3	8.6
Total	36	100.0	35	100.0

Twenty-eight interviewees had been seen at the clinic with an interpreter at some time. Qualitative comments about interpreters were almost all very positive and appreciative:

I feel very secure in the presence of the interpreter because I can express my concern to the doctor if any, or I am able to understand what the doctor says to me via the interpreter

I don't have any problem with the presence of interpreter in the room. Contrary I feel more relaxed and comfortable about having interpreter there because I know that he/she can help me to communicate with staff more effective.

I have become used to having an interpreter - I have the same interpreter for many years and it doesn't bother me at all. She is a good interpreter. I have trust in _____ (interpreter). Having a mental illness is not shameful.

Only four people said they ever worried about the possibility that interpreters may breach confidentiality, and two of these said that they had since realised that confidentiality would not be breached:

I first felt a bit hesitant because I was worried about them knowing illness, but I have gradually got used to it.

I feel that they might sometimes undeliberately talk about my illness to other people, therefore many Vietnamese people seem to know about my illness.

In summary, interpreters appeared to be provided as often as clients said they were needed. Clients expressed very positive and appreciative views about interpreters, and concern about confidentiality was rare.

Preference for case manager

This section explored whether clients had a preference for the ethnic background of their case managers. Interviewees were asked if they preferred a case manager of the same ethnic background to themselves, not the same background, or whether it did not matter. Of the 36 responses to this question (Figure 8.12), 23 (63.9 percent) said they preferred a case manager of the same ethnic background, 2 (5.6 percent) said they preferred a case manager of a different ethnic background and 30.6 percent said it didn't matter. 24 NESB people had a case manager of the same background at the time they were interviewed.

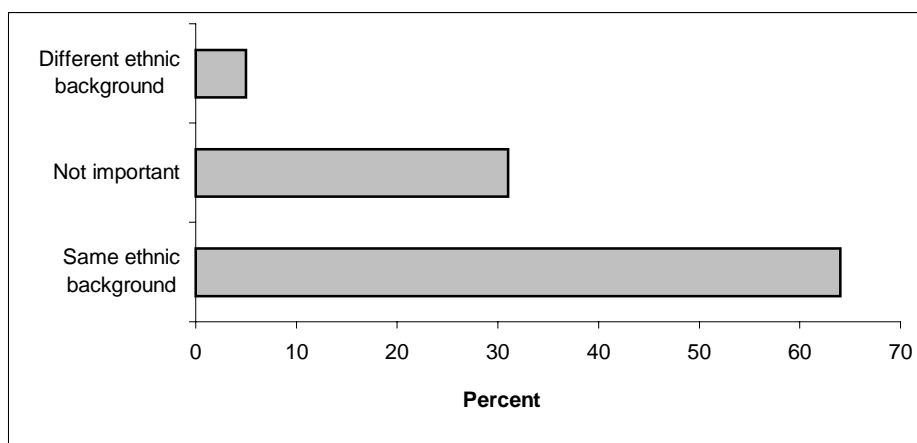


Figure 8.12 Preference for ethnic background of case manager

Clients were then asked about the advantages and disadvantages of having a case manager from the same ethnic background and from a different ethnic background.

Thirty four people identified one or more advantages of having a matched case manager. Of these, 28 (82.4 percent) mentioned the lack of a language barrier and easier communication, 8 (23.5 percent) referred to having a shared culture, and 11 (32.4 percent) believed that their case manager would understand them better. Better understanding seemed to refer to an understanding of cultural issues rather than ability to communicate in the same language as culture and understanding were usually mentioned together.

I have no difficulty with language issue. Having a Vietnamese case manager, she is able to understand my culture. As mental illness is highly stigmatised in Vietnamese culture, it is very difficult for others to understand what my family and I would have been through since I was diagnosed with Schizophrenia.

As we speak the same language, apart from helping me with my illness problems, my case manager also helps me with my other problems e.g. explaining to me the meaning of an English-written letter, making contacts with different places to help me solve my particular concern and consequently that makes me feel quite relaxed.

Because they speak Turkish as well they can understand you much better. They are aware of our culture. If I am not feeling well I have no hesitation in calling and speaking on the phone about my problem.

Thirty-one people responded to the question about the disadvantages of ethnic matching. Of these, 25 (80.6 percent) said they thought there were no disadvantages, and 3 (9.7 percent) identified possible breaches of confidentiality as a concern.

If she knew people that I knew, then I would be worried that she might talk about me. There could be gossip about me.

I am worried in case he talks about me in the Macedonian community.

Twenty-seven interviewees commented on the advantages of having a case manager from a different ethnic background. Of these, 9 (33.3 percent) said there were no advantages, 3 (11.1 percent) mentioned less difficulties with confidentiality issues, and 9 (33.3 percent) mentioned the general helpfulness and care of staff. One person also thought that this would enable her to practice her English:

She would not know my friends and then there would be no gossip

I had a very good case manager of English background. She helped me a lot and I was very satisfied with her.

I have opportunities to speak English with them.

Twenty-eight people responded to the question about the disadvantages of having a case manager from a different ethnic background. Of these, 7 (25 percent) said they thought there were no disadvantages, 19 (67.9 percent) identified language barriers, and 3 (10.7 percent) identified cultural barriers as disadvantages.

Different languages and cultures preventing good understanding of each other.

Sometimes s/he wouldn't understand some problems that I have because they wouldn't know the Macedonian culture.

The only disadvantages are that sometimes it's hard for her to fully understand my feelings and experiences that I've been through and also interpreter required for each appointment which I found very inconvenience.

The disadvantages would be not being able to speak in Greek. I don't care if he was an Australian. I also would not have the confidence to speak freely

None, as they fully complete their responsibility

In order to explore factors which contributed to the preference for ethnicity of case manager, case manager preference was coded as a dichotomous variable: 'preference for a case manager of the same background' (N=23) versus 'preference for a case manager of different background or not important' (N=13).

The relationship between this variable and others which might be expected to impact on client preference were examined. These were current case manager, difficulty in understanding English, difficulty in expressing self in English, desire for more information, whether staff should understand migration experience, whether staff should understand religious beliefs, Vietnamese-born versus other birthplace (all these were dichotomous), and maintenance of traditional culture, importance of religion (ordinal variables). Effect sizes (Goodman and Kruskal's tau) and level of statistical significance (Fisher's exact test) for these relationships were calculated, and are shown in Table 8.14.

Table 8.14 Factors predicting preference for case manager of same background.

	Effect size	p
Difficulty with English expression	0.423	<0.001
Difficulty in understanding English	0.243	0.007
Would like more information	0.139	0.031
Birthplace (Vietnam vs others)	0.091	0.164
Importance of religion	0.090	0.242
Staff should understand migration experience	0.078	0.181
Current case manager is bilingual	0.077	0.150
Greater maintenance of traditional culture	0.010	0.890
Staff should understand religious beliefs	0.005	1.00

It can be seen that the variables which were significantly related to a preference for a case manager of the same background were difficulty in English expression, difficulty in understanding English, and a desire for more information.

Regardless of statistical significance, it can be seen that English language ability had the strongest relationship to case manager preference with comparatively weak relationships for the religion, culture and migration items. The small sample size did not allow for further multivariate analysis, so it was not possible to examine interaction effects between these variables.

The main findings from this section were that two-thirds of clients expressed a preference for a case manager of their own ethnic background, and that both qualitative and quantitative data pointed to the importance of language in case manager preference. The most important predictor for preferring a case manager of the same background was English language ability. Clients most frequently identified language as the greatest benefit of a case manager of the same background and the limitation of a case manager from a different background. There were few concerns expressed about breach of confidentiality by case managers of the same background. While language was identified as important, a common comment from clients was that an ethnically similar case manager would be able to better understand him or her as a person.

Religion

Clients were asked if they were happy to discuss their religious beliefs, and if so, how important religion was to them. Spiritual beliefs were 'very important' for 67.6 percent of those who responded and 'fairly important' for another 27 percent. Only one person said that religion was not important at all.

Clients were then asked whether they believed that staff need to know about their religious beliefs. Fifteen people (45.5 percent) said staff do need to know, and another fifteen thought that staff do not need to know about spiritual beliefs. Four said they had experienced some misunderstanding of their religious beliefs by staff and eleven said

they had not. Of those who had experienced a misunderstanding, two people commented:

They think that I pray too often, and they see it as a problem.

Praying, making offerings or fasting.

Fewer people (20 only) expressed their satisfaction with staff understanding and respect for their religious beliefs, but there was a high level of satisfaction overall (Table 8.15). None of the clients who said that staff did not need to understand religion answered this question. This may have been because they saw it as irrelevant, but it is possible that interviewers chose not to ask them about satisfaction. There was no relationship between satisfaction with staff understanding and having experienced staff misunderstanding.

Table 8.15 Satisfaction with staff understanding of religion

	Number	Percent
Very dissatisfied	1	5.0
A little dissatisfied	0	0
Neither satisfied nor dissatisfied	2	10.0
A little satisfied	3	15.0
Generally satisfied	2	10.0
Very satisfied	12	60.0
Total	20	100.0

In summary, spiritual beliefs were important to most clients interviewed, but there was less agreement (compared to migration experience) that it is important for staff to understand religious beliefs. There was generally a high level of satisfaction with staff understanding, but those who believed that staff understanding was unimportant chose not to answer the question about satisfaction.

Family involvement

All clients (both NESB and Australian-born) were asked about family involvement in their treatment, to compare the importance of family involvement for ESB and NESB clients. Forty-eight clients (94.1 percent) had family in Melbourne, and 38 (79.2

percent) of these lived with a family member. There was no difference in likelihood of living with a family member by birthplace.

Clients were asked how important it was that family was involved in their treatment (Figure 8.13) and how much their family members had been involved (Figure 8.14).

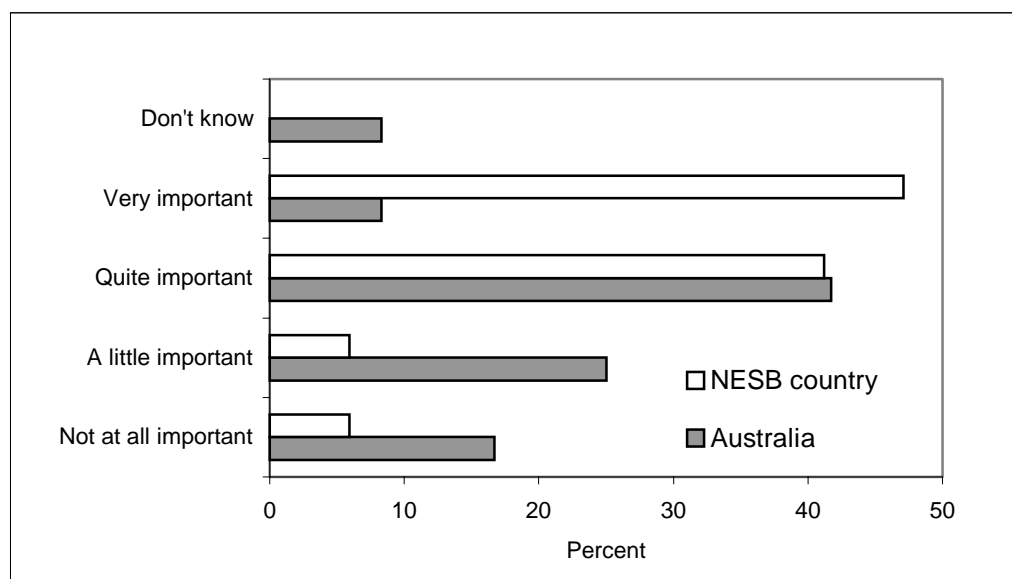


Figure 8.13 Importance of family involvement in treatment

In order to analyse this data further (and because of the small sample size), importance of family involvement was recoded a dichotomous variable, 1= not at all or a little important, and 2= quite a bit or very important. Similarly, the degree of family involvement was recoded into 1= none or a little, and 2 quite a bit or a lot.

NESB clients rated family involvement as being more important than Australian-born clients (Fischer's exact test, $p=0.028$), and NESB clients also believed that their families had a greater degree of involvement (Fischer's exact test, $p=0.028$). For NESB clients, there was no difference in importance of family involvement by type of case manager (Fischer's exact test, $p=0.27$) nor in amount of family involvement (Fischer's exact test, $p=1.00$).

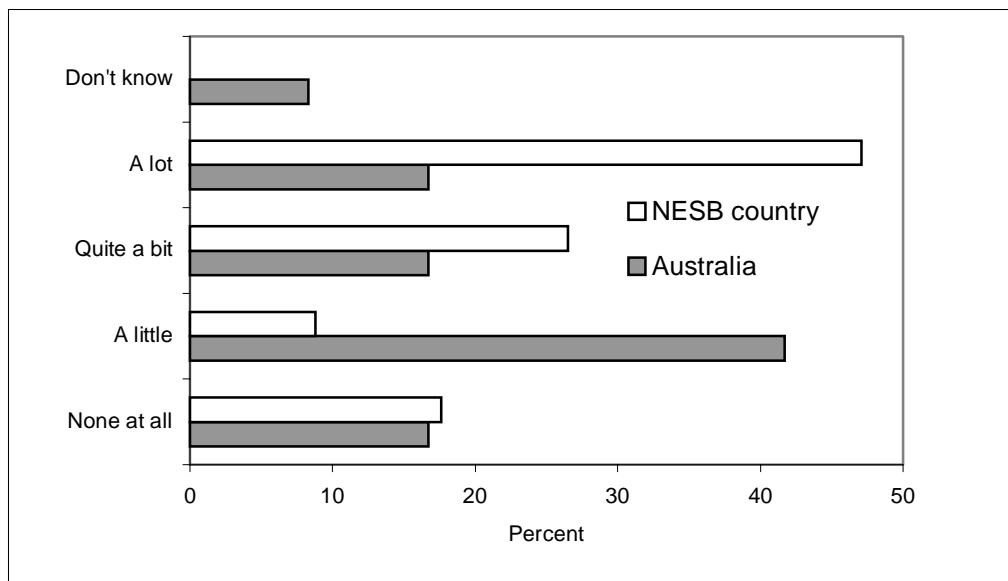


Figure 8.14 Amount of family involvement in treatment

Clients were asked if they would like family to be more involved in treatment or less involved (Table 8.16). About one third of NESB clients wanted more involvement on the part of their families, and about 12 percent wanted less, while 17 percent of Australian-born clients wanted more family involvement and 8 percent wanted less.

Table 8.16 Number of clients wanting more, or less, family involvement

	Australia		NESB	
	Number	Percent	Number	Percent
Like more family involvement	2	16.7	12	35.3
Like less family involvement	1	8.3	4	11.8
Neither	9	75.0	18	52.9
Total	12	100.0	34	100.0

Comments from those who wanted more family involvement included:

Doctor or case manager can explain to my husband about my illness and its impact on my functional abilities, my thinking and also difficulties that I am facing so my husband can be more understanding and helping me to recover.

I want my husband to come with me more to the service and to listen to my doctor saying about my illness condition so that he gets to understand my illness more.

I want my family to know about my illness and treatment, so that they can help me whenever there is a need for it.

Most of the comments about wanting more involvement came from women who wanted their husbands to be more involved so they would have more understanding of illness and treatment. In contrast, not one man mentioned made a similar comment about wanting his wife to be more involved. Comments about wanting less family involvement included:

I don't want my wife to take care of my medication. She secretly puts pills in my coffee and interferes when I talk to the doctor.

I currently don't want my family to get involved in my treatment as it previously made my family problems worse.

I don't want my family (brothers and sisters) to come to the clinic with me, I don't want them asking questions.

The main issue raised appeared to be concern about possible family intrusion into matters which clients felt were personal.

Table 8.17 Satisfaction with family involvement

	Australia		NESB	
	Number	Percent	Number	Percent
Generally dissatisfied			1	3.2
Neither satisfied nor dissatisfied			4	12.9
A little satisfied	2	20.0	2	6.4
Generally satisfied	6	60.0	5	16.1
Very satisfied	2	20.0	19	61.3
Total	10	100.0	31	100.0

Table 8.17 shows satisfaction with family involvement by birthplace. There was a high level of satisfaction for both Australian-born and NESB clients, with around 80 percent of both groups being generally or very satisfied with this item.

The main results from this section on family were that NESB clients both preferred and experienced the involvement of their families to a greater degree than ESB clients, but that one third of NESB clients wanted more family involvement. It can be concluded

that family involvement is an important aspect of cross-cultural sensitivity for most NESB clients, but there are likely to be gender differences, and some clients may perceive family involvement as intrusive.

Information received

For this section, Australian-born clients were also included for comparison. Table 8.18 shows information received by birthplace. The last row shows the percent of interviewees who said they would like more information.

Table 8.18 Number of clients who received information

	Australian		NESB	
	Yes (%)	No (%)	Yes (%)	No (%)
Diagnosis	9 (69.2)	4 (30.8)	28 (75.7)	9 (24.3)
Medication	10 (76.9)	3 (23.1)	30 (81.1)	7 (18.9)
Other services	8 (61.5)	5 (38.5)	27 (73.0)	10 (27.0)
Rights	7 (53.8)	6 (46.2)	21 (60.0)	14 (40.0)
More information?	6 (46.2)	7 (53.8)	11 (29.7)	26 (70.3)

Although there was a consistently higher percent of NESB clients saying they had received specific types of information, none of these differences were statistically significant. Similarly, for NESB clients, there was no difference in percentage of clients who received information according to whether they were matched to a BCM or not. It is notable that the category for which the fewest people said they received information was about client rights.

Interestingly, a higher proportion of the Australian-born said they would like more information, but this difference was also not significant. It might be expected that NESB people would receive less information due to language barriers, but this did not appear to be the case.

Of the 17 people who said they would like more information, the most common areas identified were; medication and side-effects (7), rights (4), and services including how to contact the mental health service in future (4).

For example, if I become unwell again, who do I need to contact and how can I be helped with, etc. I also like some information about the patient's rights.

I've been told that if I change my medication I might get fatter. I'd like to know more about side effects. I get very thirsty from the tablets. Not enough information given out about medication.

I would like to read a book written in Vietnamese about mental illness to have a better understanding about it, e.g. when it will come back or when it will be completely cured or whether it is hereditary.

I want to be get an explanation as to why they keep giving me medications that don't help me and don't explain to me other things that I ask them.

The side effects of medications. Because I suffer from psoriasis and I am starting to suffer from arthritis.

I want to know more about my diagnosis, about my rights. I think they would let me know more when necessary.

Ratings of satisfaction with information given by birthplace are shown in Table 8.19. There was a high level of satisfaction with information provided. There was no difference in satisfaction by birthplace. Although NESB clients with a case manager of the same background were slightly more satisfied (mean 6.2) than those with another case manager (mean 5.8), this difference was not statistically significant.

Table 8.19 Satisfaction with information provided by birthplace

	Australia		NESB	
	Number	Percent	Number	Percent
Very dissatisfied	1	8.3	1	2.7
Generally dissatisfied	1	8.3	1	2.7
Neither satisfied nor dissatisfied			1	2.7
A little satisfied	1	8.3	11	29.7
Generally satisfied	5	41.7	2	5.4
Very satisfied	4	33.3	21	56.8
Total	10	100.0	37	100.0

The key findings from questions about information were that there was no difference between ESB and NESB clients in amount of information received or desire for more information, and both ESB and NESB clients were generally satisfied with the information they received. Fewer clients received information about rights compared with diagnosis, medication and services available, and the most common areas for which more information was requested were mental illness, medication and rights. There was no effect of BCM on the amount of information received or desire for more.

Importance of language and culture

The last section of the interview covered NESB clients overall ratings of the importance of cultural sensitivity, and the extent to which staff had shown respect for their language and culture. The results are shown in Figure 8.15.

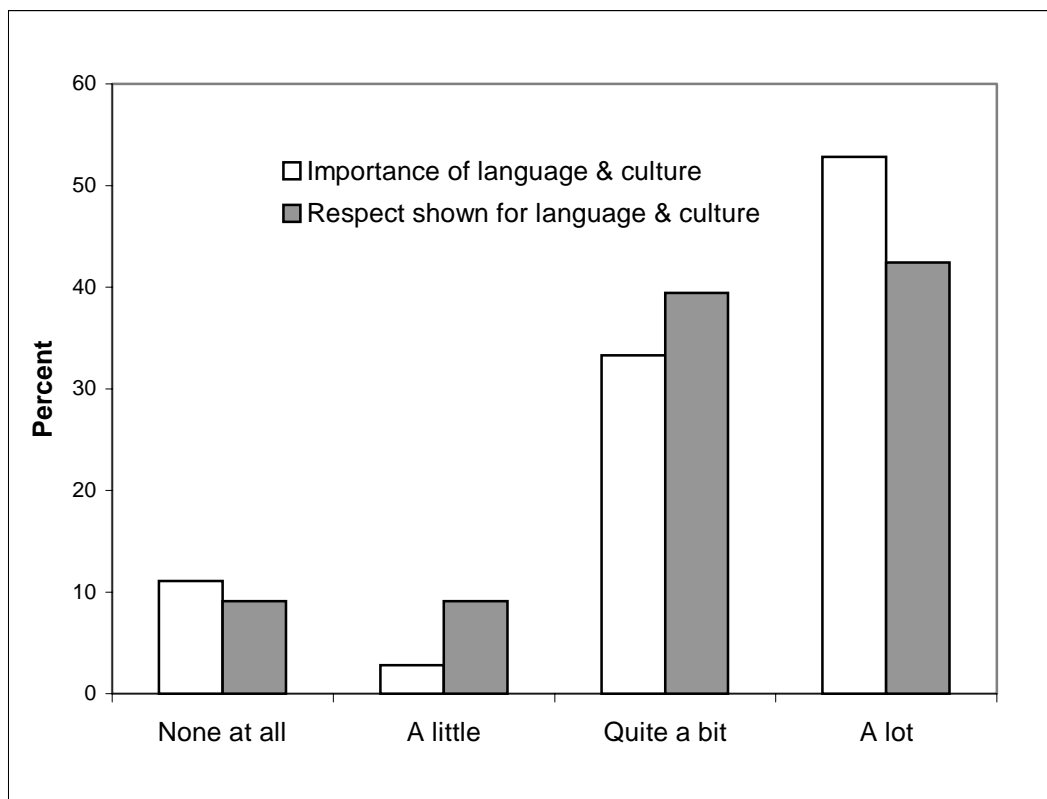


Figure 8.15 Importance and respect shown by staff for language and culture

A large majority (80 percent) of those interviewed placed ‘quite a bit’ or ‘a lot’ of importance on staff respect for their language and culture, and 69 percent thought that staff showed ‘quite a bit’ or ‘a lot’ of respect.

Best and worst things about the service

All clients were asked what were the best (or most helpful) and the worst (or least helpful) aspects of the service.

A total of 48 (12 Australian-born and 34 NESB) clients named at least one helpful aspect of the service. NESB clients were no more likely to describe a positive aspect of the service than Australian clients (Fisher’s Exact test $p=1.00$). The main aspects which clients found helpful were the kind, caring, friendly attitudes of staff; having someone to talk to; improvement due to medication, and the availability of staff when needed (including CATT after hours):

All staff members are kind and dedicated in helping me, eg. they ask me and console me when I feel sick, i.e.. my case manager and her manager.

Doctor _____ is very supportive and understanding. I sometimes share my concerns with her and also treat her the way I do to my mother. I have numerous respect for doctor _____ I’m where I am today all due to _____ (service name).

Several NESB people referred to staff of same background (doctor or case manager), while fewer referred to CATT visits.

My case manager who speaks Vietnamese and helps me with day-to-day problems. My doctor cares for me in terms of my illness.

That I have a Turkish doctor, that’s a great help, and that I have a Turkish case manager which is also a great help.

Fifteen clients (8 Australian and 7 NESB clients) named at least one unhelpful aspect of the service. NESB clients were much less likely to describe a negative aspect of the service than Australian clients, (Fisher's Exact test $p=0.005$). The main aspects which clients found unhelpful were the constant change of doctors, attending the clinics for an appointment and the doctor not being informed or the appointment not having been booked, and problems with medication:

I think when you've got an appointment and they don't write it down, 'cause you come all the way for nothing.

There was one occasion when they forgot to inform the doctor I was waiting, and I was there for about 40 minutes.

Often switching from one doctor to another, and my medication doses are too strong and that results in constipation.

That they reduce my medication.

Other things which might help

Fourteen people identified something which they felt would help them more with their problems. These included; to have a permanent doctor who did not change regularly (3), to not have medication changed again (2 people but not the same who mentioned doctors changing), for staff to be more understanding (2), more Vietnamese doctors or a Vietnamese mental health clinic (2).

Experience of being interviewed

At the end of the interview, all interviewees were asked how they felt after answering the questions. Most said they felt fine, with one person saying that he felt worse than before the interview. Two people said they found the questions difficult to understand.

Most people expressed appreciation for the service and several said they felt good that they could share their feelings and experiences with someone who was interested:

I've been extremely happy with their treatment of me. I probably wouldn't be here today without them. I feel good that I could share this with you.

I am very satisfied that I could tell you about the problems that I have and that you can understand me and treat me like a normal person. Everyone, even my sisters treat me like I'm crazy and with pity.

Interviewers were asked to rate their impression of the client's attitude to the service. Eighty-eight percent rated the clients attitude as 'fairly positive' or 'very positive'.

General satisfaction rating scale

In order to compare satisfaction by country of birth, and by matching with case manager, a total satisfaction score was calculated by summing the five general satisfaction items; satisfaction with doctor, satisfaction with case manager, satisfaction with promptness of help, satisfaction with treatment, and general satisfaction with the service. Each item was scored from 1 very dissatisfied to 7 very satisfied, giving a range of possible total scores of between 5 and 35.

The scale had an alpha coefficient of 0.82 indicating good internal reliability. The inter-item correlations are shown in Table 8.20. There were high correlations between all items and total score. The lowest correlations were between satisfaction with case manager and other items.

Table 8.20 General satisfaction scale inter-item correlations

	Case manager	Doctor	Promptness	Treatment	General
Case manager	1.00				
Doctor	0.40	1.00			
Promptness	0.26	0.34	1.00		
Treatment	0.46	0.57	0.50	1.00	
General	0.31	0.70	0.58	0.68	1.00
Total	0.56	0.78	0.72	0.86	0.87

Total satisfaction scores were highly skewed; the mean satisfaction rating was 31.43 (S.D. 4.98), or 89.8 percent of the scale maximum of 35. This high level of satisfaction was reflected in the comments made:

Generally I'm pretty pleased with the way they look after me. I don't know what else they could do. I don't think they know either but I think they're doing OK.

I am very satisfied. They have always helped me, they are always on time for sessions. The service is close to my house. Doctors and nurses here are highly dedicated to their patients and treat them kindly. Therefore, I sincerely thank them for their care and treatment to my illness.

I've got nothing to compare it with.

They are very kind. I am very satisfied with the services especially that of my Vietnamese case manager.

Perhaps unsurprisingly, there was a high correlation between interviewers rating of client satisfaction and the client's total satisfaction score (Spearman's $\rho=0.60$, $p<0.001$, $N=50$). NESB clients were more satisfied overall than Australian born clients (Mann-Whitney $U=163.0$, $p=0.048$), and were also more satisfied with the promptness of help received (Mann-Whitney $U=158.5$, $p=0.021$). Interestingly, given the comments made about the changing of doctors, clients were more satisfied with case managers than they were with doctors (Wilcoxon Matched-pairs Signed-Ranks test, $p=0.017$).

Cultural sensitivity rating scale

An overall rating of cultural sensitivity was calculated from the responses to questions about individual aspects of culture. Descriptive data for the five cultural sensitivity questions ('satisfaction with understanding of migration', 'satisfaction with understanding of religion', 'satisfaction with family involvement with treatment',

‘satisfaction with information received’, and ‘rating of respect shown by staff for language and culture’) is shown below in Table 8.21

Table 8.21 Cultural sensitivity items

Item	Range	Mean	S.D.	N	Missing
Understanding of migration	1-7	5.92	1.46	37	2
Understanding of religion	1-7	6.00	1.59	20	19
Information received	1-7	5.97	1.46	37	2
Involvement of family	1-7	6.16	1.32	31	8
Respect for language and culture	1-4	3.15	.94	33	6

A total cultural sensitivity score was calculated as described in the method section, excluding the question about religion which received a low response rate. The final ‘cultural sensitivity scale’ was comprised of four items (‘satisfaction with understanding of migration’, ‘satisfaction with family involvement with treatment’, ‘satisfaction with information received’, and ‘rating of respect shown by staff for language and culture’) and had a standardised item alpha coefficient of 0.83. The inter-item correlations are shown in Table 8.22. They varied from a minimum of 0.43 between ‘satisfaction with information received’, and ‘rating of respect shown by staff for language and culture’, to a maximum of 0.75 between ‘satisfaction with family involvement with treatment’, and ‘satisfaction with information received’.

Table 8.22 Cultural sensitivity rating scale inter-item correlation matrix

	Understanding of migration	Involvement of family	Information received	Respect for language and culture
Understanding of migration	1.0000			
Involvement of family	.5101	1.0000		
Information received	.5489	.7536	1.0000	
Respect for language/culture	.5097	.5876	.4299	1.0000
Total score	.7860	.8725	.8360	.7735

The mean score for the final scale was 8.0 with a standard deviation of 2.4. There was a high correlation between the cultural sensitivity score and the total satisfaction score ($r=0.81$, $N=39$, $p<0.001$). When analysed by birthplace (Vietnam versus other), the correlation between these two variables was lower for the Vietnamese ($r=0.51$, $N=18$, $p=0.029$) than for the ‘other birthplace’ group ($r=0.90$, $N=21$, $p<0.001$). These results imply that the Vietnamese made a greater distinction between general satisfaction and satisfaction with cultural sensitivity than other clients.

There was a trend for those who had acculturated more to Australian culture to be more satisfied with the cultural sensitivity of the service (Spearman's $\rho=0.32$, $p=0.052$, $N=37$), but no opposite trend was found for those who maintained their culture more to be less satisfied (Spearman's $\rho=-0.20$ $p=0.235$ ($N=37$)).

The main findings from the section on cultural sensitivity were that cross-cultural sensitivity of staff was important to most NESB clients, and there was generally a high rating of the cross-cultural sensitivity shown by staff. Satisfaction with cross-cultural sensitivity was highly correlated with general satisfaction, but Vietnamese clients made a greater distinction between general satisfaction and cross-cultural sensitivity than other NESB clients.

The effect of ethnic matching on rating of client satisfaction and cross-cultural sensitivity are presented in the next section.

Client satisfaction and cultural sensitivity by ethnic match

Ratings on all five client satisfaction items and the total score were slightly higher for NESB clients matched to a BCM compared with other NESB clients, but none of these was statistically significant (using the Mann-Whitney U test). Similarly, ratings on four out of five of the cultural sensitivity items and the total score were slightly higher for those matched with a BCM compared to those with another case manager but none of these were statistically significant.

It could be concluded that ethnic matching has no effect on client satisfaction. However, if there was no difference in satisfaction between matched and unmatched clients, it would be expected that unmatched clients would rate higher on some items and matched on others (i.e. that this would be a binomial distribution with an equal probability that one would be higher than the other). Since there was a pattern of consistently higher ratings for satisfaction and cross-cultural sensitivity for matched clients, another interpretation is that there was an effect for matching, but the sample size was too small to detect it.

To investigate this possibility further, the mean scores on the five cross-cultural sensitivity items, the five service satisfaction items, and the interviewer rating of client attitude toward the service were recoded as being higher for those with an ethnic match (1), or higher for those without an ethnic match (0). Clients matched to a case manager of the same background had higher scores than other NESB clients for nine out of the eleven items, and the scores were equal for one other item.

Excluding the equal rating, the chances of nine out of ten items being in favour of matched clients, assuming no effect of ethnic match is $p=0.021$ (using Fisher's exact binomial test). If the interviewer rating item is also excluded (as it may be unduly affected by clients ratings) the chances of eight out of nine items being in favour of matched clients, assuming no effect of ethnic match, is $p=0.039$ (Fisher's exact binomial test). These results imply that NESB clients matched to a case manager of the same background were more satisfied than other NESB clients, but lack of power (small sample size and perhaps small effect size) meant that this difference could not be detected on individual items.

Summary of findings

Among the clients interviewed there was a high level of satisfaction with mental health services assessed both qualitatively and quantitatively, satisfaction with case managers was higher than satisfaction with doctors, and the most helpful aspects of the service were effective medication, the caring, friendly attitudes of staff, and having someone to talk to. The main area of dissatisfaction was that doctors changed very frequently and that medication was often also changed as a result. NESB clients were more satisfied overall than Australian born clients.

The major findings about cross-cultural sensitivity are presented below. A majority of NESB clients thought that staff should understand their settlement history, and there was a high level of satisfaction with staff understanding of this area. Few clients had experienced a misunderstanding of their migration experience but this group were less

satisfied. It can be concluded that an understanding of settlement experiences of migrants is an important component of cultural sensitivity

There was a high level of maintenance of traditional culture, with less adoption of Australian customs, and clients who adopted Australian practices were less likely to maintain traditional practices. In spite of the fact that the people interviewed had spent an average of 20 years in Australia, a substantial number still experienced difficulties with English. About one third had some difficulty in understanding English and almost half had difficulty expressing themselves in English. Areas of most difficulty were understanding medical terminology about symptoms and medication, and being able to express feelings and problems.

Interpreters appeared to be provided as often as clients said they were needed. Clients expressed very positive and appreciative views about interpreters, and concern about confidentiality was uncommon.

A majority of NESB clients expressed a preference for a case manager of their own ethnic background, and that both qualitative and quantitative data pointed to the importance of language in case manager preference. The most important predictor for preferring a case manager of the same background was English language ability. Clients most frequently identified language as the greatest benefit of a case manager of the same background and the limitation of a case manager from a different background. There were few concerns expressed about breach of confidentiality by case managers of the same background.

While language was identified as important, a common comment from clients was that an ethnically similar case manager would be able to better understand him or her as a person.

Spiritual beliefs were important to most clients interviewed, but there was less agreement (compared to migration experience) that it is important for staff to understand religious beliefs. There was generally a high level of satisfaction with staff understanding of spiritual beliefs.

NESB clients both preferred and experienced the involvement of their families to a greater degree than ESB clients, but that one third of NESB clients wanted more family involvement. It can be concluded that family involvement is an important aspect of cross-cultural sensitivity for most NESB clients, but there are likely to be gender differences, and some clients may perceive family involvement as intrusive.

There was no difference between ESB and NESB clients in amount of information received or desire for more information, and both ESB and NESB clients were generally satisfied with the information they received. Fewer clients received information about their rights, and the most common areas for which more information was requested were mental illness, medication and rights.

The cross-cultural sensitivity of staff was important to most NESB clients, and there was generally a high rating of the cross-cultural sensitivity shown by staff. Satisfaction with cross-cultural sensitivity was highly correlated with general satisfaction, but Vietnamese clients made a greater distinction between general satisfaction and cross-cultural sensitivity than other NESB clients. Those who were more acculturated to Australian practices were more satisfied with the cross-cultural sensitivity of the service.

The pattern of results for client satisfaction and cross-cultural sensitivity implied that NESB clients matched to a case manager of the same background were more satisfied than other NESB clients, but lack of power (small sample size and perhaps small effect size) meant that this difference could not be detected on individual items.

SERVICE UTILISATION

Sample

Data were obtained for 2935 clients. Country of birth of the sample is shown in Table 8.23, and diagnosis is shown in Figure 8.16. Eighteen percent of clients were missing a diagnosis. Sixty-one percent of all clients, (or 75 percent of all clients with a diagnosis)

had a diagnosis of a psychosis (including bipolar affective disorder).

From Table 8.23, it can be seen that twenty-six percent of clients were born in a non-English speaking country, and thirteen percent had a preferred language other than English. Seventy percent were single (including never married, separated, widowed and divorced), and fifty-three percent male. Of the 680 NESB clients, 185 had some contact with a BCM and the other 495 had no contact. There was no difference between these two groups on sex, marital status or diagnosis, but NESB clients with some BCM contact were slightly younger compared to other NESB clients (mean of 44.1 compared to 46.4 years of age, $t(675)=2.05$, $p=0.04$).

Table 8.23 Demographic characteristics and diagnosis

Birthplace	Number (%)	Percent
Australia	2121	72.3
Other English speaking countries	134	4.6
Italy	162	4.6
Greece	109	3.7
Republics of the former Yugoslavia	95	3.2
Turkey	68	2.3
Macedonia	64	2.2
Vietnam	140	4.8
Missing	42	1.4
Total	2935	100.0

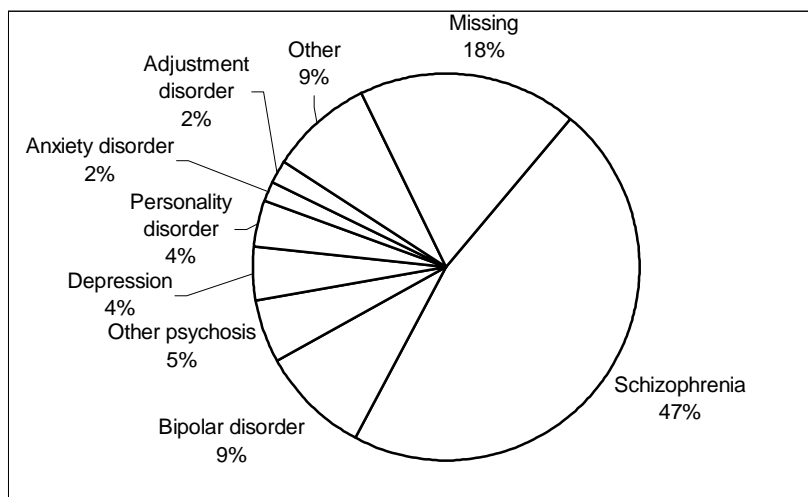


Figure 8.16 Principal diagnosis

Contacts with Continuing Care Teams

Duration of telephone contact with CCT per year

The median duration of telephone contacts with CCT for all clients was 67 minutes per year (S.D. 127.5 minutes). The regression was significant ($F=14.15$, $p<0.001$, Adjusted $R^2=0.031$). The results of the regression are shown in Table 8.24. Each of the tables with the regression results show predictors of the outcome variable, the beta coefficient, the t-value and the two-tailed probability for the beta coefficient.

Table 8.24 Duration of telephone contact with CCT

	Beta coefficients	t	p
(Constant)		4.893	.000
Country of birth	-.041	-1.926	.054
Proportion of contacts with a BCM	.100	4.947	.000
Age	-.120	-5.690	.000
Sex	.060	2.931	.003
Diagnosis	.060	2.947	.003
Interaction	.005	.210	.833

Other than the interaction term (between country of birth and proportion of contacts with a BCM, as defined in the ‘Methods’ section) and country of birth, all of the variables entered into the equation were significant predictors of telephone contacts. Clients who had more contacts with a BCM, who were younger, who were female or who had a diagnosis other than a psychosis had a greater duration of telephone contact with the CCT. There was also a trend for clients of English speaking background to have greater duration of telephone contact which did not quite reach significance ($p=0.054$).

Frequency of telephone contacts with CCT per year

The median frequency of telephone contacts with the CCT was 7.5 contacts per year (S.D. 13.0 contacts). The regression was significant ($F=22.34$, $p<0.001$, Adjusted $R^2=0.056$). The results of the regression are shown in Table 8.25.

Table 8.25 Frequency of telephone contacts with CCT

	Beta coefficients	t	p
(Constant)		19.345	.000
Country of birth	-.079	-3.276	.001
Proportion of contacts with a BCM	.129	5.911	.000
Age	-.162	-7.354	.000
Sex	.052	2.422	.016
Diagnosis	.070	3.264	.001
Interaction	.007	.292	.770

Other than the interaction term, all of the variables entered into the equation were significant predictors of telephone contacts.

Clients who had more contacts with a BCM, who were younger, who were female, who were born in an English speaking country or who had a diagnosis other than a psychosis had more frequent telephone contacts with the CCT.

Duration of direct contact with CCT per year

The median duration of direct contacts with CCT was 461.5 minutes, or 7.7 hours, per year (S.D. 502.5 minutes). The regression was significant ($F=11.57$, $p<0.001$, Adjusted $R^2=0.025$). The results of the regression are shown in Table 8.26.

Table 8.26 Duration of direct contact with CCT

	Beta coefficients	t	p
(Constant)		28.693	.000
Country of birth	-.018	-.796	.426
Proportion of contacts with a BCM	.123	5.867	.000
Age	-.073	-3.425	.001
Sex	.075	3.652	.000
Diagnosis	.037	1.819	.069
Interaction	.077	3.480	.001

Other than country of birth and diagnosis, all of the variables entered into the equation were significant predictors of duration of direct contacts. Clients who had more contacts with a BCM, who were younger, or who were female had a greater total duration of direct contacts with the CCT. Of clients who had a BCM, those of NESB had a greater total duration of direct contacts with the CCT than Australian-born clients.

These results indicate that NESB clients matched to a BCM had a greater total duration

of direct contacts with the CCT (median 706.9 minutes per year) than other NESB clients (median 402.7 minutes), after controlling for age, sex, diagnosis, and differences between the BCM group and other staff.

Frequency of direct contacts with CCT per year

The median frequency of direct contacts with the CCT was 18.4 contacts per year (S.D. 14.6 contacts). The regression was significant ($F=5.08$, $p<0.001$, Adjusted $R^2=0.010$). The results of the regression are shown in Table 8.27.

Table 8.27 Frequency of direct contacts with CCT

	Beta coefficients	t	p
(Constant)		-41.921	.000
Country of birth	-.003	-.112	.911
Proportion of contacts with a BCM	.086	4.080	.000
Age	-.059	-2.745	.006
Sex	.025	1.200	.230
Diagnosis	-.016	-.778	.437
Interaction	.054	2.421	.016

Proportion of contacts with a BCM, age and interaction were significant predictors of frequency of direct contact. Clients who had more contacts with a BCM or who were younger had more frequent direct contacts with the CCT. Of clients who had a BCM, those of NESB had more frequent direct contacts with the CCT than Australian-born clients. Country of birth, sex and diagnosis were not significant predictors.

These results indicate that NESB clients matched to a BCM had a higher frequency of direct contacts with the CCT (24.6 median contacts per year) than other NESB clients (median 17.3 contacts), after controlling for age, sex, diagnosis, and differences between the BCM group and other staff.

Contacts with Crisis Assessment and Treatment Teams

Duration of telephone contact with CATTs per year

The median duration of total telephone contact with CATTs was 83.3 minutes per year (S.D. 190.3 minutes). The regression was significant ($F=23.25$, $p<0.001$, Adjusted $R^2=0.163$). The results of the regression are shown in Table 8.28.

Table 8.28 Duration of telephone contact with CATTs

	Beta coefficients	t	p
(Constant)		-2.145	.032
Country of birth	.052	1.662	.097
Proportion of contacts with a BCM	-.100	-3.365	.001
Age	-.083	-2.882	.004
Sex	.040	1.416	.157
Diagnosis	.151	5.373	.000
Frequency of CCT direct contacts	-.121	-1.678	.094
Duration of CCT direct contact	.072	1.014	.311
Frequency of CCT phone contacts	.210	6.259	.000
Duration of CCT phone contacts	.206	5.459	.000
Interaction	-.116	-3.700	.000

Proportion of contacts with a BCM, age, diagnosis, frequency of CCT phone contacts and total duration of CCT phone contact were significant predictors of duration of CATT phone contacts. Clients who had less contact with a BCM, who were younger, who had a non-psychotic diagnosis, who had more CCT phone contacts or greater total duration of CCT phone contact had a greater total duration of telephone contacts with CATTs. Of clients who had a BCM, those of NESB had a lower total duration of phone contacts with CATTs than Australian-born clients. Country of birth, sex, frequency of CCT direct contacts and duration of CCT direct contacts, were not significant predictors.

These results indicate that there was a trend ($p=0.097$) for NESB clients to have a longer duration of phone contact with CATTs. NESB clients matched to a BCM had a lower total duration of CATT phone contact (median 38.2 minutes per year) than other NESB clients (median 82.9 minutes), after controlling for age, sex, diagnosis, contacts with CCT teams overall, and differences between the BCM group and other staff.

Frequency of telephone contacts with CATTs per year

The median frequency of telephone contacts with CATTs was 8.2 contacts per year (S.D. 17 contacts). The regression was significant ($F=23.44$, $p<0.001$, Adjusted $R^2=0.164$). The results of the regression are shown in Table 8.29. Proportion of contacts with a BCM, age, diagnosis, frequency of CCT phone contacts and total duration of CCT phone contact were significant predictors of frequency of CATT phone contacts. Clients who had less contact with a BCM, who were younger, who had a non-psychotic diagnosis, who had more CCT phone contacts or greater total duration of CCT phone contact had more frequent telephone contacts with CATTs. Of clients who had a BCM, those of NESB had less frequent phone contacts with CATTs than Australian-born clients. Country of birth, sex, frequency of CCT direct contacts and duration of CCT direct contacts were not significant predictors.

Table 8.29 Frequency of telephone contacts with CATTs

	Beta coefficients	t	p
(Constant)		-8.421	.000
Country of birth	.059	1.891	.059
Proportion of contacts with a BCM	-.086	-2.896	.004
Age	-.081	-2.815	.005
Sex	.034	1.205	.228
Diagnosis	.142	5.034	.000
Frequency of CCT direct contacts	-.137	-1.892	.059
Duration of CCT direct contact	.087	1.228	.220
Frequency of CCT phone contacts	.208	6.215	.000
Duration of CCT phone contacts	.218	5.773	.000
Interaction	-.118	-3.760	.000

These results indicate that there was a trend ($p=0.059$) for NESB clients to have more frequent phone contact with CATTs compared with ESB clients. NESB clients matched to a BCM had less frequent CATT phone contacts (median 4.3 contacts per year) than other NESB clients (median 9.0 contacts), after controlling for age, sex, diagnosis, contacts with CCT teams overall, and differences between the BCM group and other staff.

Duration of direct contacts with CATTs per year

The median duration of total direct contact with CATTs was 150.8 minutes per year (S.D. 392.5 minutes). The regression was significant ($F=11.49$, $p<0.001$, Adjusted $R^2=0.090$). The results of the regression are shown in Table 8.30.

Table 8.30 Duration of direct contact with CATTs

	Beta coefficients	t	p
(Constant)		.364	.716
Country of birth	.070	2.088	.037
Proportion of contacts with a BCM	-.040	-1.232	.218
Age	-.053	-1.696	.090
Sex	.000	.005	.996
Diagnosis	.091	2.988	.003
Frequency of CCT direct contacts	-.003	-.040	.968
Duration of CCT direct contact	.078	1.033	.302
Frequency of CCT phone contacts	.150	4.117	.000
Duration of CCT phone contacts	.121	2.952	.003
Interaction	-.074	-2.132	.033

Country of birth, diagnosis, frequency of CCT phone contacts and total duration of CCT phone contact were significant predictors of total duration of CATT direct contacts.

Clients who were born in a NESB country, who had a non-psychotic diagnosis, who had more CCT phone contacts or greater total duration of CCT phone contact had a higher total duration of direct contact with CATTs. Of clients who had a BCM, those of NESB had lower total duration of direct contact with CATTs than Australian-born clients.

Proportion of contacts with a BCM for all clients, age, sex, frequency of CCT direct contacts and duration of CCT direct contacts, were not significant predictors.

These results indicate that NESB clients had a longer duration of contact with CATTs compared with ESB clients, but NESB clients with some BCM involvement had a lower duration of direct contact with CATT (median 96.8 minutes per year) than NESB clients with no BCM involvement (median 178.9 minutes per year), even though there was no effect for the BCM staff over all clients.

Frequency of direct contacts with CATTs per year

The median frequency of direct contacts with CATTs was 4.1 contacts per year (S.D. 10.4 contacts). The regression was significant ($F=11.49$, $p<0.001$, Adjusted $R^2=0.090$). The results of the regression are shown in Table 8.31.

Table 8.31 Frequency of direct contacts with CATTs

	Beta coefficients	t	p
(Constant)		1.057	.291
Country of birth	.050	1.508	.132
Proportion of contacts with a BCM	-.036	-1.095	.274
Age	-.037	-1.193	.233
Sex	-.015	-.477	.633
Diagnosis	.085	2.828	.005
Frequency of CCT direct contacts	.001	.011	.991
Duration of CCT direct contact	.083	1.106	.269
Frequency of CCT phone contacts	.157	4.348	.000
Duration of CCT phone contacts	.134	3.287	.001
Interaction	-.058	-1.696	.090

Significant predictors of frequency of direct contact with CATTs were diagnosis, frequency of CCT phone contacts and total duration of CCT phone contact. Those with a non-psychotic diagnosis, who had more CCT phone contacts or greater total duration of CCT phone contact had more frequent direct contact with CATT.

Hospital admissions

Total inpatient length of stay per year

The median length of inpatient stay per year was 18.7 days (S.D. 40.1 days). The regression was significant ($F=8.73$, $p<0.001$, Adjusted $R^2=0.093$). The results of the regression are shown in Table 8.32.

Table 8.32 Total length of stay per year

	Beta coefficients	t	p
(Constant)		4.848	.000
Country of birth	.088	2.183	.029
Proportion of contacts with a BCM	-.062	-1.511	.131
Age	.033	.883	.377
Sex	-.032	-.860	.377
Diagnosis	.016	.445	.657
Frequency of CCT direct contacts	.329	3.384	.001
Duration of CCT direct contact	-.201	-2.091	.037
Frequency of CCT phone contacts	-.020	-.174	.862
Duration of CCT phone contacts	.197	1.743	.082
Interaction	-.091	-2.142	.033

The interaction term, country of birth, frequency of direct CCT contacts and total duration of CCT phone contacts were significant predictors of total length of stay per year. Clients who were born in a NESB country, who had more CCT direct contacts or greater total duration of CCT phone contact had longer lengths of stay. Of clients who had a BCM, those of NESB had lower length of stay than Australian-born clients.

These results indicate that NESB clients had longer average length of stay than ESB clients, but that NESB clients with some BCM involvement had a lower length of inpatient stay (median 16.2 days per year) than NESB clients with no BCM involvement (median 27.8 days per year), even though there was no effect for the BCM staff over all clients. Conversely, there was no difference in length of stay for Australian born clients with some BCM involvement (median 17.9 days per year) compared to those with no BCM involvement (median 17.8 days per year).

Total admissions per year

The median rate of admission was 1.21 admissions per year (S.D. 1.43 admissions). The regression was significant ($F=34.51$, $p<0.001$, Adjusted $R^2=0.308$). The results of the regression are shown in Table 8.33.

Table 8.33 Admissions per year

	Beta coefficients	t	p
(Constant)		-2.209	.027
Country of birth	.060	1.505	.133
Proportion of contacts with a BCM	-.033	-0.816	.415
Age	-.059	-1.608	.108
Sex	-.043	-1.174	.241
Diagnosis	.233	6.551	.000
Frequency of CCT direct contacts	-.120	-1.246	.213
Duration of CCT direct contact	.157	1.643	.101
Frequency of CCT phone contacts	.189	1.695	.091
Duration of CCT phone contacts	-.023	-0.208	.835
Interaction	-.068	-1.633	.103

The only significant predictors of frequency of admissions per year were diagnosis, proportion of contacts with a BCM, total duration of phone contact with CCT and frequency of phone contact with CCT. Clients with a diagnosis other than psychosis, who had less contacts with a BCM, who had a higher total duration of phone contact with CCT, or lower frequency of phone contact with CCT had a higher frequency of admission. These results indicate that NESB clients with some BCM involvement had the same frequency admissions per year as NESB clients with no BCM involvement.

Legal status of admissions

In order to examine the possible impact of the BCM program on legal status of admission, the proportion of admissions which were voluntary was calculated and used as an outcome measure. For clients who were admitted to hospital, a median proportion of 0.45 of all their admissions were voluntary (S.D. 0.46). The regression was significant ($F=4.14$, $p<0.001$, Adjusted $R^2=0.040$). The results of the regression are shown in Table 8.34

The only significant predictor of legal status of admission was diagnosis; those with a diagnosis other than psychosis were more likely to be admitted voluntarily than those with a psychosis. These results indicate that the proportion of admissions which were involuntary was the same for NESB clients with some BCM involvement as NESB clients with no BCM involvement.

Table 8.34 Proportion of admissions per client which were voluntary

	Beta coefficients	t	p
(Constant)		-1.597	.111
Country of birth	-.033	-.800	.424
Proportion of contacts with a BCM	-.048	-1.174	.241
Age	.028	.722	.470
Sex	.050	1.336	.182
Diagnosis	.160	4.363	.000
Frequency of CCT direct contacts	-.174	-1.778	.076
Duration of CCT direct contact	.182	1.913	.056
Frequency of CCT phone contacts	.037	.838	.402
Duration of CCT phone contacts	.019	.377	.706
Interaction	.053	1.228	.220

Analysis by birthplace

In order to examine whether there were differences between ethnic groups in the impact of ethnic matching, regression analyses were conducted separately for each ethnic group compared to the Australian-born.

Vietnamese

For those born in Vietnam, there was a trend for clients matched to a Vietnamese case manager to have a greater total duration of direct contact with CCT (median 747.0 minutes per year) compared to clients with another case manager (median 598.8 minutes). This was not quite statistically significant ($p=0.057$), after controlling for age, sex, diagnosis, and differences between the BCM group and other staff.

Vietnamese clients matched to a Vietnamese case manager had a lower total duration of telephone contact with CATTs (median 46.1 minutes per year) compared to Vietnamese clients with another case manager (median 127.2 minutes), after controlling for age, sex, diagnosis, differences between the BCM group and other staff, and differences in contacts with the CCT. They also had less telephone contacts per with CATTs (median 4.6 contacts per year compared to 12.4 contacts) and a lower duration of direct contact per year with CATTs (median 92.9 minutes per year compared to 354.4 minutes).

Vietnamese clients matched to a Vietnamese case manager had a lower total length of hospital stay per year (median 11.5 days per year) compared to those with another case

manager (median 34.2 days), after controlling for age, sex, diagnosis, differences between the BCM group and other staff, and differences in contacts with the CCT. They also had fewer hospital admissions per year (median 1.0 admissions per year) compared to clients with another case manager (median 1.7).

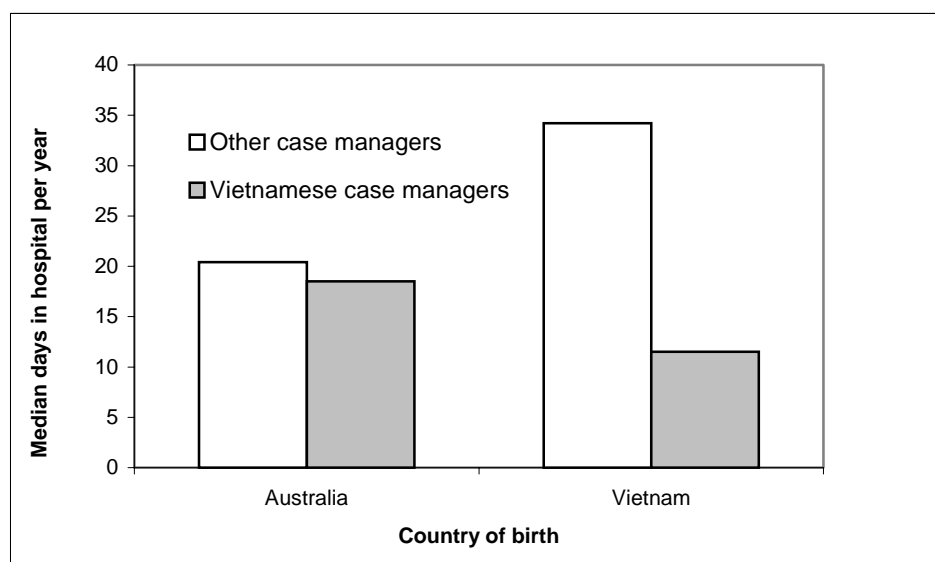


Figure 8.17 Hospital stay per year for Australian-born and Vietnamese-born

There were 34 Vietnamese clients admitted over the two years, 17 had a Vietnamese case manager, and 17 had another case manager. Clients of Vietnamese case managers had a median length of stay 22.7 days per year lower than clients of other case managers (Figure 8.17). At a cost of \$297 per hospital day, this amounts to \$6742 less expenditure for each client of a Vietnamese case manager, and for the 17 such clients admitted over the two year period this is an estimated difference of \$114 612, or about \$57 000 per year.

Greek

For those born in Greece, clients matched to a Greek case manager had more telephone contacts with CCT per year (median 16.2 contacts per year) compared to clients with another case manager (median 3.9 contacts), after controlling for age, sex, diagnosis, and differences between the BCM group and other staff. They also had a greater total duration of direct contacts with CCT per year (median 772.4 minutes per year compared

to 317.2 minutes).

Greek clients matched to a Greek case manager had a lower total duration of telephone contacts with CATTs per year (median 34.9 minutes per year) compared to clients with another case manager (median 72.0 minutes), after controlling for age, sex, diagnosis, differences between the BCM group and other staff, and differences in contacts with the CCT. They also had less telephone contacts with CATTs per year (median 4.1 contacts per year compared to 7.2 contacts), and less direct contacts with CATTs per year (median 2.4 contacts per year compared to 4.0 contacts).

There was no effect of ethnic matching on hospitalisation for Greek clients.

Italian

For those born in Italy, clients matched to an Italian case manager had a greater total duration of direct contacts with CCT per year (median 1007.6 minutes per year) compared to clients with another case manager (median 484.9), after controlling for age, sex, diagnosis, and differences between the BCM group and other staff. They also had more direct contacts with CCT per year (median 32.9 contacts per year compared to 16.1 contacts).

There was no effect of ethnic matching on CATT contact or hospitalisation for Italian clients.

Turkish

For those born in Turkey, clients matched to a Turkish case manager had a greater total duration of telephone contacts with CCT per year (median 348.9 minutes per year) compared to clients with another case manager (median 88.9), after controlling for age, sex, diagnosis, and differences between the BCM group and other staff. There was no effect of ethnic matching on CATT contacts or hospitalisation for Turkish clients.

Croatian

For Croatian clients, there was no effect of ethnic matching on CCT contact, CATT contact or hospitalisation

Macedonian

For those born in Macedonia, clients matched to a Macedonian case manager had a lower total duration of telephone contacts with CATTs per year (median 27.9 minutes per year) compared to clients with another case manager (median 48.0 minutes), after controlling for age, sex, diagnosis, differences between the BCM group and other staff, and differences in contacts with the CCT. They also had less telephone contacts with CATTs per year (median 3.0 contacts per year compared to 6.6 contacts).

As the Croatians, Macedonians and Turkish had smaller numbers of clients represented, it may have been more difficult to detect an ethnic matching effect for these groups due to lower statistical power. To investigate this, the effect of ethnic matching was analysed for these three groups combined. This analysis showed no effect of ethnic matching on CCT contact, CATT contact or hospitalisation.

Summary for all NESB clients

A summary of the effects of ethnic matching by birthplace is shown in Table 8.35. The most pronounced effect of ethnic matching was for the Vietnamese, where there was greater duration of contact with case managers and lower number and duration of telephone contacts with the CATT, a lower duration of direct contact with CATTs, less days in hospital per year and less admissions per year for Vietnamese clients with a Vietnamese case manager compared to Vietnamese clients with a non-Vietnamese case manager. For other groups there was a general trend to greater CCT contacts and fewer CATT contacts.

Table 8.35 Effect of ethnic matching on service utilisation by ethnic background

Description	All groups	Vietnamese	Greek	Italian	Turkish	Croatian	Macedonian
Duration of CCT phone contact					Higher		
Frequency of CCT phone contact			Higher				
Duration of CCT direct contact	Higher	Higher	Higher	Higher			
Frequency of CCT direct contact	Higher			Higher			
Duration of CATT phone contact	Lower	Lower	Lower				Lower
Frequency of CATT phone contact	Lower	Lower	Lower				Lower
Duration of CATT direct contact	Lower	Lower					
Frequency of CATT direct contact			Lower				
Total length of stay per year	Lower	Lower					
Frequency of admissions per year		Lower					
Proportion of admissions voluntary							

For each birthplace group, Table 8.35 shows the effect of matching clients with a BCM compared to other clients from the same birthplace. For example, for Vietnamese clients, those matched to a BCM have a higher duration of direct contact with the CCT than other Vietnamese clients.

Summary of findings

The results showed that clients of non-English speaking background who had a case manager of the same ethnic background, in comparison to other NESB clients, had:

- more direct contacts with the CCT per year
- greater total duration of direct contacts with the CCT per year.
- less CATT phone contacts per year
- lower total duration of CATT phone contact per year
- lower total duration of CATT direct contact per year
- fewer hospital admissions per year (for Vietnamese clients only)
- less days in hospital per year (for Vietnamese clients only)

For Vietnamese clients, there was an estimated saving of \$57 000 per year in reduced hospital stay for those matched to a Vietnamese case manager

SOCIAL FUNCTIONING

Sample

Multnomah Community Ability Scale (MCAS) ratings were completed for 340 clients (Table 8.36). Figure 8.18 shows the number of ratings for each client over the two-year period. One hundred and thirty five clients were rated only once and not included in the longitudinal analysis, but the relationship between levels of functioning and discharge status was explored for this group. There were useable data on change in social functioning over time for 197 clients. For this group, 53.1 percent were male, 60.4 percent were not married, and the mean age was 43.0 (S.D. 11.7). Birthplace is shown in Table 8.37. Of those with a diagnosis (168), 73 percent were diagnosed with schizophrenia, and a further 16 percent with another psychosis.

Of the 128 NESB clients included, 70 (54.7 percent) had no BCM involvement and 58 (45.3 percent) had some BCM involvement. There was no difference between these two groups on sex, but the group with some BCM contact were younger (mean of 41.2 compared to 47.8 years of age, $t(124)=3.34$, $p=0.001$), were more likely to be married and a greater proportion had a diagnosis other than a psychosis (18.5 percent compared to 3.6 percent).

Table 8.36 Number of clients rated by centre

	Frequency	Percent
Broadmeadows	42	12.4
Inner West	68	20.0
Mid West	58	17.1
North West	66	19.4
South West	106	31.2
Total	340	100.0

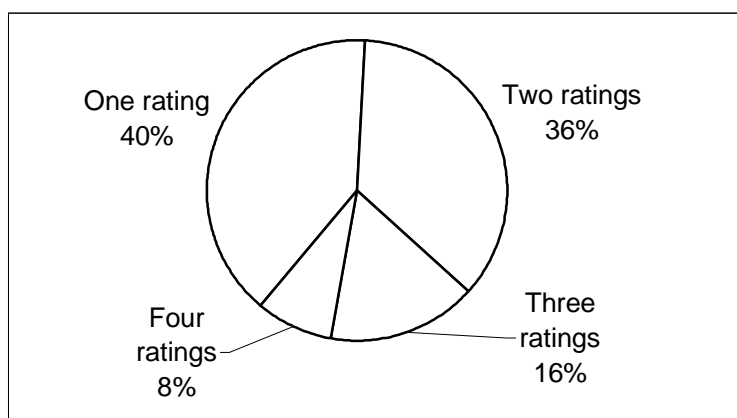


Figure 8.18 Frequency of MCAS ratings per client

Table 8.37 Birthplace of clients rated

	Frequency	Percent
Australia	50	25.4
Other English speaking	4	2.0
Italy	31	15.7
Greece	25	12.7
Croatia	8	4.1
Turkey	15	7.6
Macedonia	7	3.6
Vietnam	44	22.3
Other	12	6.1
Total	197	100.0

The amount of time between first and last MCAS ratings is shown in Figure 8.19. Approximately one third had two ratings six months apart, and another third had two or

more ratings with 2 years between the first and last rating. The rest of the sample was rated over 12 or 18 months.

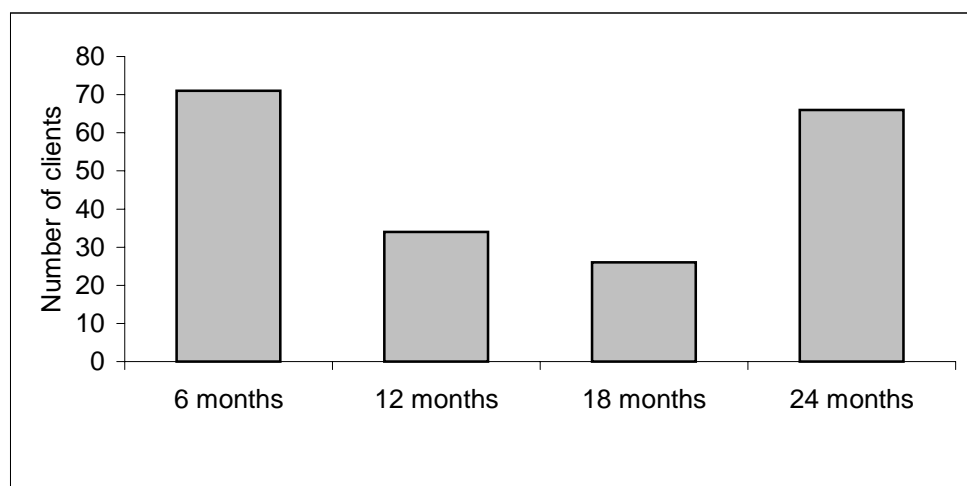


Figure 8.19 Time between first and last MCAS ratings

Predictive validity of MCAS

To check the predictive validity of the MCAS with this sample, the relationship between initial MCAS score and hospitalisation was examined. Hospital admission data (from the data used in the analysis of service utilisation reported above) and initial MCAS scores were available for 180 clients. Initial MCAS score was related to both length of stay in hospital ($r=0.25$, $p=0.001$, $n=180$) and number of admissions ($r=0.19$, $p=0.011$, $n=180$). Logistic regression also showed those with higher initial MCAS scores (i.e. with a better level of functioning) were less likely to be hospitalised (Wald=7.04, $df=1$, $R=0.170$, $p=0.008$).

Discharged versus continuing clients

Of the 340 clients who were rated, 135 received only one MCAS rating. Seventy-six (56.3 percent) of these 135 clients were discharged after one rating. The other 59 clients may have been discharged or they may have continued as clients in the service but were not rated again, but it was not possible to obtain information about this group. Of the 76 clients for whom discharge information was available, 45 had been discharged to another mental health service, and 31 to a general practitioner (GP). Differences in

MCAS scores were compared between these discharged clients and those who continued in the current service (clients with one MCAS rating for whom no discharge information was available were excluded from the analysis). Data was available for 261 clients.

Mean MCAS scores were compared for clients discharged to a GP, clients discharged to another mental health service, and clients who remained in the service and received more than one rating. For this last group, the first MCAS score was used for comparison. Analysis showed that there was a statistically significant difference between the groups ($F(2, 258)=8.4, p<0.001$). The mean scores for each group are shown in Table 8.38 – higher scores indicate better social functioning. Post-hoc tests (Scheffé) showed that clients discharged to a GP had higher total score than those referred to another service ($p<0.001$) or who remained in the current service ($p=0.003$), but there was no difference between these last two groups.

Table 8.38 Mean MCAS score by discharge status

Group	Number	Mean MCAS score*	Standard Error
Discharged to GP	31	67.2	2.00
Discharged to another mental health service	45	56.8	1.67
Remained in the current service	185	59.7	0.82
Total	261	60.1	0.71

Clients discharged to GP's were generally higher functioning than those who remained in the service or were referred to another mental health service. As this is what would be expected from clinical practice, this finding provides some additional support for the predictive validity of MCAS.

Change in functioning by ethnic match

For clients who remained in the service and who received more than one MCAS rating (197) the change in functioning over time was calculated as described in the methods section above. The minimum initial MCAS score rated was 31 (compared to a possible minimum of 17) and the maximum score was 85 (possible 85). The mean initial MCAS score was 59.4, and mean final score was 61.9. The mean time between first and last MCAS rating was 14.6 months. The mean change in social functioning per six months

for the whole sample was 0.77 (S.D. 0.95) - equivalent to 1.54 points increase per year on the MCAS scale.

There was a significant correlation between the initial MCAS score and change in MCAS scores ($r=-0.44$, $p<0.001$) indicating that those with lower initial scores were more likely to improve over time. There were no main effects of diagnosis, age, sex, birthplace, marital status, or case manager type on change in functioning. To explore whether NESB clients matched to a BCM would have greater improvement than NESB clients with another case manager, the individual slopes were then analysed using ANOVA to examine the effect of country of birth (ESB versus NESB), and case manager (BCM versus other case manager) on the change in social functioning over time. The intercept was entered as a covariate to control for the starting MCAS score.

Mean rates of improvement for ESB and NESB clients matched with a BCM or other case manager are shown in Figure 8.20. This appears to show interaction effect with NESB people having better functioning with BCM than with other case managers, but little difference for ESB clients. However results of the ANOVA showed a significant effect for the initial MCAS score $F(1,192)=14.6$, $p<0.001$), but no interaction between birthplace and case manager type $F(1,192)=1.0$, $p=0.32$).

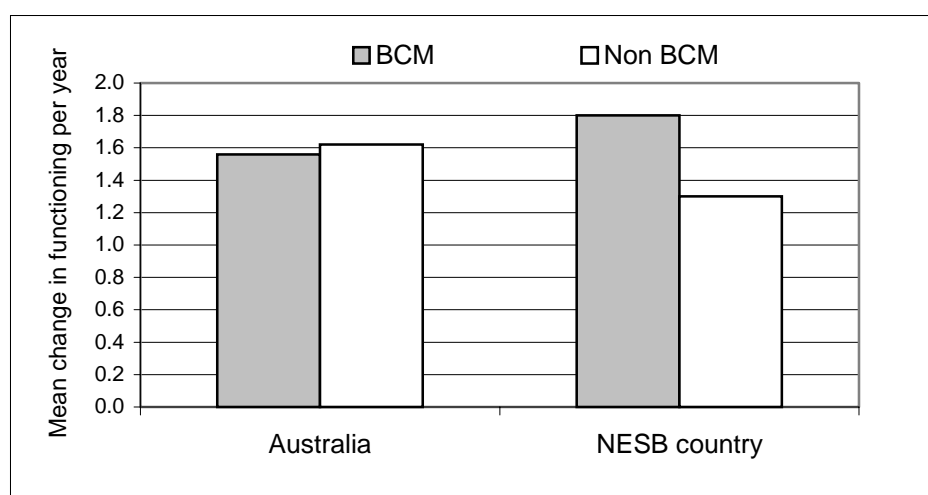


Figure 8.20 Mean rates of improvement adjusted for initial scores

On inspection of the data, it appeared that there was a difference in improvement scores by the length of the rating period (time between first and last ratings). Those who had

their first and last ratings 6 months apart had a mean increase (per six months) of 0.94, whereas those whose first and last ratings were 24 months apart had a mean increase (per six months) of 0.56. These results suggest that the improvement in social functioning per six months diminished as the period between initial and final ratings increased. There also appeared to be an interaction effect with country of birth.

To explore this further, the analysis was restricted to those who had had ratings over 6 months or 24 months, and the period of time (6 versus 24 months) was added as another factor in the ANOVA. There was a significant effect for time elapsed ($F(1,128)=5.9$, $p=0.016$). The results are shown in Table 8.39. It can be seen that ESB and NESB clients had similar rates of improvement over six months for both BCM and other case managers.

However, over 24 months, NESB clients had poorer rates of improvement (mean of 0.37) compared to ESB clients (mean change of 0.96). The interaction between time and birthplace was significant ($F(1,136)=4.31$, $p=0.040$), showing that ESB clients who were rated over 24 months had better rates of improvement than those rated over 6 months, but this was reversed for NESB clients. That is, the longer the period over which NESB clients were rated, the lower their rates of improvement.

When the background of the case manager was taken into account, NESB clients of BCM had better improvement rates than NESB clients of non-BCM's - the interaction between case manager type, time period and birthplace was significant ($F(1,128)=4.6$, $p=0.033$). Conversely, ESB clients of BCM had lower rates of improvement compared with other case managers, although there were only three ESB clients of BCM rated over 24 months, making this comparison tentative.

There was no difference between the 6 and 24 months groups in the initial MCAS score ($t(135)=-0.506$, $p=0.61$). This suggests that the difference in mean change over time between the two groups did not occur because the two clients groups differed in overall level of functioning.

Table 8.39 Mean change in MCAS scores by case manager and birthplace

	Birthplace	6 months (N)	24 months (N)
Non BCM	ESB	0.87 (11)	1.11 (15)
	NESB	0.86 (30)	0.11 (23)
BCM	ESB	0.89 (13)	0.16 (3)
	NESB	0.99 (17)	0.58 (25)
All case managers	ESB	0.90 (24)	0.96 (18)
	NESB	0.90 (47)	0.37 (48)
All clients		0.90 (71)	0.53 (66)

Summary of findings

Initial Multnomah Community Ability Scale scores showed predictive validity with respect to hospital admission and length of stay, and clients discharged to general practitioners had higher levels of functioning than those who remained in the service or were referred to another mental health service.

There was a small mean improvement in social functioning per year, with a greater rate of improvement for those with lower initial functioning.

Rates of improvement were lower for clients rated over the whole two year period compared to those rated over only six months. NESB and Australian-born clients rated over a six month period only had similar rates of improvement, but for those rated over two years, NESB clients had much poorer rates of improvement than the Australian-born.

For clients rated over a six month period, there was no difference in rates of improvement between NESB or ESB clients by type of case manager. For those rated over two years, NESB clients matched to a case manager of the same background had better rates of improvement compared to NESB clients of other case managers.

9. DISCUSSION

INTRODUCTION

The results of the six areas of investigation of this thesis were described in detail in the last chapter. This chapter presents a summary of the key findings for each study, a discussion of the results and the limitations of each study. The major themes of the research are discussed, and the implications, at both the service and central policy levels, for the future employment of bilingual staff is discussed. Finally, the limitations and strengths of the research are identified and the final conclusions presented.

CASE MANAGEMENT IN MENTAL HEALTH

Aims and key results

This study aimed to investigate whether case management is effective compared to standard community care without case management, by conducting a meta-analysis of the results of controlled studies of case management effectiveness. A second aim was to compare outcomes for assertive community treatment to clinical case management.

It was found that ACT reduced the total number of admissions and the proportion of clients hospitalised whereas clinical case management increased both. Both ACT and clinical case management reduced hospital days used, but ACT was significantly more effective. ACT and clinical case management were equally effective in reducing symptoms, increasing contacts with services, reducing drop-out rates from mental health services, improving social functioning, and increasing client satisfaction with services. Both ACT and clinical case management lower the family burden of care and improve family satisfaction with services. The total cost of care was reduced by both types of case management, but different methods of costing limit confidence in this finding.

Discussion

This study found that clinical case management is generally effective in improving outcomes from mental health services (e.g., improving clients' level of social functioning, reducing symptoms, increasing client and family satisfaction, and decreasing family burden of care). These results directly contradict the claim of Marshall and colleagues that there is 'little evidence of case management causing an improvement in mental state, social functioning or quality of life' (Marshall, Gray, Lockwood et al., 1998).

The study also elaborated on Marshall's finding that clinical case management increases the proportion of clients admitted, by showing that it increases the total number of admissions, but decreases the total length of stay in hospital. This means that although clinical case management led to more admissions than usual treatment, these admissions were shorter, reducing the total number of days in hospital. These results suggest that the overall impact on hospitalisation is positive, again contradicting Marshall's rather pessimistic conclusions.

The results also confirm the findings of previous reviews in showing that ACT programs are superior to clinical case management in reducing hospitalisation (both in terms of the proportion of clients admitted and total length of stay). A caution in interpreting these results is that ACT may deal with a different client group to clinical case management programs; ACT clients had a greater number of previous admissions before entering the program than clients of clinical case management.

It is useful to consider the effect of different aspects of case management on outcomes. ACT programs often include a specific goal to avoid or at least minimise hospitalisation, and staff on these teams may be able to make decisions about admissions, while staff on other programs do not. This may have a major influence on hospitalisation as a measure of outcome, independent of other considerations for admission such as mental state or level of social functioning.

A notable feature of the data was significant diversity in terms of outcomes. One reason for this may be that the tension between monitoring and support of people with a mental

illness may impact differentially on outcomes. A greater emphasis on monitoring may result in more admissions, and less client satisfaction, as clients may perceive case managers to be too intrusive and controlling.

That clinical case management programs result in more clients being admitted, and more admissions overall, than usual treatment could be evidence of greater monitoring. However, the smaller total length of stay (together with the overall improvement in symptomatology and social functioning) suggest instead that admissions may be more timely, and thus prevent the need for a longer period in hospital. Nevertheless, reconciling the monitoring and support functions remains an important dimension of case management programs. Another reason for differences in outcomes may have been variation in the difference between the case management programs and usual treatment (for example, some comparison services may have incorporated aspects of case management into their standard practices and procedures).

The main difference between this study and the Cochrane studies (Marshall, Gray, Lockwood et al., 1998; Marshall & Lockwood, 1998) is that this study included a greater number of studies by (i) including matched as well as randomly assigned control groups, (ii) including outcome data regardless of whether the measure had previously been reported in a peer reviewed journal, and (iii) not excluding studies which used parametric methods with skewed data. It is worth considering the effects of these differences.

It was demonstrated that the inclusion of matched control studies increased the power of the analysis, and enabled conclusions to be drawn for a broader range of outcomes than previously considered, but without lower quality studies biasing the results. It was also demonstrated that the use of unpublished outcome measures tended to under-estimate effect sizes, but nonetheless provided evidence in favour of the effectiveness of case management. Thus these results may in fact under-estimate the effectiveness of case management. The analysis of skewed data with parametric statistics could be of concern, but simulation studies indicate e.g. (Sawilowsky & Blair, 1992) that tests are robust to skewness as long as the sample sizes are reasonably large (i.e. larger than 30). That was the case for the studies included in this analysis.

There is some scepticism about the technique of meta-analysis (Bailar, 1999). For example, some meta-analyses may not take into account the tendency for studies finding non-significant results to be published less often; the 'file drawer problem' (Cooper & Hedges, 1994; Marchioli & Tognoni, 1998). In this study, the decrease in hospital days used, increased contacts with services, increased client satisfaction, and improved social functioning could be considered to be robust against the file drawer criticism. Another limitation of meta-analyses is that they rely on the data supplied by original studies, which may not provide enough detail about some areas. For example, the studies in this meta-analysis included descriptions of case management programs which varied from great detail covering several pages, to only a sentence or two.

An added strength of this meta-analysis over individual studies (even of the highest quality) is that it includes the results from a wide range of services overall, accommodating the natural variation across services. This means that these findings can be more confidently generalised to the mental health service system as a whole. In comparison, the findings from individual studies may have limited generalisability due to the specific nature of the service under examination.

While the effects of case management appear to be small to medium according to the criteria advocated by Cohen (1988), this is a finding consistent with many other new social programs or treatments. Citing the results of two analyses of twenty-four (Gilbert, Light & Mosteller, 1975) and thirty-six meta-analyses (Light, 1983), Cook, Cooper, Cordray et al. (1992) conclude that 'one strong finding from various meta-analyses is that most new treatments have, at best, small to moderate effects.' Similarly, one meta-analysis of the effectiveness of psychotherapy (not specifically for serious mental illness) found an effect size equivalent to $r=0.3$ (Shadish, 1992), which is about the mid-point of the range of effects found for case management. These findings therefore suggest that the effect of case management should neither be overstated, nor dismissed.

It can be concluded that case management brings about small to moderate improvements in the effectiveness of mental health services. The results reinforce the view that both clinical case management and ACT should be a feature of mental health programs, and that ACT should be targeted at those clients who are at greatest risk of hospitalisation (Essock, Frisman & Kontos, 1998).

What implications do these results have for case management in mental health services in Victoria? The conclusions here are less positive. A noticeable feature of clinical case management programs included in this study is that half had caseloads of less than 20 clients per case manager – in contrast to the average of about 35 clients per case manager in Victorian Continuing Care Teams at present. There is some evidence that increasing caseloads and workloads decreases quality of care (Segal, Egley, Watson, Miller & Goldfinger, 1995), and one meta-analytic review found that the only factor influencing case management effectiveness was the size of caseloads (Gorey, Leslie, Morris et al., 1998).

While the number of clients per case manager is a fairly crude measure of input or ‘dose-size’ (because some clients require more time and effort than others), these results suggest that the time able to be provided for individual clients may be inadequate for their needs. Informal feedback from staff and managers suggested that many case management staff felt that they were only able to respond to crises with limited time for preventive work such as client and family support, education, client skills training and counselling. These results raise some doubt about the effectiveness of case management as it currently operates in mental health services in Victoria – it may be less effective than in the studies reviewed, or it may not be effective at all.

IMPLEMENTATION OF THE PROGRAM

Aims and key results

This study aimed to investigate the implementation of the BCM program, specifically changes to the program model upon implementation, size and composition of the caseloads for bilingual staff, activities undertaken by bilingual case managers, the relationships between BCM staff and other staff and services, and whether any aspects of the program needed to be changed in order for it to operate more effectively.

Additional funding was provided for the first year by the Western Region Office of the Department of Human Services, and then all the positions were incorporated into the services' core budgets. This 'seed' funding was very important in enabling the program to be established. The staff who were employed had limited experience in mental health. However, managers felt that they were extremely enthusiastic, eager to learn and dedicated to their work. After a few months, they had gained credibility within the services and from other staff.

Support for staff, clinical supervision and access to training were provided in the first twelve months as the staff were relatively inexperienced, and the positions somewhat unusual. The supervision provided by individual clinical supervisors and Yvonne Stolk, Ethnic Mental Health Consultant, were seen by staff to be very useful and important.

During the establishment of the program, there had been some discussion with managers about the criteria to be used to select ethnic groups to be covered by the program. These criteria included the size of the group within the catchment area, the proportion of people from each group who spoke English poorly or not at all, the amount of other resources available to each community (for example ethnic community agencies), recency of arrival, and the distribution of ethnic groups across the region generally (as opposed to individual catchment areas). Managers made the final decisions about these criteria, and in the end, the languages targeted were those with the largest populations in each catchment area.

About half the clients seen by the BCM came from the same ethnic background, as proposed initially. The size of caseloads for BCM increased from 23 (around two-thirds of other staff) in 1998 to 32 (90 percent of those of other staff) in 2000, while those for other staff remained fairly constant at about 35 clients per case manager. Secondary consultation increased over time, but formal joint case management was rare. Managers felt that the BCM's had raised the awareness, and discussion, of cultural issues (for example at clinical review meetings), and had made a major contribution towards making their services more culturally sensitive.

Community work covered family education, community education, liaison with ethnic agencies, and organising support groups. This work would not have occurred without

the BCM staff, but the extent of community work was limited by increasing caseloads. Community work was more feasible for staff where more than one per ethnic group was employed (Greek, Italian and Vietnamese) compared to the other BCM's (who spoke Croatian, Macedonian and Turkish).

BCM's believed that their NESB clients needed more time from staff because they had less access to other social support services due to language and cultural barriers, and most staff interviewed felt that clients from the same ethnic background expected more from BCM's because of shared ethnic identity. Most BCM's, supervisors and managers believed that a shared ethnic background between client and case manager would lead to a better therapeutic engagement, because clients felt more comfortable being able to speak in their first language, particularly about difficult emotional issues, and that an ethnic match enabled trust to be established more quickly.

Discussion

Writing on the potential difficulties of hiring bilingual staff suggested pointed to several potentially difficult issues: unrealistic expectations of bilingual staff on the part of services and clients, services' tendency to refer all clients to a clinician from the same background, marginalisation of bilingual staff, and a service focus on individual case management making collaborative work and community work more difficult.

The ethnic composition of caseloads were roughly equivalent to that proposed. This was important in enabling the BCM's to work with a range of different clients in their direct work and also to be seen as part of the team rather than as an isolated ethno-specific worker. In addition, the opportunity to meet as a group, compare experiences and discuss aspects of the work proved to be important in enabling staff to share and compare experiences, and establish a group identity. It appears that these features prevented the marginalisation of the staff, and the tendency for bilingual staff to adopt all clients of the same background (although this was something which had to be actively resisted).

Sole case management was the main area of clinical work for all except one person. There was some work with other staff but this seemed to be minimal and ad hoc, and this was more common for the Vietnamese workers than for those from other backgrounds. A striking feature of the work done by the staff in this program was the emphasis on working with families to provide support, information and education, and this featured in much of the joint work being done. However the increase in caseloads raised questions about the long-term feasibility of BCM positions having lower caseloads in order to work on community development activities. The increase was mainly in clients of Anglo-Saxon background. These results suggest that either a more formal mechanism must be found to restrict caseloads, or that BCM's be expected to do no more community work than other case management staff.

These two findings – minimal secondary consultation and difficulty finding time for community work - reflect those of Mitchell, Malak & Small (1998). The focus on individual responsibility and direct clinical work seems a feature of many mental health services, and attempts to introduce roles outside this framework (particularly community-focussed work) seem destined to be fraught with difficulties.

BCM's generally only saw clients who lived within the catchment area of the service where they were employed – although the possibility of seeing a wider group of clients was discussed at the start of the program, this did not eventuate. Under the service arrangements operating at the time (i.e. funding for services based on specific geographical catchment areas), it seems infeasible for BCM's to have a regional rather than a strictly area-oriented role, except with some aspects of community work.

Most BCM staff interviewed felt that clients from the same ethnic background expected more from BCM's because of shared ethnicity – a result which has also been found in some previous research (e.g. Abreu, (2000)). These greater expectations were manifested both in terms of the amount the staff were requested to do, and in difficulties over boundary issues - clients expected bilingual staff to become involved in their lives more like friends than professionals. As Abreu (2000) has suggested, these demands posed some difficulties for staff, and meant that they often had to spend considerable time clarifying roles and boundaries with clients and families.

Clients also generally expected BCM's to understand their explanatory models of illness, and to share their beliefs. While it is possible that the BCM's had a better understanding of clients' explanatory models, as suggested by Flaskerud (1986), Kagawa-Singer & Chung (1994) and Sue (1998), BCM's often felt that they faced a conflict between working within their own and the services' explanatory paradigms (the biopsychosocial model) and those of clients (which often had spiritual or metaphysical features). So although the models may not have been 'shared', staff may have been better able to negotiate the differences.

Most BCM's, supervisors and managers believed that a shared ethnic background between client and case manager would improve the therapeutic relationship. They believed that clients felt more comfortable being able to speak in their first language, particularly about difficult emotional issues, and that an ethnic match enabled trust to be established more quickly. These findings mirror arguments previously proposed by a number of authors e.g. (Flaskerud, 1986; Sue, Fujino, Hu et al., 1991; Yeh, Eastman & Cheung, 1994). If this was the case, it might be expected that the improved therapeutic alliance would lead to better outcomes for clients with an ethnic match (Frank & Gunderson, 1990). This question is explored in the results of the next four studies.

The major limitation of this study was that information was collected from key informants; BCM staff, their supervisors and service managers. Other staff, for example, psychiatrists and other case managers were not interviewed. These staff may have held different impressions of the program or its value. However, the clinical supervisors and service managers interacted with other staff a great deal, and it could be expected that they would have a reasonable feel for the attitudes of these staff.

MEDICATION MANAGEMENT

Aims and key results

This study aimed to investigate the impact of ethnicity, as determined by country of birth and preferred language, on the management of antipsychotic prescribing in a community mental health setting.

The results showed that there was no effect of ethnic match on medication dose and receipt of an atypical medication: matched clients had the same average medication dose and were just as likely to receive an atypical neuroleptic, as unmatched clients. However, clients of non-English speaking background who had a case manager of the same ethnic background, were less likely to receive depot medication, and more likely to comply with medication, than other NESB clients of the service.

Discussion

Clients born in Vietnam received significantly lower doses (mean dose 244 mg/day) than other clients (mean dose 342 mg/day). This finding matches those of studies of other Asian groups (Lin, Poland, Nuccio et al., 1989). Dose sizes for both Asian born clients and those from other backgrounds appear consistent with guidelines for good clinical practice, with the mean dose for non-Asians at the lower end of the recommended range for maintenance doses of 300-600 CPZe mg/day (Gray & Pi, 1998; Lehman, Steinwachs & co-investigators, 1998).

It was hypothesised that clients of NESB might have restricted access to the atypical antipsychotics. The findings from this study revealed, however, that there was no difference in likelihood of being prescribed an atypical antipsychotic by country of birth, preferred language, or ethnic matching with case manager. Older clients were less likely to be on an atypical antipsychotic, but this was a trend independent of ethnicity and gender. A separate analysis of medication management in mental health services in

Melbourne found that NESB clients were less likely to receive an atypical antipsychotic (Lambert, 1999). As the sample size in that study was much larger than in the present analysis, it is possible that it had greater power to detect a difference. However, Lambert's study did not control for the effect of age, so it is possible that receipt of atypical medication was confounded with age for NESB clients.

In terms of route of administration, NESB clients were more likely than the Australian born to receive a depot medication. This supports the notion that clinicians may err on the side of caution with respect to route of administration when faced with cultural, ethnic or communication barriers. Lambert's study also found that NESB clients were more likely to receive depot medication (Lambert, 1999).

The majority of clients (72.6 percent) included in this study usually or almost always took medication as advised, while only 27.4 percent complied with their medication regime only sometimes or rarely. These results are similar to those of a recent study (Azrin & Teichner, 1998) which found a compliance rate of 73 percent, and suggest that non-compliance is an important issue for a significant proportion of clients.

There was a very high correlation between non-compliance with medication and lack of cooperation with service providers. Clients who were cooperative with services tended to comply with administered medications. This result confirms previous research that found that a good client-clinician relationship is a contributor to greater compliance when measured independently of the clinician (Frank & Gunderson, 1990), and suggests that fostering a collaborative relationship between case manager and client may help to improve cooperation and compliance.

Clients matched with a case manager of the same ethnic/linguistic background had higher rates of medication compliance, and were much less likely to receive depot medication than those matched with a case manager from a different ethnic background. These two results differ from an earlier report of this study (Ziguras, Lambert, McKenzie et al., 1999). In retrospect, it appears that the previous analysis did not adequately control for other variables when examining compliance and depot medication.

It could be assumed that a shared cultural and linguistic background between clients and case managers allows greater communication about the illness, and the importance of medication in addressing symptoms. It may be that clients are more willing to accept advice from case managers who they feel have a better understanding of their cultural values and beliefs. Another possibility is that bilingual case managers were generally allocated clients who were more likely to be compliant. However, investigation of this possibility indicated that there was no difference overall in the mean ratings of compliance for all clients of bilingual staff, compared to clients for other staff, so the 'differential referral' hypothesis was not supported.

There were some limitations of this study. First, the data collection pro-forma included space for only three medication types (although some case managers added more); some clients may have received more than three different medication but these would generally not have been recorded. The small proportion of clients recorded as receiving both oral and depot medication suggests that multiple medication types were underestimated. In addition, levels of clinical dysfunction may have varied for different client groups, but it was not possible to include such data.

A second limitation was the use of perceived compliance as a measure of objective compliance, because perceptions of the clinician may be influenced by the general cooperation of the client. Cummings, Kirscht, Becker & Levin (1984), however, have shown that clinician-rated compliance was superior in construct validity to either client-reported compliance or physiological indicators of compliance. Nevertheless, in the present study, a high correlation was evident between perceived compliance and ratings of the client's cooperation, leaving open the possibility that the compliance measure reflects simply the clinician's general view of the client's cooperation. Against this argument, is the parallel finding by Frank & Gunderson (1990) that the strength of therapeutic alliance between the clinician and the client was correlated with medication compliance, when the latter was measured using behavioural indices independent of the clinician's perceptions. That is, the correlation between cooperation and compliance may be 'real' regardless of how compliance is measured, and not simply an artefact of the methods used in the present study.

The third limitation concerns the study design, which was cross-sectional. Medication data were collected at only one point in time, and it was not possible to examine change in medication management over time. Although it did not appear that clients allocated to the BCM staff as a group differed on the key measures to other clients, it is possible that the difference between matched and non-matched NESB clients was due to allocation bias rather than the effect of the BCM staff.

That ethnic matching increases compliance could be expected to affect other outcomes, such as less relapse, better control over symptoms and, perhaps in the long term, improved social functioning. These are investigated below.

CLIENT SATISFACTION AND CROSS-CULTURAL SENSITIVITY

Aims and key results

This study aimed to investigate clients' satisfaction with mental health services, and their views about, and satisfaction with the cultural sensitivity of service providers, using both structured and open-ended approaches. A second aim was to investigate whether NESB clients had a preference for a case manager of the same background. The third aim was to investigate whether clients matched to a case manager of the same background were more satisfied with the mental health service, and the cross-cultural sensitivity of service providers, than NESB clients with another case manager.

Among the clients interviewed there was a high level of satisfaction with mental health services assessed both qualitatively and quantitatively. Satisfaction with case managers was higher than satisfaction with doctors. The most helpful aspects of the service were seen to be effective medication, the caring, friendly attitudes of staff, and having someone to talk to. The main area of dissatisfaction was that doctors changed very frequently and that medication was often also changed as a result. NESB clients were more satisfied overall than Australian born clients.

The importance of various aspects of cross-cultural sensitivity was explored with NESB clients. A majority of NESB clients thought that staff should understand their settlement history, and there was a high level of satisfaction with staff understanding of this area. Few clients had experienced a misunderstanding of their migration experience but this group were less satisfied. It can be concluded that an understanding of settlement experiences of migrants is an important component of cultural sensitivity

There was a high level of maintenance of traditional culture, with less adoption of Australian customs, and clients who adopted Australian practices were less likely to maintain traditional practices. In spite of the fact that the people interviewed had spent an average of 20 years in Australia, a substantial number still experienced difficulties with English. About one third had some difficulty in understanding English and almost half had difficulty expressing themselves in English. Areas of most difficulty were understanding medical terminology about symptoms and medication, and being able to express feelings and problems.

Interpreters appeared to be provided as often as clients said they were needed. Clients expressed very positive and appreciative views about interpreters, and concern about confidentiality was uncommon.

A majority of NESB clients (about two-thirds) expressed a preference for a case manager of their own ethnic background, and that both qualitative and quantitative data pointed to the importance of language in case manager preference. The most important predictor for preferring a case manager of the same background was difficulty with English. Clients most frequently identified language as the greatest benefit of a case manager of the same background and the limitation of a case manager from a different background. There were few concerns expressed about breach of confidentiality by case managers of the same background.

While language was identified as important, a common comment from clients was that an ethnically similar case manager would be able to better understand them as people.

Spiritual beliefs were important to most clients interviewed, but there was less agreement (compared to migration experience) that it is important for staff to

understand religious beliefs. There was generally a high level of satisfaction with staff understanding of spiritual beliefs.

NESB clients both preferred and experienced the involvement of their families to a greater degree than ESB clients, but one third of NESB clients wanted more family involvement. Family involvement, then, is an important aspect of cross-cultural sensitivity for most NESB clients, but there are likely to be gender differences, and some clients may perceive family involvement as intrusive.

There was no difference between ESB and NESB clients in amount of information received or desire for more information, and both ESB and NESB clients were generally satisfied with the information they received. Fewer clients received information about their rights, and the most common areas for which more information was requested were mental illness, medication and rights.

The cross-cultural sensitivity of staff was important to most NESB clients, and there was generally a high rating of the cross-cultural sensitivity shown by staff. Satisfaction with cross-cultural sensitivity was highly correlated with general satisfaction, but Vietnamese clients made a greater distinction between general satisfaction and cross-cultural sensitivity than other NESB clients. Those who were more acculturated to Australian practices were more satisfied with the cross-cultural sensitivity of the service. These results suggest that the following are important features of cross-cultural sensitivity of services providers:

- staff understanding of migration and settlement experience
- the ability to communicate clearly in English and to avoid or explain medical and service jargon short-hand
- involvement of interpreters or bilingual staff for those with poor English, and occasionally for those with reasonably good English if highly technical issues are to be discussed, or where clients need to express difficult emotional issues
- it is important to explain confidentiality of staff and interpreters as early as possible and to accept that it may take clients some time to fully trust this

- it is less clear that clients expect staff to understand their religious beliefs, this varies considerably
- family involvement in treatment, especially providing information to partners about diagnosis, services, and treatment

Statistical analysis of the pattern of results for client satisfaction and cross-cultural sensitivity suggested that NESB clients matched to a case manager of the same background were more satisfied than other NESB clients, but lack of power (small sample size and perhaps small effect size) meant that this difference could not be detected on individual items.

Discussion

The high level of satisfaction among clients interviewed reflects the findings of previous studies in mental health (Lebow 1983; Pascoe, Attkisson & Roberts 1983; Williams & Wilkinson 1995). The extent to which quantitative measures of satisfaction reflect 'true levels of satisfaction' is a moot point, but the responses to open-ended questions in this study showed the same high degree of satisfaction, suggesting that these results do reflect the 'real satisfaction' of clients interviewed.

Clients thought that the most helpful aspects of the service were medication which controlled symptoms, the caring, friendly attitudes of staff, and having someone to talk to. These results highlight the importance of both treatment by medication, and the therapeutic relationship, and imply that case managers also need to focus on interpersonal aspects of the role, not just the administrative tasks of planning, referral, and monitoring medication.

The main areas of dissatisfaction were that doctors changed frequently and medication was often changed at the same time. Satisfaction with case managers was higher than satisfaction with doctors, perhaps reflecting the turnover of medical staff. This suggests that the issue of continuity of care is an important one to clients, and raises some questions about quality, especially as some clients felt medication had been changed

simply because the doctor had changed. This seems to be an area where further investigation is required.

NESB clients were more satisfied overall than Australian born clients. This finding reflects that of Leavey, King, Cole et al. (1997), who suggested that it may be related to lower expectations of care of those born overseas: NESB clients may have lower expectations of services in Australia as their knowledge of services is based on experience or knowledge of mental health services in their country of origin, and perhaps the limited number of health and welfare services available at all.

The results also showed that cultural sensitivity is an importance aspect of service delivery for a majority of NESB clients, and that many aspects of cultural sensitivity discussed in theoretical literature are also considered important by clients. Generally, clients showed a high level of satisfaction with the cross-cultural sensitivity shown by staff.

Although the clients interviewed had been in Australia for an average of twenty years, a substantial number still had difficulty with English, especially in understanding medical terminology and being able to express emotional and practical difficulties. Many clients are proficient in English at a level to enable day to day conversation and some staff may feel that interpreters are unnecessary for this group. These findings suggest that such clients may still need interpreting assistance in circumstances where new or complex terminology is being used or explained, or when they need to discuss a difficult emotional issue.

A majority of clients interviewed expressed a preference for a case manager of the same ethnic background. This findings mirrors previous research conducted with counsellors (Atkinson & Lowe 1995). Somewhat surprisingly, the finding that two-thirds of NESB clients express this preference is almost identical to one found in a study of patients of general hospital services (Hawthorne, Toth and Hawthorne, in press) where 62 percent said it was 'important' or 'very important' to have a nurse from the same cultural background. Another similarity in results was that both this study and the Hawthorne et al. study found that the most significant indicator of preference for a culturally similar professional was English language proficiency. This suggests that client preference is

based mainly on ease of communication, and certainly this was the most common issue raised by clients in interviews.

However, this study suggested that 'being understood as a person' was also an important issue for clients and that they felt more comfortable with culturally similar case managers. Given that clients of mental health services have frequent contact with staff over a long period of time, and they must deal with the difficult social and psychological effects of having a mental illness, this 'need to be understood', and the clinical relationship may well be more important in mental health than for acute general health services. The pattern of consistently higher satisfaction ratings for matched clients was statistically significant, and suggests that satisfaction was higher among matched clients. These results are consistent with the interpretation that NESB clients prefer a matched clinician because they feel more understood.

There were some limitations to this study. First, as described in Chapter Seven, recruiting clients was a very difficult process, primarily because staff appeared too busy to contact clients about the project. While this may also be a reflection of lack of interest in the project or in research generally (and there were certainly some staff who gave this impression), even those who were enthusiastic about the project did not have time to follow-up clients. As a result, the relatively small number of clients recruited for interviews meant that some of the analyses conducted suffered from a lack of statistical power. This meant that it would not have been possible to detect some effects.

Second, as was the case for the previous study, the design for this study was cross-sectional, and did not assess change in satisfaction over time. The difference in satisfaction between matched and non-matched NESB clients may have been due to allocation bias, so that BCM were allocated clients generally more satisfied. On the other hand, the overwhelming preference of NESB clients for a BCM (which reflects many previous studies), and the discussion of language as a key issue suggests that the difference in satisfaction was not due to biased allocation.

Another limitation was the self-selected nature of the sample. Although clients to be interviewed were chosen on the basis of characteristics matched between BCM clients and others, clients could decide not to participate. It is possible that those who were less

satisfied, or that those NESB clients who were more concerned about breaches of confidentiality or shame, decided not to participate. If that was the case, these results may not reflect the opinions of all clients, a problem amplified by the relatively low response rate. This is, of course, a problem with any study which relies on interviews with clients, and it has been suggested as one reason why satisfaction with services is uniformly high (Nguyen, Attkisson & Stegner, 1983). However, the ethical decree that clients participate voluntarily in research means that this issue is one that is difficult, if not impossible, to avoid.

SERVICE UTILISATION

Aims and key results

This study aimed to investigate whether NESB clients matched to a case manager of the same background differed from NESB clients with another case manager on: frequency and duration of Continuing Care Team community contacts; frequency and duration of Crisis Assessment and Treatment Teams (CATT) contacts; and frequency, legal status and total duration of hospital admissions.

The results showed that clients of non-English speaking background who had a case manager of the same ethnic background, in comparison to other NESB clients, had: more direct contacts with the CCT per year, greater total duration of direct contacts with the CCT per year, less CATT phone contacts per year, lower total duration of CATT phone contact per year, lower total duration of CATT direct contact per year, fewer hospital admissions per year (for Vietnamese clients only), and less days in hospital per year (for Vietnamese clients only).

Discussion

Clients matched to a case manager of the same background had more contact with the CCT, (presumably with their case manager) than other NESB clients, after controlling for a range of other factors. This finding reflects that of most previous research

(Flaskerud & Hu, 1994; Flaskerud & Liu, 1991; Fujino, Okazaki & Young, 1994; Jerrell, 1995; Jerrell, 1998; Sue, Fujino, Hu et al., 1991; Takeuchi, Sue & Yeh, 1995; Yeh, Eastman & Cheung, 1994; Ying & Hu, 1994). The bilingual staff interviewed, and some clinical supervisors, spoke of the need to spend more time with NESB clients because of difficulties in accessing other services due to language and cultural barriers, and additional needs due to lack of English, settlement issues, and family separation. This reflected similar comments made by the bilingual staff interviewed by Mitchell et al. (1998). The BCM staff may have been more aware of these additional needs, and concentrated more time on them. The absence of language barriers would also have made it easier for clients to communicate and to express their concerns, feelings and needs, so there may also have been more demand from the client group for the BCM time.

Most BCM's also reported that they felt that NESB clients who shared their background had higher expectations of them than other clients because of their shared ethnic identity. Clients may have expected BCM staff to be more available, and to spend more time with them as a result.

Ethnic match was also associated with less contact with CATTs. On the one hand, it may have been that clients relapsed less often, and therefore needed CATT intervention less frequently. Alternatively, NESB clients may have turned to the BCM as a source of support during crises, or been referred back from CATT to BCM earlier after CATT intervention as CATT staff felt that the BCM were better able to work with these clients due to their shared language. The higher contact rate with CCTs for these clients suggest the BCM may have taken on some of the crisis response role usually handled by CATTs. However, the amount of contact with CCTs was entered as a covariant into the CATT regression analyses, but the effect of ethnic matched remained – suggesting that the lower rate of CATT contact was not just due to the higher rate of CCT contact.

Finally, it was found that Vietnamese clients with a Vietnamese case manager had fewer hospital admissions per year, and spent less time in hospital per year, than Vietnamese clients with another case manager. This would suggest that these clients were in fact more stable and relapsed less often, as it is unlikely that the BCM would be able to prevent admission simply by spending more time with clients after a relapse had

occurred. One of the Vietnamese case managers spoke of the opportunity to get to know her clients well; the case manager, the client and sometimes members of the clients social network were able to detect re-occurring symptoms earlier and to consult with the doctor to temporarily increase the persons medication as needed. This case manager was also able to provide more information and education to clients than other case managers were able to, and the absence of a language barrier meant that clients were able to communicate their experiences more easily.

Why was there an impact on hospitalisation only for Vietnamese clients? There are several possibilities. Vietnamese clients generally have poorer English ability, and communication with non-bilingual staff may be more difficult than for other client groups. Second, there may be a greater cultural distance between Vietnamese culture and Australian Anglo-Saxon culture, which results in comparatively more cultural misunderstanding of Vietnamese clients compared to other client groups, and may mean that Vietnamese clients feel less comfortable with mainstream workers than do other clients. Third, as more recent arrivals, Vietnamese probably experience more current settlement issues (finding work, sponsoring relatives to migrate, diminished social networks etc), and BCM may be more attuned to these than other staff.

The manager of a psychiatric disability service suggested that the lower length of stay for some Vietnamese clients may be due to the presence of Vietnamese staff in non-government psychiatric disability services in some areas. It seems likely that some of the joint work carried out by Vietnamese workers from all of the services (such as women's and men's groups, respite camps and community forums) would have contributed to better outcomes for clients. However, many Vietnamese clients using these services had a non-Vietnamese case manager, but the difference between Vietnamese and other case managers remained.

Ethnic matching increased contacts with case managers and decreased contacts with crisis services. In the case of Vietnamese clients, ethnic matching also reduced frequency and duration of hospitalisation. The decrease in crisis contact, and hospitalisation, was not due to increased case manager contact alone, as this was controlled for in the regression analyses. These results suggest that ethnic matching should also result in better social functioning for NESB clients, and that the effect of

ethnic matching may be most pronounced for more newly arrived groups, or those with poorer English.

The major limitation to this study was that it was a quasi-experimental design which means that the clients of BCM staff may have differed to those of other staff in a way which caused the differences in service contact rates. The NESB clients matched to a BCM were slightly younger than other NESB clients (44.1 years of age compared with 46.4) years of age, but age was included as a covariate in all of the analyses. There was no difference between the groups in sex, marital status or diagnosis, suggesting that the differences in contact rates were not due to differences between the two groups of NESB clients, at least on the variables measured.

SOCIAL FUNCTIONING

Aims and key results

The aim for this study was to investigate whether NESB clients matched to a case manager of the same background had a greater improvement in social functioning over time than NESB clients with another case manager.

Initial Multnomah Community Ability Scale scores showed predictive validity with respect to hospital admission and length of stay, and clients discharged to general practitioners had higher levels of functioning than those who remained in the service or were referred to another mental health service.

There was a small mean improvement in social functioning per year, with a greater rate of improvement for those with lower initial functioning.

Rates of improvement were lower for clients rated over the whole two year period compared to those rated over only six months. NESB and Australian-born clients rated over a six month period only had similar rates of improvement, but for those rated over two years, NESB clients had much poorer rates of improvement than the Australian-born.

For clients rated over a six month period, there was no difference in rates of improvement between NESB or ESB clients by type of case manager. For those rated over two years, NESB clients matched to a case manager of the same background had better rates of improvement compared to NESB clients of other case managers.

Discussion

There was a small mean improvement in social functioning per year in the sample studied – equivalent to around 1.5 MCAS scale points increase per year on the MCAS scale which can vary from 17 to 85. This small degree of improvement may reflect the nature of the client group, who are primarily people with chronic mental illness and a high level of associated disability. On the other hand, this may also reflect under-resourcing of services, and show that improvement in client social functioning is constrained by inadequate staffing levels or caseloads.

Improvement in social functioning was poorer for people rated over two year period compared to those rated over six months. Those rated over a shorter period improved faster and may have been more likely to be discharged to a GP. This is also consistent with shorter rating period, as it would mean that they were not in the service long enough to be rated over two years. The results of measurement over two years would have been less subject to short-term fluctuations, and also reflect the situation of clients who had attended the clinic for two years or more; they may therefore be a better indication of outcome for continuing mental health service clients.

Over a period of six months, there was no difference in change in social functioning between ESB and NESB clients, or between NESB clients matched to a BCM compared with other NESB clients. These results are similar to those found in other research into the effect of ethnic matching on social functioning (Flaskerud & Hu, 1994; Flaskerud & Liu, 1991; Fujino, Okazaki & Young, 1994; Takeuchi, Sue & Yeh, 1995). For example, in the Fujino et al. (1994) study, clients were seen for between 7 and 11 sessions (presumably once per month or more frequently), and in the Flaskerud and Hu (1994) study they were seen for a median of 3.6 sessions (one session per month).

Over a rating period of two years, though, NESB clients had significantly lower rates of improvement in social functioning than ESB clients. This could reflect problems in communication between clinicians and NESB clients, greater initial needs of NESB clients due to settlement issues and cultural differences, and/or a lack of culturally appropriate and accessible community support services.

Over the two year period, there was also a significant effect of ethnic matching, with NESB clients matched to a BCM having better rates of improvement compared with other NESB clients. These findings suggest that the effect of ethnic matching takes some time to have an impact on rates of client functioning. This is not surprising given that many clients have long-standing and severe psychiatric disabilities, which are not likely to be changed quickly. It was also found that ESB clients of the BCM had poorer rates of improvement compared to other ESB clients, but there were only 3 clients in the former group, making this result somewhat questionable.

It appears that previous studies did not find an effect of ethnic matching because they were conducted over too short a time period for this effect to be discernable. The results from the present study show that there are long-term benefits of ethnic matching on social functioning for NESB clients of community mental health services.

As for the analysis of service utilisation, the major limitation to this study was that it was a quasi-experimental design which means that the clients of BCM staff may have differed to those of other staff in a way which resulted in the differences in social functioning. The NESB clients matched to a BCM were younger than other NESB clients, more likely to be married and more likely to have a diagnosis other than psychosis. However neither sex, age, marital status or diagnosis had an effect on level of improvement in functioning. This suggests that the differences in social functioning were not due to differences between the two groups of NESB clients, at least on the variables measured.

Another difficulty in this study was the large amount of missing data, due both to clients moving to other services or being discharged, and case managers failing to complete follow-up MCAS ratings for continuing clients. Although changes in social functioning

were calculated in a way which attempted to overcome the missing data problem (hierarchical linear modelling), the sample attrition may have biased the results.

Finally, using a measure of social functioning completed by clinicians may have introduced some bias because the bilingual staff were aware that their performance was being scrutinised; i.e. the measure used was more 'reactive' for the BCM staff than for other staff because only the BCM staff were being evaluated. However, clients rated over a period of six months had similar rates of improvement regardless of whether they were matched to a BCM or not. If it existed, it is unlikely that the bias would have applied only to measures taken over two years and not for a shorter period of time. Moreover, it could be assumed that case managers knew their clients better than anyone else, and were better placed to provide an accurate rating of their level of functioning. An alternative would have been to employ research staff to conduct the MCAS ratings. Although such staff may have been more independent, it is doubtful that they could have provided an accurate assessment of a person's social functioning on the basis of a single interview, especially in areas such as medication compliance, social networks, independent living skills and so on.

WHY IS THE EMPLOYMENT OF BILINGUAL STAFF EFFECTIVE?

The results of this research have shown that outcomes for NESB clients matched to a case manager of the same ethnic background were superior to those for NESB clients with another case manager. Why, then, is ethnic matching effective? Let us consider four factors; shared language, bilingual staff cultural knowledge, shared explanatory models, and shared ethnic identity.

Most obviously, it could be that being able to speak the client's first language leads to better communication and understanding of clients needs, and less potential for misunderstandings. Difficulty in speaking English had the strongest relationship with a preference for a bilingual clinician. This would suggest that English ability and communication was the most important aspect of ethnic matching. This is consistent with the results of Sue, Fujino, Hu et al. (1991) who found that ethnic match was a significant predictor of outcome for Mexican Americans but not African Americans or

Asian Americans. However, when considering only clients for whom English was not the primary language, ethnic match was significantly related to improved functioning. Having both ethnic and language match for these clients was particularly important.

However, if English proficiency is considered an indicator of acculturation, then the findings from the client interviews could be interpreted as showing that lack of acculturation had the strongest relationship with a preference for a bilingual clinician. Having a shared ethnic background might mean that BCM may have a better understanding of the client's values, beliefs, modes of emotional expression, and the meaning of non-verbal gestures, and correspondingly, that less-acculturated clients have more difficulties with staff from other backgrounds. This understanding of language and culture may also allow for more accurate monitoring of medication compliance and mental state, and the capacity to detect and respond to relapses more quickly.

Most BCM also reported that they felt that NESB clients who shared their background had higher expectations of them than other clients because of their shared ethnic identity, reflecting both Abreu's (2000) and Mitchell's (1998) findings. Clients may expect BCM staff to be more helpful and make themselves more available because they are 'one of us'. Clients and their families are also able to contact bilingual staff more easily, and they may be more able and willing to seek help when they need it urgently, rather than wait until the next scheduled appointment.

While some have suggested that shared explanatory models may be a feature of ethnic matching, this did not seem to be an important factor in this program. Bilingual staff reported that clients often expected them to share their beliefs about the cause of illness (for example, in terms of spirit possession or black magic), whereas staff generally operated from the biopsychosocial model. Although they may still understand clients' beliefs, staff found this expectation to be very difficult to work with, and they still attempted to educate clients in the Western models. Of course, it may have been easier to provide such education, and to negotiate an approach between the two perspectives. If explanatory models were important to ethnic match, it would be relevant to the process of negotiating different models and expectations, rather than having a shared belief in them.

Many NESB clients felt more comfortable with a mental health professional from their own ethnic background; this and the ease of communication suggest that BCM's are able establish rapport and create a therapeutic clinical relationship more effectively. The capacity to foster and maintain a sense of trust between clinician and client would seem to be a crucial issue. As Frank and Gunderson (1998) have shown, an enhanced 'therapeutic alliance' is associated with better medication compliance and clinical outcomes. Research into ethnic matching in the USA has found that ethnic identity itself is an important factor, especially as ethnic match has been shown to be important for some groups (such as African-Americans) that have a high proportion of native English speakers.

Based on the results of this research, it appears that the key elements of ethnic matching are the ability to communicate in the same language, and a clients' sense that bilingual staff will be more helpful because they share the same ethnic identity and culture. Both of these result in a better therapeutic alliance, which is itself a predictor of better outcomes. However, it is difficult to disentangle bilingual staff characteristics (cultural knowledge, sense of ethnic identity, degree of acculturation), client characteristics (ethnic background, preferred language, English proficiency, degree of acculturation, sense of ethnic identity, explanatory models of illness), and characteristics of other staff (familiarity with particular cultures, general comfort and skills in cross-cultural work, willingness or ability to use interpreters). Interactions between these variables may also be important: for example, it is possible that less acculturated clients from more 'culturally distant' ethnic backgrounds have poorer outcomes when allocated to staff from an Anglo-Australian background, so that ethnic matching for this group has comparatively more effect. These issues remain important for future research.

IMPLICATIONS FOR THE EMPLOYMENT OF BILINGUAL STAFF

This thesis has found that the introduction of the BCM program has been successful in improving mental health services for NESB people, and implies that bilingual staff should be employed more widely in the mental health system.

The BCM model implemented in the Western Region appears to have overcome some, but not all, of the difficulties previously encountered with bilingual positions. The results suggest that a number of features are important to prevent marginalisation and isolation of bilingual staff: the opportunity for staff to meet regularly as a group, support and coordination from an external agency, location in mainstream teams (rather than being seen as additional or project staff) and mixed caseloads comprising clients from the same and other ethnic backgrounds.

The location of bilingual mental health staff in mainstream mental health teams, as opposed to specialist ethnic agencies, has a number of advantages and disadvantages. On the positive side, staff have the benefit of professional supervision, ready access to doctors and other professional staff, the opportunity for specialist training in mental health, and peer support in dealing with difficult mental health issues such as lack of compliance, limited insight and so on, other staff in the services have ready access to information about cultural issues facing some of their clients, and the bilingual staff may enhance the cultural sensitivity of the service as a whole.

On the other hand, the pressure of resources, and focus on individual clinical work limit the amount of community-oriented work which can be done, and, to some extent, also the degree of collaborative work with other staff, and there is always the danger that the 'ethno-specific' focus of the positions will be watered down over time to the point where it becomes completely absent. Mental health staff employed in ethno-specific organisations may be able to avoid some of these difficulties, but would not have access to the support of mental health colleagues. In any case, this is a moot point, because there is virtually no funding available for such positions in Australia, and little prospect of it becoming available.

Despite the success of the program, though, the results raise a number of dilemmas. Outcomes for Australian-born clients matched to a BCM are generally similar as those for other case managers, but for NESB clients, they are better. This suggests that BCM have the most pronounced clinical effect when working with clients from their own ethnic backgrounds, and should target those clients in their work. However, this contradicts another principle of the program, that BCM should have a range of clients so that they do not become marginalised with one ethnic group only.

There is also a trade-off between community work and direct case management. Community work was seen as an important because this has been a noticeable gap for ethnic communities. However the effectiveness of allocating BCM to NESB clients means that there is a temptation to focus the efforts of the BCM on to clinical rather than community work.

It was intended that the BCM would have lower caseloads to enable them to engage in more community work, but this has become progressively more difficult as the caseloads of BCM have increased. As such, the capacity of BCM to conduct community activities is severely curtailed, and unless caseloads decrease, this will continue. On the other hand, services face continuing pressure to allocate case managers to new clients, and without an increase in resources, it is difficult to see this situation improving. Most of the increase in caseloads for the BCM have been Australian-born clients of Anglo-Saxon backgrounds – suggesting that these clients were referred to the BCM due to a general shortage of case management staff.

The lower value placed on community work seems a feature of the mental health system generally, and it is difficult to see this changing, especially given the pressures (political, managerial and ethical) to focus work on the immediate needs of clients with serious mental illness who may be at risk of harming themselves or others. Perhaps the most that could be expected in the long term is that community work remains an aspiration of such positions, but expectations about the amount undertaken remain moderate.

The staff employed represent six of the largest language groups of clients in the Western region: these languages comprise around 53 percent of all clients with a preferred language other than English. As such, they tended to be the longest-established (e.g. Greek, Italian, Croatian and Macedonian), with relatively better English skills than the more newly arrived groups.

The emphasis on the largest groups in each catchment area led to several staff being employed for the largest ethnic groups, but even if each of the eleven staff had been from a different background, many ethnic groups would not benefit from this approach.

There is also a trade-off between direct relevance to catchment area of the language spoken by BCM, versus the desire to cover as many groups as possible. Area managers wish to employ staff who will be able to work with the maximum number of clients within that service's catchment area, not staff who may service a geographically dispersed community with relatively few members in any one service catchment.

However some staff questioned the emphasis on the size of ethnic communities and asked why smaller and more newly arrived communities are not targeted. It could be argued that the need for community work is greater among newer arrivals, and some of the findings also suggest that ethnic matching may be more effective for those with poorer English, more newly arrived, and with a greater cultural distance between their own and Australian culture. These results suggest that future positions should target more newly arrived groups, but such groups tend to be smaller and more geographically dispersed, making it more difficult to employ staff to work with them. There are also likely to be less trained and experienced mental health professionals available for these groups.

If it was desired that the program target a larger range of groups, there are some alternatives. One option would be to nominate bilingual staff as a separate program area, with its own funding, and make a service with a larger geographic focus responsible for this funding. But one of the strengths of the current program seems to be that staff are part of the existing service structure, and not seen as 'attachments' and marginal to the rest of the service.

Another approach would be to make staff available for smaller language groups on a sessional basis to assist with assessments, secondary consultation, and perhaps community work as well. There are a substantial number of bilingual staff currently working in mental health who could be involved in such a program, which would need to be centrally coordinated.

Another strategy could be for services to employ staff for smaller groups and be able to accept clients from outside the catchment area - this would enable those staff to see more than just the few clients from within the catchment area. NESB people are happy to travel some distance to be able to see a GP from their own ethnic background, and it

could be expected that many NESB clients would prefer to see a clinician of the same background, even if it meant travelling some distance. However, some form of client-based funding would need to be implemented to reimburse services for these out-of-area clients – this poses a large difficulty to the establishment of such a system.

LIMITATIONS AND STRENGTHS

As mentioned above, for the studies of outcome, the major drawback of this research was that clients were not randomly allocated to BCM or other staff. This means that a possible reason for the differences in outcomes for between NESB clients matched to a BCM compared to other NESB clients was that the clients themselves differed between these two groups. Although differences on some variables were assessed (such as age, gender, marital status and diagnosis), and did not seem to account for the differences between groups, the effect of other variables not measured cannot be ruled out.

Random allocation of clients was considered at the beginning of the evaluation but proved impossible for several reasons. It may have been possible to randomly allocate new clients of the ethnic backgrounds being considered when they were first referred to the service, but there were very few such clients, and if the evaluation had been restricted to this group, the number of clients included would have been insufficient. Another option was to randomly re-allocate existing clients. However, this would have meant breaking the continuity of care of clients with their existing case managers purely for research purposes. It was believed that continuity of case manager was an important consideration for clients, and that this could not be over-ridden by the needs of the evaluation.

As Cook & Campbell, (1979) have pointed out, this is a common problem in evaluation research. In fact, Sue (2000) stated that he could find no previous studies where ethnic minority clients had been randomly allocated to different types of treatment, suggesting that this difficulty is even more pronounced in the field of ethnic mental health.

Certainly, none of the studies of ethnic matching reviewed for this thesis (Flaskerud & Hu, 1994; Flaskerud & Liu, 1991; Fujino, Okazaki & Young, 1994; Jerrell, 1995;

Jerrell, 1998; Sue, Fujino, Hu et al., 1991; Takeuchi, Sue & Yeh, 1995; Yeh, Eastman & Cheung, 1994; Ying & Hu, 1994) randomly allocated clients.

Another limitation of this research was the small sample sizes for some analyses, and missing data for many clients. Attempts were made to overcome these problems by using non-parametric statistics and hierarchical linear modelling. There is still the danger that the samples included differed from the total client group, although, on the variables measured (such as diagnosis, sex and age) this did not seem to be the case. Again, this seems a common problem in evaluation research (Cook & Campbell, 1979).

It is also possible that the positive results obtained by the BCMs were due to the Hawthorne effect rather than the fact that they were bilingual. That is, the BCM staff may have performed better knowing that they were under scrutiny, and also because the program was new, and the staff enthusiastic and highly motivated. However, this seems unlikely because in two of the studies (service utilisation and social functioning) the impact of matching with a BCM was greater for clients of the same ethnic background than for other clients. If the Hawthorne effect was the only mechanism operating, it would be expected that all clients of the BCM would have better outcomes than clients of other staff, but this was not the case.

In spite of the limitations, this thesis also includes a number of strengths. It includes a broader review of case management effectiveness. This is the most extensive review yet completed: it has substantially extended the findings of the Cochrane reviewers, while at the same time contradicting the negative conclusions about the effectiveness of clinical case management reached by those authors. The examination of both the implementation and outcome of the BCM program enabled conclusions to be drawn both about the design of the program and its 'fit' with the service system, and the effectiveness of matching case managers and clients on the basis of ethnic background. This is the first time in Australia that such research has been conducted.

Although limited by small sample size, the use of both quantitative and qualitative methods to explore client satisfaction resulted in a more complete view of client opinions than the use of either approach by itself. In addition, this research assessed cultural sensitivity from the point of view of clients; this is the first time (to the authors

knowledge) that the validity of concept of cross-cultural sensitivity has been investigated with client using both quantitative and qualitative methods.

The research has also extended previous research on ethnic matching by including client satisfaction as a measure of outcome, and by investigating the impact of ethnic matching on social functioning over an extended period of time. In particular, the analysis of social functioning showed that the impact of ethnic matching may take two years to become apparent – this is a significant result in light of previous research which had concluded that there was no relationship between these.

Finally, four different domains with different sample were used to assess the impact of ethnic matching, and positive results were obtained for each of them. This provides greater confidence in the conclusion that ethnic matching is an effective strategy for improving services to NESB clients.

There are some areas for more research suggested by this thesis. First, it is important that the investigation of client satisfaction and social functioning over two years be replicated elsewhere, as this is the first time that these results have been reported. Second, the importance of ethnic matching for clients should be investigated with greater consideration of client characteristics such as ethnic background, preferred language, English proficiency, degree of acculturation, sense of ethnic identity, and explanatory models of illness. It is possible that the effectiveness of ethnic matching is mediated by some or all of these variables.

CONCLUSION

The BCM program has been successful in improving mental health services for NESB people. Clinical and social outcomes for NESB clients were superior for those who had a case manager of the same ethnic background, and the majority of clients (but not all) express a preference for such staff. The introduction of the BCM program also improved access to, and the cultural sensitivity of, the services overall. The model implemented in the Western Region has managed to overcome some of the difficulties previously encountered with bilingual positions.

These results provide substantial support to the argument that bilingual staff should be employed more widely throughout the mental health system where there are a significant number of NESB clients. However, a range of issues, such as the number and location of positions, language groups to be targeted, service catchment areas and out-of-area clients, and realistic roles of staff, require some attention from central policy makers for such an approach to overcome the limitations inherent in the current service system.

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APPENDICES

APPENDIX I: LIST OF STAFF INTERVIEWED

Bilingual Case Managers

Christine Chiappini
Silvia Collinetti
Susan di Fabio
Thuy Dinh
Hanife Guducu
Vesna Ilijevski
Diana Jurcic
Moisis Moisis
Anh Nguyen
Anh-Thu Nguyen
Quan Nguyen
Trinh Nguyen
Marie Panebianco
Theresa Pagano
Nicki Vlahakis

Supervisors

Kellie Barker
Graeme Barnett
Alice Berliner
Guy Coffey
Bruce Falconer
Robyn Garlick
Brendan O'Hanlon
Jonathan Howes

Continuing Care Team Managers

Trish Altieri
Paul Ferrie
Wendy Fromhold
Andrew McKenzie

Area Managers

Mario Blandin de Chalain
Trish Saunders
Jenny Smith
Les Potter

APPENDIX II: INTERVIEW QUESTIONS FOR STAFF

The questions below were used in interviews with bilingual staff, slight modifications were made to the questions for supervisors and managers but the same general topics were covered.

Goals

What do you see as the aims of the Bilingual Case Management program?
 (Were these goals clear to you when you started? Have your ideas changed)
 What do you think your service sees as the aims of the programs? Are there any differences?

Workload and work arrangements

List of clients for each case manager.
 Need to know COB, languages spoken, ethnic background, parents preferred language, any which are joint case management

Any clients from outside the catchment area of the service you work in?
 How is it decided when you should take on new clients, and who they should be?
 (discuss this with anyone else?)
 How much say do you have about how many clients to take on and which ones? Is this different to other staff?

Roles of BCM

What are the different types of work that you do here as a Bilingual Case Manager?
 (prompts - sole case management, joint case management, family support and education, community education, others)
 Can you tell me more about the community development and other project work (e.g, community forum, media work, translations, staff presentations; why, how much time was involved, other staff, who initiated it?).
 How satisfied are you with the balance between different types of roles (e.g, the amount of time spent on community or family education versus direct case management)
 How much control or say do you have in deciding how much time to put into these different roles?

Clinical issues

How do you see the role of case manager in this service?
 Questions: is case management mostly about coordinating other services or do you see yourself as a service provider as well (continuum between brokerage and clinical case management)
 How often do you see your clients on average. What is the range (i.e. most and least).
 Specialisation - do you do any work based on your professional background rather than as a case manager (e.g, psychological tests, counselling, family therapy, injection clinic);

To what extent do clients have a say in the work you do with them? (e.g, putting together an individual service plan, deciding on treatment)

Where do you generally see clients (at the clinic, at the persons home, other) Estimate of how much in each? When would you see someone at home rather than at the clinic? What would you do if someone did not turn up for an interview with you or a doctor?

Cultural issues

Any differences in the way that you provide case management to your clients of NESB compared to clients of English speaking backgrounds?

Do you think that there are any differences in how case management needs to be done with clients of NESB compared with ESB?

When you conduct a mental state assessment of a client, what cultural factors would you look at?

When you do a service needs assessment with a new client, what cultural factors would you look at? One of the assumptions of this program is that Bilingual Case managers would be knowledgeable about cultural issues of the ethnic groups they work with. Do you feel that this is a realistic expectation. How much do you feel you are able to provide information about cultural issues to other staff.

Diversity within ethnic groups - what differences have an impact on work or relationship (e.g, year of arrival, level of English, acculturation?)

Supervision

What supervision do you receive in your job. (Prompts - How frequently, how long, from who)

What do you see as the purpose of supervision?

What sort of things do you discuss in supervision? (How satisfied, how useful)

Relationships with other staff

How many clients do you have where you are joint case manager?

For these clients, what areas would you work with compared with the other case manager?

Explore nature of joint case management - how they think it works. If no joint cases, why not?

Do you think that other staff in the clinic understand your role as Bilingual Case Manager?

(Any aspects they don't understand, value they hold the position in, use your skills and knowledge effectively?)

Involvement with staff from other teams - CATT, MSTT, inpatient unit, Child and Adolescent, Aged? (Do they know about your position? Should they?)

Organisational issues

Has management done anything to make your work easier or more difficult?

Management refers to the Continuing Care Team manager, managers of other teams and the Area manager.

How would you describe the culture of this service? (E.g, assumptions, values, normal practices.) Does any aspect of the culture affect your work?

Does any aspect of the way the service is set up affect your work (E.g, relationships between CCT, MSTT and CATTs or between professional groups, administrative and clinical management)

Is there anything which you think management could or should do in future to improve the BCM program?

Coordination and support

How would you describe the role of the VTPU and Yvonne (EMHC) in the BCM program?

What have been the most useful aspects of the meetings at the VTPU for you? What have been the least useful aspects?

What would you like to see done at these sessions in future? How often to meet?

Is there anything else you would like to see the VTPU to do in order to support you in your role?

Personal details

Country of birth?

If born overseas, when did you migrate to Australia?

How old were you then?

Age now

First language? Other languages?

Ethnic background? Parents COB

Qualifications and where obtained?

When did you start in this position?

Experience in mental health before this position?

Experience in other areas of health/ welfare?

Other

What do you find the most satisfying part of your work?

What is the least satisfying part of your work?

What are your own goals in this position? What would you like to do in this position in future? How does this match with you won personal career goals (e.g, promotion, specialisation, education etc).

Have you been to any training sessions since starting this job. Which ones, how long?

Do you think you need to have more training in any aspects of your work?

Are there any changes you would like to see made to any aspect of the BCM program in future?

Is there anything you would like to say about the position which we haven't covered in this interview so far? If you think of anything, you can contact me at the VTPU.

APPENDIX III: NUD*IST CODING CATEGORIES FOR INTERVIEWS

- (1) /Program design**
- (1 1) /Program design/Languages
 - (1 2) /Program design/Ethno-general
 - (1 3) /Program design/Cross-area work
 - (1 5) /Program design/Goals
 - (1 5 1) /Program design/Goals/Own views
 - (1 5 2) /Program design/Goals/Others
 - (1 6) /Program design/Future changes
- (2) /BCM Staff**
- (2 1) /BCM Staff/Supervision
 - (2 2) /BCM Staff/Training
 - (2 3) /BCM Staff/Previous experience
 - (2 4) /BCM Staff/Roles
 - (2 4 1) /BCM Staff/Roles/Sole CM
 - (2 4 2) /BCM Staff/Roles/Joint CM
 - (2 4 3) /BCM Staff/Roles/Consultation
 - (2 4 4) /BCM Staff/Roles/Community development
 - (2 4 5) /BCM Staff/Roles/Staff development
 - (2 4 6) /BCM Staff/Roles/Interpreting
 - (2 7) /BCM Staff/Others attitudes
 - (2 7 1) /BCM Staff/Others attitudes/Positive
 - (2 7 2) /BCM Staff/Others attitudes/Negative
 - (2 8) /BCM Staff/Own attitudes
 - (2 8 1) /BCM Staff/Own attitudes/Positive
 - (2 8 2) /BCM Staff/Own attitudes/Negative
 - (2 9) /BCM Staff/Personal goals
- (3) /Organisational**
- (3 1) /Organisational/Management
 - (3 2) /Organisational/Role of VTPU
 - (3 3) /Organisational/Structure
 - (3 4) /Organisational/Culture
 - (3 5) /Organisational/Relationships
 - (3 6) /Organisational/Effects
 - (3 6 1) /Organisational/Effects/Access
 - (3 6 2) /Organisational/Effects/Other effects
- (4) /Clinical**
- (4 1) /Clinical/Case management
 - (4 2) /Clinical/Caseload
 - (4 2 1) /Clinical/Caseload/Size
 - (4 2 2) /Clinical/Caseload/Composition

- (4 2 3) /Clinical/Caseload/Allocation
- (4 3) /Clinical/Specialisation
- (4 4) /Clinical/Assessment
- (4 4 1) /Clinical/Assessment/MSE
- (4 4 2) /Clinical/Assessment/Needs for service

- (5) /Cultural issues**
- (5 1) /Cultural issues/Ethnic ID
- (5 2) /Cultural issues/BCM knowledge
- (5 4) /Cultural issues/General
- (5 5) /Cultural issues/Relationship

- (6) /Base data**
- (6 1) /Base data/Discipline
- (6 1 1) /Base data/Discipline/Social work
- (6 1 2) /Base data/Discipline/Nursing
- (6 1 3) /Base data/Discipline/Psychology
- (6 1 4) /Base data/Discipline/OT

- (6 2) /Base data/Service
- (6 2 1) /Base data/Service/South West
- (6 2 2) /Base data/Service/Mid West
- (6 2 3) /Base data/Service/Inner West
- (6 2 4) /Base data/Service/North West
- (6 2 5) /Base data/Service/Broadmeadows
- (6 3) /Base data/Gender
- (6 3 1) /Base data/Gender/Male
- (6 3 2) /Base data/Gender/Female
- (6 4) /Base data/Language
- (6 4 1) /Base data/Language/Vietnamese
- (6 4 2) /Base data/Language/Greek
- (6 4 3) /Base data/Language/Italian
- (6 4 4) /Base data/Language/Croatian
- (6 4 5) /Base data/Language/Macedonian
- (6 4 6) /Base data/Language/Turkish
- (6 5) /Base data/Interviewer
- (6 5 1) /Base data/Interviewer/SZ
- (6 5 2) /Base data/Interviewer/JP
- (6 6) /Base data/Birthplace
- (6 6 1) /Base data/Birthplace/Australia
- (6 6 2) /Base data/Birthplace/Overseas
- (6 7) /Base data/Position
- (6 7 1) /Base data/Position/Bilingual case manager
- (6 7 2) /Base data/Position/Supervisor
- (6 7 3) /Base data/Position/CCT Manager
- (6 7 4) /Base data/Position/Area Manager

APPENDIX IV: POSITION DESCRIPTION (SAMPLE)

WESTERN HEALTH CARE NETWORK ADULT, CHILD AND ADOLESCENT MENTAL HEALTH PROGRAM NORTH WEST AREA MENTAL HEALTH SERVICE

POSITION DESCRIPTION

Title:	<i>Bilingual Case Manager North West Area Mental Health Service</i>
Contact for Applicants:	<i>Paul Ferrie, Manager, Continuing Care Service (ph: 9387 4955)</i>
Salary:	<i>As per award.</i>

1.0 INTRODUCTION

The North West Area Mental Health Service forms part of the Western Health Care Network Adult, Child and Adolescent Mental Health Program. It provides a comprehensive range of psychiatric service to those who reside in the local government areas of Moreland and Hume. The position of Bilingual Case Manager for the North West Continuing Care Service will undertake a range of duties, including intake/assessment and case management with a focus on one of Arabic or Italian, clients of the service. They will also consult and liaise with other agencies and community groups, especially those associated with the provision of services to clients from Arabic or Italian backgrounds. In addition, the worker will be involved in focussed educational and community development activities for the service.

The position is one of ten positions being established as part of the Bilingual Case Management Project - a joint initiative of the Western Health Care Network and the Victorian Transcultural Psychiatry Unit (VTPU). The VTPU has an ongoing role in the development, coordination and evaluation of the project. The position is based at North West Continuing Care Service, which has its main office in Brunswick, and will work with clients who are residents in the local government areas of Moreland and Hume. The population has many interesting characteristics, including a diversity of cultural groups, socio-economic categories and environments.

Psychiatric services to residents residing in the North West Area include the Crisis Assessment and Treatment Team, the Mobile Support and Treatment Team, the Continuing Care Team, the Inpatient Unit at Royal Park Psychiatric Hospital. These services provide a range of acute, continuing care and rehabilitation service relating to psychiatric assessment and treatment of severe psychiatric disorder. The effective delivery of high quality psychiatric services requires a high level of consultation and liaison between the component services of the North West Area Mental Health Service and with a wide range of community services and agencies.

2.0 MAJOR RESPONSIBILITIES

2.1 Undertake complex casework with a range of clients, with a focus on clients from either an Arabic or Italian background.

2.2 Provide joint case management, with other mental health staff from the Area Mental Health Service, to clients from an Arabic or Italian background.

2.3 Provide consultation to professional staff from the Area Mental Health Service and the Western Health Care Network on matters related to the provision of services to clients from an Arabic or Italian background.

2.4 As a member of the multidisciplinary team provide input to the development, implementation and review of services.

2.5 Consult and liaise with other mental health programs of the Western Health Care Network and other agencies and community groups, especially those associated with the provision of services to clients from Arabic or Italian backgrounds.

2.6 Contribute to the training and supervision of staff and students as appropriate.

2.7 Assist in the administration of functions related to the provision of professional services.

2.8 Participate in evaluation activities as required.

3.0 QUALIFICATIONS

3.1 Preferred qualifications include:

- ◆ Nurse: Registered as a Nurse with the Nurses Board of Victoria in Division 1 with approved Post Graduate Qualifications in Psychiatric Nursing or registered as a Psychiatric Nurse with the Nurses Board of Victoria in Division 3;
- ◆ Occupational Therapist: Approved Degree from a recognised school of Occupational Therapy or other qualifications approved for membership of the Australian Association of Occupational Therapy (Vic);
- ◆ Social Worker: Approved degree in Social Work, or other qualifications approved for membership of the Australian Association of Social Workers;
- ◆ Psychologist: Eligible for registration with the Psychologists' Registration Board of Victoria. Approved post-graduate qualification in Clinical Psychology and/or membership of the College of Clinical Psychologists (Australian Psychological Society)

3.2 Applicants with qualifications and experience in a related area may be considered.

4.0 REPORTING RELATIONSHIPS

4.1 The Bilingual Case Manager is responsible to the Manager, North West Continuing Care Service.

5.0 MINIMUM REQUIREMENTS

5.1 Post graduate experience in social work, psychology, psychiatric nursing or occupational therapy in a psychiatric service within a community-based setting and a capacity to deal appropriately with crisis situations.

5.2 Fluency in either Arabic or Italian, and a knowledge of Arabic or Italian culture.

5.3 Sound knowledge of the Mental Health Act, and other relevant legislation, policy and strategic directions in psychiatric services.

5.4 Sound communication and interpersonal skills, and experience in consultation and community development activities.

5.5 Demonstrated ability to provide a full range of professional services and participate in program implementation and review.

5.6 Ability to function independently, and as part of a multi-disciplinary team.

5.7 A commitment to on-going professional development.

5.8 Current Victorian driver's licence is required.

6.0 OTHER HELPFUL SKILLS, KNOWLEDGE AND EXPERIENCE

6.1 Ability to provide input to the policy and program development functions of the service.

6.2 Ability to work with clients from a range of ethnic backgrounds.

7.0 OTHER RELEVANT INFORMATION

7.1 Out of hours work may be required.

7.2 Occupant may be required to travel between or work from any of the North West offices.

7.3 The tasks, roles and responsibilities of the position will be reviewed after a period of six months.

APPENDIX V: ADDITIONAL PRISM CODES

Sub. Codes at each clinic for Bilingual Case Management Staff

South West AMHS: **Sub. Code 07**

Mid West AMHS: **Sub. Code 08**

Inner West AMHS: **Use individual staff Sub. Code**

North West AMHS: **Sub. Code 05**

Broadmeadows MHT: **Sub. Code 05**

Field 10. Type of contact for bilingual case managers

Primary consultation

Sole case management

Joint case management

Secondary consultation: cultural issues

Secondary consultation: mental health

Community education: cultural issues

Community education: mental health

Field 11. Team from which service was provided

1. CCT
2. CATT
3. MSTT
4. Inpatient
5. Other

Explanation of categories

Field 10. Type of contact for bilingual case managers

1. Primary consultation

Primary consultation refers to a direct contact (face-to-face or phone) with a client who you are not the case manager for. It includes participation in assessment interviews (e.g. with the CATT or duty worker) and direct phone calls from new or existing clients. If the person is an existing client, they would be recorded as 'Type A Registered Client' with their UR number. If the person is new to the service, they would be recorded as 'Type B Unregistered Client'. If they are not registered at your own AMHS they would also be recorded as an 'Unregistered Client'.

2. Sole case management

This category applies to contacts with registered clients who you are the sole case manager for. Record PRISM data as usual, but in addition, in Field 10, write in '2' indicating sole case management.

3. Joint case management

This category refers to contacts with clients where you have an ongoing role as joint case manager with another staff member from your AMHS. The client type would be 'A Registered Client' and the person's UR number entered. If both staff see the client at the same time, the bilingual case manager should complete the contact record for that contact.

4. Secondary consultation: cultural issues

This category refers to contact with another staff member, either from your own service or any other service, about cultural issues for a specific client, when the client is not present. The client type should be recorded as 'Type B, Unregistered Client', regardless of whether they are registered at your own AMHS or not.

5. Secondary consultation: mental health

This refers to a contact with a worker outside the mental health service who wishes to discuss possible psychiatric issues for a client. The client type should be recorded as 'Type B, Unregistered Client', regardless of whether they are registered at your own AMHS or not.

6. Community education: cultural issues

This category should be used for educational activities about cultural issues for a group of staff or an agency, including staff at your own service. The client type would be 'C Community centred service'. This would not be used if the activity is concerning a specific client - in this case 'secondary consultation: cultural issues' should be used, and the client listed as 'B Unregistered client'.

7. Community education: mental health

This category should be used for educational activities about psychiatric conditions or mental health services for a group or an agency. The client type would be 'C Community centred service'. This would not be used if the activity is concerning a specific client - in this case 'secondary consultation: mental health' should be used, and the client listed as 'B Unregistered client'.

Field 11. Team from which service was provided

Field 11 records the team which the bilingual case manager was working from when the contact occurred. Most sole and joint case management will occur from the CCT, as this is where the bilingual case managers are based. For example, assessments done with CATTs would be recorded as '2 (CATT)'. A primary consultation conducted at an inpatient unit would be recorded as '4 (Inpatient)', unless the person is a client of the bilingual case manager, in which case this would be recorded as '1 (CCT)' as this is seen as part of the normal role of case managers in the CCT.

APPENDIX VI: CROSS-CULTURAL CLIENT SATISFACTION QUESTIONNAIRE

CROSS-CULTURAL CLIENT SATISFACTION QUESTIONNAIRE

S Zигuras, Y Stolk and S Klimidis

<i>Client's preferred language</i>	<i>Interviewer</i>
<i>UR Number</i>	<i>Date</i>/...../.....

Instructions for interviewers

Please ask the questions as written, and try to record answers as accurately as possible in the space provided. Where an answer is not clear, or you think that the client has something more to say, you may ask further questions. Some further questions are suggested in italics.

If you believe the client is having great difficulty in understanding the questions, or in answering them, and you feel that the information being provided is not very useful, consider ending the interview. This may also be the case if the client is very agitated, distracted or upset. If you decide to end the interview early, say something like:

'These questions seem to be difficult for you to answer at the moment. If it's alright with you, I would like to stop here, and perhaps we can go over the other questions at another time.'

Even if you end the interview early, clients will still receive the \$20 as promised.

For each interview, please check that you have completed:

- \$20 given to client
- Client has signed the receipt
- Information on cover sheet (this page)
- Answers to open-ended questions recorded in English
- Scale questions completed
- Interviewers impressions on last page completed after interview

Introduction for clients

As the staff have explained to you, I am from the Victorian Transcultural Psychiatry Unit, which is doing this study with the University of Melbourne.

We are interviewing people who use mental health services to find out what they think of the service they go to. The questions I am going ask you are about the (*name of service*); and about what you think about that service and how the staff understand your cultural background.

Your opinion about these services is very important for us to know because it can help to improve services in the future.

Your participation in this survey is **voluntary**. You only need to answer these questions if you want to, and you can stop at any time - just let me know if you want to stop. You can also choose not to answer any questions you don't want to.

Your responses are **confidential**. We are interviewing around 100 people and the answers from all of these will be combined in our report, but nothing you say will be identified with you personally. (For example, we might say that one person said this, or that most people thought something.) Your name will not be in the report.

We are giving everyone \$20 to cover the cost of doing the interview.

Do you have any questions before I start the interview? Yes No

(If yes, record questions and answers)

Is it all right if I go ahead with the interview? Yes No

Section A. ABOUT YOU

Firstly, I need to ask a few questions about you. This is so we can see whether a wide range of people have given their views about the service.

1. What country were you born in? _____
2. What language do you prefer to speak at the clinic?

3. What language do you speak at home? _____
4. Gender (*Please tick box*) *Male* *Female*
 1 *2*
5. What year did you arrive in Australia?

6. What year were you born in? _____

Section B. ABOUT(name of Mental Health Service)

The following questions ask about the(name of service) and the services you have received here.

7. How long have you been going to this clinic? _____

8. How often do you go? _____

9. What happens when you go to the clinic?

10. Do you see a doctor when you go to the clinic? Yes No
 Don't know

11. Who is your doctor? _____

12. What does the doctor do for you?

13. How satisfied are you with your doctor (for example, with his or her attitude towards you)? Are you:

For interviewers: *For satisfaction questions, first ask, Are you generally satisfied, generally dissatisfied or neither?, and tick the relevant box. If satisfied, then ask: Are you very satisfied or a little satisfied? Similarly, if dissatisfied, then ask: Are you very dissatisfied or a little dissatisfied?*

If someone does not wish to state whether they are 'very satisfied (or dissatisfied)' or a 'little satisfied (or dissatisfied)', tick 'not further stated'.

Generally satisfied,	<input type="checkbox"/>	Are you very satisfied,	or a little satisfied?	Not further stated
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally dissatisfied,	<input type="checkbox"/>	Are you very dissatisfied,	or a little dissatisfied?	Not further stated
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
or neither	<input type="checkbox"/>			
Don't know	<input type="checkbox"/>			

14. Do you see a case manager when you go to the clinic? Yes No Don't know

(If person asks what a case manager is, answer 'the worker who is your main contact person at the clinic who you can talk to and who tries to help you with any problems').

15. Who is your case manager? _____

16. What does the case manager do for you?

17. How satisfied are you with your case manager (for example, with his or her attitude towards you)? Are you:

<i>Generally satisfied,</i>	<input type="checkbox"/> ...	<i>Are you very satisfied,</i>	<i>or a little satisfied?</i>	<i>Not further stated</i>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Generally dissatisfied,</i>	<input type="checkbox"/> ...	<i>Are you very dissatisfied,</i>	<i>or a little dissatisfied?</i>	<i>Not further stated</i>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>or neither</i>	<input type="checkbox"/>			
<i>Don't know</i>	<input type="checkbox"/>			

18. Are there other staff who you see who help you? Yes No Don't know

19. Who are they? _____

20. How do they help?

Section C. SATISFACTION WITH SERVICES

Now, I would like to ask you a few questions about how satisfied you are with the help you get at this clinic.

21. How satisfied are you with how quickly you have got help from this service when you have needed it? Are you:

<i>Generally satisfied,</i>	<input type="checkbox"/> ...	<i>Are you very satisfied,</i>	<input type="checkbox"/>	<i>or a little satisfied?</i>	<input type="checkbox"/>	<i>Not further stated</i>
<i>Generally dissatisfied, or neither</i>	<input type="checkbox"/> ...	<i>Are you very dissatisfied,</i>	<input type="checkbox"/>	<i>or a little dissatisfied?</i>	<input type="checkbox"/>	<i>Not further stated</i>
<i>Don't know</i>	<input type="checkbox"/>					

(Comments)

22. How satisfied are you with the **treatment** you have received for your condition from this service? Are you:

<i>Generally satisfied,</i>	<input type="checkbox"/> ...	<i>Are you very satisfied,</i>	<input type="checkbox"/>	<i>or a little satisfied?</i>	<input type="checkbox"/>	<i>Not further stated</i>
<i>Generally dissatisfied, or neither</i>	<input type="checkbox"/> ...	<i>Are you very dissatisfied,</i>	<input type="checkbox"/>	<i>or a little dissatisfied?</i>	<input type="checkbox"/>	<i>Not further stated</i>
<i>Don't know</i>	<input type="checkbox"/>					

(Comments)

23. So, overall, how satisfied are you with the help you have received from this service? Are you:

<i>Generally satisfied,</i>	<input type="checkbox"/> ...	<i>Are you very satisfied,</i>	<i>or a little satisfied?</i>	<i>Not further stated</i>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Generally dissatisfied,</i>	<input type="checkbox"/> ...	<i>Are you very dissatisfied,</i>	<i>or a little dissatisfied?</i>	<i>Not further stated</i>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>or neither</i>	<input type="checkbox"/>			
<i>Don't know</i>	<input type="checkbox"/>			

(Comments)

Section D: ABOUT CULTURE

Now, I would like to ask you a few questions about your culture and your experience in migrating and settling in Australia. The reason for asking these questions is that we are interested in how well staff have understood your background and culture.

Settlement

24. What were the good things about coming to Australia as a migrant? What were the difficulties?

25. So, are these still the same or have they changed? What is it like now?

26. Do you think that staff should understand the experiences you went through when you migrated and settled here?

Yes No Don't know No answer

27.	How much understanding do staff have of what it was like for you to settle in this country?	<i>None at all</i>	<i>A little</i>	<i>Quite a bit</i>	<i>A lot</i>	<i>Don't know</i>
		<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>9</i>

28. Have there been any times when you thought that staff at this clinic do not understand what it is like to have been a migrant?

Yes No Don't know No answer

29. If YES to Q. 28, Can you tell me about this?

30. So, how satisfied are you with the understanding that staff have of what it was like for you to settle in this country?

<i>Generally satisfied,</i>	<input type="checkbox"/> ...	<i>Are you very satisfied,</i>	<i>or a little satisfied?</i>	<i>Not further stated</i>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Generally dissatisfied,</i>	<input type="checkbox"/> ...	<i>Are you very dissatisfied,</i>	<i>or a little dissatisfied?</i>	<i>Not further stated</i>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>or neither</i>	<input type="checkbox"/>			
<i>Don't know</i>	<input type="checkbox"/>			

Now I would like to ask you a couple of questions about culture. By culture, I mean the things like, the sort of food you generally eat, what you believe in, which language you mostly use, what sort of music you listen to.

31.	Thinking about those things I have mentioned, how much have you taken up Australian ways of doing things?	<i>Not at all</i>	<i>A little bit</i>	<i>Quite a bit</i>	<i>A lot</i>	<i>Don't know</i>
		<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>9</i>

32.	Again, thinking about the things I have mentioned, how much do you keep _____ ways of doing things?	<i>Not at all</i>	<i>A little bit</i>	<i>Quite a bit</i>	<i>A lot</i>	<i>Don't know</i>
		<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>9</i>

(Comments)

English proficiency

I'd like to ask you a few questions about your English and how easy or difficult it is to talk with staff.

33.	In general, how well would you say that you speak English?	<i>Not at all</i>	<i>Not well</i>	<i>Well</i>	<i>Very well</i>	<i>Don't know</i>
		1	2	3	4	9

34.	How hard is it for you to understand the staff when they speak to you in English?	<i>Very hard</i>	<i>Quite hard</i>	<i>A little bit hard</i>	<i>Not at all hard</i>	<i>Don't know</i>
		1	2	3	4	9

35. When the staff speak to you in English are there any things you do not understand because of your English?

Yes No Don't know No answer

36. If YES to Q. 35: Can you tell me about these?

37.	How hard is it for you to say what you want to say in English?	<i>Very hard</i>	<i>Quite hard</i>	<i>A little bit hard</i>	<i>Not at all hard</i>	<i>Don't know</i>
		1	2	3	4	9

38. Are there any things you find hard to say in English compared to your first language?

Yes No Don't know No answer

39. If YES to Q. 38: Can you tell me about these?

Interpreters

I would like to ask you some questions about interpreters.

40.	How often do you need an interpreter when you talk with staff?	<i>Never</i>	<i>Only sometime</i>	<i>Quite often</i>	<i>Always</i>	<i>Don't know</i>
		<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>9</i>

41.	How often is an interpreter present when you talk with staff?	<i>Never</i>	<i>Only sometime</i>	<i>Quite often</i>	<i>Always</i>	<i>Don't know</i>
		<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>9</i>

42. Have you ever had an interpreter when you were talking to staff at the clinic?

Yes No Don't know No answer

If NO to Q. 42, go to the next section on 'Staff' on p. 14

43. If YES to Q. 42: What are your feelings about having an interpreter in the room when you see staff at the clinic?

44. Sometimes people worry that interpreters talk about them in their own community. Have you ever worried about this?

Yes No Don't know No answer

If NO to Q. 44, go to the section on 'Staff' on p. 14

45. If YES to Q. 44: Can you tell me a bit about this?

46. Have you talked about these concerns with any of the staff?

Yes No Don't know No answer

47. **If YES to Q. 46:** What did you talk about? How do you feel about this now?

Staff

48. We spoke earlier about case managers (*'the worker who is your main contact person at the clinic who you can talk to and who tries to help you with any problems'*). If you had the choice, would you prefer to see a (*ethnic background of client*) case manager or someone who is not (*ethnic background of client*)?

- (*ethnic background of client*) Not (*ethnic background of client*)
Doesn't matter Don't know

49. Is your case manager (*ethnic background of client*) at the moment? Yes No

50. What is(would be) good about having a (*ethnic background of client*) case manager?

51. What are(would be) the disadvantages of having a (*ethnic background of client*) case manager?

52. What is(would be) good about having a case manager who is not (*ethnic background of client*)?

53. What are(would be) the disadvantages of having a case manager who is not (*ethnic background of client*)?

Religion

54. Can I ask you a couple of questions about your spiritual beliefs? Yes No

If NO to Q. 54, go to next section on 'Family' on p. 16

55. If YES to Q. 54: How important are religious or spiritual beliefs to you?

<i>Not at all important</i>	<i>Fairly important</i>	<i>Very important</i>	<i>Don't know</i>
1	2	4	9

If Not at all important to Q 55, go to next section on 'Family' on p. 16

56. Do you think that staff at the clinic need to know about your spiritual beliefs and take them into account when they are trying to help you?

Yes No Don't know No answer

If NO to Q. 56, go to next section on 'Family' on p. 16

57. How satisfied are you with the understanding that staff have of your spiritual beliefs? Are you:

<i>Generally satisfied,</i>	<input type="checkbox"/> ...	<i>Are you very satisfied,</i>	<i>or a little satisfied?</i>	<i>Not further stated</i>
<i>Generally dissatisfied,</i>	<input type="checkbox"/> ...	<i>dissatisfied, <input type="checkbox"/></i>	<i>dissatisfied? <input type="checkbox"/></i>	<i>Not further stated <input type="checkbox"/></i>
<i>or neither</i>	<input type="checkbox"/>			
<i>Don't know</i>	<input type="checkbox"/>			

58. Has there been any time when staff at this clinic have not understood a spiritual belief or practice which was very important for you? (For example, praying at certain times of the day, fasting, eating only certain types of food, getting help from a spiritual healer).

Yes No Don't know No answer

59. If YES to Q. 58: Can you tell me about that?

Break -ask the client if they would like a break for a couple of minutes.

Family

I would like to ask you a few questions about your family.

60. Do you have any family members in Melbourne? Yes No

If NO to Q 60, go to next section on 'Information' on p. 18

61. Do you have any contact with your family in Melbourne? Yes No

If NO to Q. 61, go to next section on 'Information' on p. 18

62. Do you live with any of your family? Yes No

63. If YES to Q. 62: Which family members do you live with?

64.	How important is it for you for staff to include your family in your treatment?	<i>Not at all important</i>	<i>A little important</i>	<i>Quite important</i>	<i>Very important</i>	<i>Don't know</i>
		<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>9</i>

65.	How much have the staff involved your family in your treatment?	<i>Not at all</i>	<i>A little</i>	<i>Quite a bit</i>	<i>A lot</i>	<i>Don't know</i>
		<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>9</i>

66. Would you like your family to be more involved?

Yes No Don't know No answer

If NO to Q. 66, go to Q. 69

67. **If YES to Q. 66:** Who in your family would you like to be involved?

68. In what way? (*Probes: for example, to come to the clinic with you? To talk to the doctor or case manager? To keep track of your medication?*) then go to **Q. 71**

69. **If NO to Q. 66:** Would you like your family to be less involved?

Yes No Don't know No answer

70. **If YES to Q 69:** In what way? (*Probes: for example not to come to the clinic with you? Not to talk to the doctor or case manager? Not to keep track of your medication*)

71. So, how satisfied are you with how much the staff have included your family in your treatment?

Generally satisfied,	<input type="checkbox"/> ...	Are you very satisfied,	or a little satisfied?	Not further stated
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally dissatisfied,	<input type="checkbox"/> ...	Are you very dissatisfied,	or a little dissatisfied?	Not further stated
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
or neither	<input type="checkbox"/>			
Don't know	<input type="checkbox"/>			

Information

Have you been given information about any of the following things:

72. Your diagnosis? No Yes
If YES, was this written or by talking to staff? Which language was it in?

73. What about medication? No Yes
If YES, was this written or by talking to staff? Which language was it in?

74. Other services which may help you? No Yes
If YES, was this written or by talking to staff? Which language was it in?

75. Your rights? No Yes
If YES, was this written or by talking to staff? Which language was it in?

76. Is there anything which you want more information about? Yes No

77. If YES to Q. 76: What do you want information about?

For interviewers: *If the client asks if you could get them information, or whether you could ask there case manager for information, suggest that they approach their case managers themselves because you are not allowed to pass on any information about this interview to staff.*

78. How satisfied are you with the **information** that has been given to you at the clinic? Are you:

Generally satisfied,	<input type="checkbox"/>	Are you very satisfied,	or a little satisfied?	Not further stated
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally dissatisfied,	<input type="checkbox"/>	Are you very dissatisfied,	or a little dissatisfied?	Not further stated
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
or neither	<input type="checkbox"/>			
Don't know	<input type="checkbox"/>			

General

We are almost finished, I've just got a few general questions to go.

79.	First, thinking about all the things which we have talked about, how important is it to you that staff respect your language and culture?	<i>Not at all important</i>	<i>A little important</i>	<i>Quite important</i>	<i>Very important</i>	<i>Don't know</i>
		1	2	3	4	9

80.	So, overall, how much respect do you think that staff show for your language and culture?	<i>None</i>	<i>A little bit</i>	<i>Quite a bit</i>	<i>A lot</i>	<i>Don't know</i>
		1	2	3	4	9

81. What are the best or most helpful things about this service? (*Probe - if response is 'they help me', ask how do they help? What do they do which helps you?*)

82. In your experience, what are the worst or least helpful things about this service?

83. Is there anything else that you think might help you with your problems?

No Yes

84. **If Yes to Q. 83:** What do you think could help?

85. Is there anything else you would like to add? How do you feel after talking about these things?

Thank you for your help. I appreciate you giving me your time, and the things you have had to say are very important for us to know about.

For interviewers: Please turn over.

For interviewers:

Pay client \$20 and ask them to sign the slip stating that they have received the money.

After you have finished interview please complete Q. 86-88:

86.	What is your impression of the client's general attitude to the service?	<i>Very positive</i>	<i>Fairly positive</i>	<i>Neutral</i>	<i>Fairly negative</i>	<i>Very negative</i>
		<i>5</i>	<i>4</i>	<i>3</i>	<i>2</i>	<i>1</i>

87.	What is your impression of how well the client was able to understand the questions?	<i>No difficulty in understanding</i>	<i>Some difficulty in understanding</i>	<i>Great difficulty in understanding</i>
		<i>1</i>	<i>2</i>	<i>3</i>

88. Any comments or remarks about the interview?

Please check the list on the front page before finishing.

APPENDIX VII: CLIENT INFORMATION**VICTORIAN TRANSCULTURAL PSYCHIATRY UNIT****INFORMATION FOR CLIENTS****CROSS-CULTURAL CLIENT SATISFACTION PROJECT**

The University of Melbourne and the Victorian Transcultural Psychiatry Unit are conducting a study to look at the care provided by community mental health centres. The study will look at the satisfaction of clients with the services they receive and how well the staff understand client's backgrounds.

If you agree to be part of the study, you will be interviewed about your satisfaction with the service you receive. The interview will be about 60 minutes long, and will be conducted in your preferred language. The interviews will be done by a researcher who is not employed at this centre, and anything you have to say about the clinic or the service will not be passed on to staff unless you want it to be.

Information provided by clients, is completely confidential and it will not be used to identify the person who provided it. Everyone who is interviewed will receive \$20 to cover any expenses for doing the interview.

There is no obligation to participate in this research. You will continue to be eligible for treatment and help from this clinic whether you decide to be involved or not. You can also ask for any information provided to be withdrawn. If you would like more information about the project or would like to discuss any aspect of the research, please feel free to contact Stephen Ziguras at the Victorian Transcultural Psychiatry Unit, ph: 9411 0311.

Mr. Stephen Ziguras, Victorian Transcultural Psychiatry Unit

A/Prof Alun Jackson, School of Social Work, University of Melbourne

Dr. Geoff Stuart, Centre for Cultural Studies in Health, Department of Psychiatry, University of Melbourne

APPENDIX VIII: CLIENT CONSENT FORM

VICTORIAN TRANSCULTURAL PSYCHIATRY UNIT

CLIENT CONSENT FORM

CROSS-CULTURAL CLIENT SATISFACTION PROJECT

I, _____ (name)

have been fully informed about the purpose of this study. I have been advised that all information will be completely confidential and I have been informed that I may withdraw from the study at any time.

Please tick the boxes and sign

I agree to be interviewed

I agree that general information about my background can be used in this study, but this does not include my name or other identifying information

Signature _____ Date _____

Address: _____

Phone: _____

Please return to:

**Stephen Ziguras
Victorian Transcultural Psychiatry Unit
St. Vincent's Hospital
41 Victoria Pde.
Fitzroy 3065**



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Author/s:

ZIGURAS, STEPHEN

Title:

Evaluation of the Bilingual Case Management Program in community mental health services in Melbourne

Date:

2001-06

Citation:

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