The Culture-Oriented Mental Health Practice of Bicultural Professionals:

A Grounded Theory Study

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Statement of Authorship

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis accepted for the award of any other degree or diploma.

No other person's work has been used without due acknowledgment in the main text of the thesis.

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Victorian Transcultural Mental Health. (2016). *Responding to diversity: An evaluation of VTMH programs and services, 2013–2015* [Report]. Fitzroy, VIC: Victorian Transcultural Mental Health https://vtmh.org.au/wp-content/uploads/2008/01/VTMHEvaluationReportFinalDIGITAL.pdf

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Abbreviations

ABS	Australian Bureau of Statistics
AG	Australian Government
CALD	culturally and linguistically diverse
LOTE	language other than English
MH-AOD	mental health, alcohol and other drugs
PeMH/EI	people or person experiencing mental health or emotional issues
VG	Victoria State Government

Thesis Abstract

Background: Information about cultural practitioners in mental health tends to be high level and generic in Australian diversity policies and frameworks. In Victoria, their work is rarely acknowledged.

Aim: The Study enquired directly of professionals who assist people experiencing mental health or emotional issues with whom they share a similar cultural, linguistic or faith background, or recent migration or refugee stories, in order to characterise these individuals and their work, explore their perspectives, and develop theory that explains their practice. The data were generated during 2015 and 2017.

Methodology: This qualitatively-led mixed method study used a constructivist grounded theory methodology. 44 individuals completed an online survey and 19 of this group were interviewed. The analysis was iterative and used constant comparison.

Findings: Professionals were diverse in their countries of birth, ancestries and languages spoken, and most were born overseas. Nearly all held health, psychology of welfare qualifications, although this did not always confer status. Three cultural responsiveness principles were especially important to their practice approach: acknowledging cultural diversity, offering marginalised communities spaces of sanctuary, and utilising cultural perspectives. Speaking a shared language could enrich interpersonal encounters with service users and enhance community engagement. Several participants described feeling excluded at work or experiencing racism from colleagues and service users.

Theory: The culture-oriented practices of bicultural professionals arise out of dynamic interactions between being free to act on the responsibilities they feel toward others, the values of local service settings, and the recognition and regard of others. Their practices are principled, interactional, embodied and performed. These professionals are also reflective; their marginal position affords them critical views on service delivery and discourses about cultural responsiveness and bicultural professionals.

Conclusion: Study findings offer a deeper understanding of these professionals and the conditions that enable and hinder the acknowledgement and development of this workforce.

Chapter 1 Introduction

Introduction

This chapter introduces the central issue investigated in this research; the work undertaken by bicultural and bilingual professionals in mental health and health systems to assist people who are of similar backgrounds, language, faith or culture to them or who like them have a personal or family story of recent migration. Initially I set the scene by providing an overview of migrant and refugee mental health in Australia and the inequitable access to mental health care these populations experience. I then discuss bicultural professionals in the context of workforce diversity and describe some of the approaches they take to working with people of culturally and linguistically diverse backgrounds. My motivations for this research are presented and I conclude with the aims of the Study.

Mental health services and cultural diversity

Mental health issues among migrant and refugee populations

Australia is becoming increasingly culturally and linguistically diverse. Victoria's population is nearing 6 million and is growing at a faster rate than the national average. At the 2016 Census, more than 28 per cent of Victoria's population was born overseas, almost half (49.1%) were either born overseas of have a parent who was, 26 per cent spoke a language other than English at home (Victoria State Government (VG), 2020a). Australia has adopted a multicultural citizenship model where multiple ethnocultural communities exist within a single society.

The stresses associated with migration may make people more susceptible to mental health and emotional issues, including adjustment disorders, psychoses or major mood disorders, (Johnstone & Boyle, 2018, p. 129). For example, several decades of research in the UK has consistently found higher rates of diagnoses of "psychoses [in] people who are themselves or whose families were immigrants to Western countries" (Johnstone & Boyle, 2018, p. 129). A recent Australian report notes that people of refugee background have higher rates of mental ill-health, post-traumatic stress, depression and anxiety compared with individuals born in Australia (Australian Institute of Health and Welfare, 2018). The stressors that accompany migration affect individuals and their families and migrants face a range of experiences before or after migration. Migration itself is "extremely heterogeneous" (Bhugra, 2004, p. 243) and is only part of the story of understanding a

person's identity, mental health and wellbeing, and interaction with mental health services. As Johnstone and collaborators (2018, p. 130) also note: efforts to interpret the patterns in how people experience mental health and emotional issues and their implications need to take "account of the ideological and social context surrounding minority ethnic groups' experience of distress or troubling behaviour and professionals' response to it".

Health and inequalities and injustices facing migrant and refugee populations

Health and social and emotional wellbeing, including mental health, can be understood through a social lens. Health inequalities express the graded association, articulated by Marmot (2018, p. 186) "between an individual's position on the social hierarchy and health: the lower the socioeconomic position of an individual, the worse their health". While mental health is usually thought of as a problem pertaining to individual minds, an expanded social view sees the interplay of power, trauma, and life opportunities, as well as experience and meaning (Savy & Sawyer, 2010). Migrant and refugee populations may be more exposed to conditions that cause mental distress. They may have alternative ways of explaining mental distress (Lewis-Fernández & Kirmayer, 2019), and find that the ways mental health care is organised does not fit with their perspectives and priorities (Whitely, Kirmayer, & Groleau, 2006)

Mental health service access and use by migrant and refugee populations

When mental health issues arise, most Victorians will seek assistance from a general practitioner or primary care provider. Those who are more seriously affected by illness may be referred to specialist mental health services. These include clinical services that offer assessment and treatment and non-clinical services that provide programs designed to support individuals and their friends and family and "maximise their participation in community life" (Victoria State Government [VG], 2020b).

Mental health service access is the opportunity for individuals, groups and populations to reach and get appropriate services where there is a perceived need. It refers to the interface of service providers – for example features such as their appropriateness or affordability – and the capacities of communities – including the ability of individuals, families and groups to reach and engage with services (Levesque, Harris, & Russell, 2013).

Mental health services in multicultural societies such as Australia need to cater for an increasingly culturally diverse population. This includes people who are recent migrants, humanitarian arrivals, or are seeking asylum, groups who have diverse stories, concerns and needs. A consistent feature across these groups is their under-use of mental health

services relative to the broader population (Mollah, Antoniades, Lafeer, & Brijnath, 2018). This disparity, evident in Australia (Australian Bureau of Statistics (ABS), 2016; Stolk, Minas, & Klimidis, 2008) has also been observed in Europe (Jensen, Norredam, Priebe, & Krasnik, 2013), USA (DelVecchio Good & Hannah, 2015), and Canada (Rousseau & Frounfelker, 2019). Newly arrived refugees have a heightened risk of not receiving mental health care (Shrestha-Ranjit, Patterson, Manias, Payne, & Koziol-McLain, 2017) and young people may be especially disadvantaged (de Anstiss & Ziaian, 2010; Colucci, Szwarc, Minas, Paxton, & Guerra, 2014).

Two analyses of Victorian public mental health data, in mid 1990s, and again in mid 2000s, compared Australian-born service users with members of overseas-born ethnic populations. These populations were found to seek specialist help later in the course of an episode of illness or distress, comprise the larger proportion of all individuals subject to involuntary treatment, use voluntary and community-based mental health services less often and stay in these programs for shorter periods (Stolk et al. 2008). As far as we know, migrant and refugee populations in Victoria, and Australia more broadly, continue to use services at lower rates when compared to Australian-born counterparts.

Culturally responsive mental health service delivery

Contemporary cultural perspectives on mental health conceptualise identity as multifaceted and dynamic, and acknowledge the plurality of societies and subgroups (Kirmayer et al., 2020). The cultural dimensions of "gender, race, ethnicity, sexual orientation, disability, age, socio-economic status, and religion" (Watkins et al., 2015) are all relevant to understanding mental health and wellbeing. Individuals can experience intersecting and compounding forms of marginalisation and disadvantage due their social locations (Crenshaw, 1995).

"Culture" also connotes the less tangible aspects of social life such as ideas, beliefs, attitudes, values, norms, practices, language, and spirituality, as well as the symbols that people share and help define them as a group (Watkins, et al., 2019). In healthcare settings, "culture" is commonly refers the distinctiveness of individuals and populations and used to underline systemic efforts to redress unequal rates of service access (DelVecchio Good & Hannah, 2015). Cultural analyses offer ways to understand structures of meaning, knowledge, power and expertise that are particular to mental health service delivery in multicultural societies (Kirmayer et al., 2020; Germov, 2009a).

Several inter-related cultural principles have been applied to delivering health and human services, including counselling and mental healthcare. The following is based on

literature available in English. *Cultural competence* considers levels of relevant professional and organisational knowledge, skills, attitudes and practices (Papadopoulos, Tilki, & Ayling, 2008; Sue et al., 2009; Kirmayer, 2012). *Cultural responsiveness* describes the capacity of professionals and organisations to act in accordance with access and equity policy and legal obligations and therefore meet the needs of diverse populations (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007; Whealin & Ruzek, 2008; Hernandez, Nesman, Mowery, Acevedo-Polakovich, & Callejas, 2009, VG, 2009). Other principles specify how to develop competence and responsiveness. *Cultural humility* involves professionals cultivating self-awareness, a readiness to be person-centred, and prioritising dialogue over implementing pre-determined service-led one-size-fits all solutions (Tervalon & Murray-Garcia, 1998; Davis, et al., 2018). Calls for professionals to adopt a *multicultural orientation* are premised on being attentive to the ways attitudes and values infuse therapeutic relationships and interactions (Watkins et al., 2019). Further, the notion of *cultural safety* cuts across professional and service responsibilities; it is premised on recognising the power imbalances inherent to seeking and providing formal healthcare, and that this makes mental health service encounters especially unsafe for members of minority groups (Johnstone & Kanitsaki, 2007; Chen, 2017; Cheong Poon, Cassaniti, Sapucci, & Ow, 2020).

Each of these cultural principles have developed in the context of wider cultural debates, social movements and human rights discourses and international momentum to create more progressive mental health service delivery systems (Kirmayer et al., 2012; Hankivsky, 2014; Kirmayer, 2018; Kirmayer et al., 2020). Some of these influences are listed in Table 1.

Table 1 Discourses and Trends in Mental Health Service Delivery

Cultural, societal and political discourses	Trends in mental health service delivery
Globalisation	Recovery
Migration	Shared decision making
First Nations	Peer-led interventions
Colonisation	Family-inclusion
Human rights	Innovations in service delivery, e.g. Open dialogue (Aaltonen, Seikkula, & Lehtinen, 2011)
Racism, prejudice and discrimination	
Gender and sexuality	Innovations in conceptualisations of distress, e.g. Power threat meaning framework (Johnstone & Boyle, 2018)
Intersectionality	
	Person-centred
	Family-focused
	Trauma and healing informed
	Evidence-informed approaches
	Cross-sectorial service delivery
	Global mental health
	Social and cultural neuroscience
	Social and cultural determinants of health
	Diversity responsiveness

In summary, adopting a cultural lens when providing mental healthcare involves generating diverse explanations for psychological experiences and distress, exploring language and meaning, and contextualising categories of diagnosis and treatment. (Kleinman & Benson, 2006). It also entails understanding the structures of knowledge and power at play in mental health encounters for both service users and providers (Kirmayer et al., 2020). A services provider's relative success in reaching and supporting culturally and linguistically diverse populations is commonly termed organisational cultural competence or responsiveness (Sue, Zane, Nagayama Hall, & Berger, 2009). Contemporary mental healthcare professionals are expected to understand "how the cultural worldviews, values, and beliefs of the client and the therapist interact and influence one another to co-create a relational experience" (Davis, et al., 2018, p. 90).

It is customary for national and state government policy and planning documents to stipulate the need for all professionals and services to become more culturally responsive in order to ensure the whole population has access to quality mental health care (VG, 2009). This inclusive approach has been paired with provision for language services alongside a limited range of culturally specific programs and specialist services for refugees who have experienced trauma (Kirmayer & Minas, 2000). In addition, state government funded transcultural centres, that work alongside mainstream mental services operate in some states, including Victoria (Embrace Multicultural Mental Health, 2020).

Even so, mental health services in Victoria, and Australia more widely, have not been designed with diversity in mind (Minas et al., 2013). While there are national and state statements and standards related to "diversity" in mental health service delivery, there are currently no requirements to report against these objectives, nor are there any mandatory diversity, equity and inclusion standards in the national hospital accreditation scheme (Australian Council on Healthcare, 2018).

Workforce diversity

Inclusion and diversity: the mental health workforce

There is increasing attention on workplaces becoming more diverse and inclusive (Diversity Council of Australia, 2020). Some research has been done in the USA in general health settings to explore how greater workforce diversity could help to mitigate the negative consequences of social determinants of health (LaVeist & Pierre, 2014; Jackson & Gracia, 2014). This rationale informs some health workforce policy statements in Australia, for example Queensland Health's (2017) "Workforce Diversity and Inclusion Strategy

Diversity and Inclusion Strategy 2017-2022". A recent discussion paper, developed in Canada with a transcultural mental health lens, argues that:

> In an equitable society, the diversity of the health workforce would mirror that of the population. International medical graduates and other professionals who are themselves members of specific cultural communities are important resources to improve the response of the mental healthcare system to diversity (Kirmayer & Jarvis, 2019, p. 5).

Information about workforce diversity in Victorian mental health services is lacking, and this is potentially contributing to the lower rates of service access and therefore poorer mental health outcomes of refugee and more recently arrived migrant populations.

Relatively little research has been undertaken in Australia that explores relationships between the inequitable mental health care access among more recent migrant and refugee populations, the social and cultural determinants of health and low levels of cultural of diversity among the mental health workforce.

Internationally, and within Australia, addressing health access and equity concerns experienced by migrant and refugee communities and the appropriateness and quality of service users' experiences is usually characterised as efforts to improve the cultural "competency" or (more commonly in Australia) "responsiveness" of all practitioners, agencies or systems. Cultural and structural humility and safety are increasingly being referenced as principles that need to underpin dialogue about service delivery reform (Productivity Commission, 2020). That is, there is a need to listen to and learn from consumers and families, and critique power relations in service encounters. Less attention has been paid to how multiple perspectives and power imbalance are also reflected within the culture of services and systems themselves and the experiences of those who work in them.

Bicultural professionals and mental health care

Bicultural individuals are sometimes described as having dual or multiple identities – cultural, faith, or national identities – characterised collectively based on common experiences – of migration, having a refugee story, or their encounters with bias and discrimination. They have also been characterised as "living in more than one world" (West, Zhang, Yampolsky, and Sasaki, 2017) or occupying spaces "in-between" (Butcher & Thomas, 2003). Individuals in this Study also used these words and narratives to explain themselves

and their circumstances.

Bicultural and bilingual professionals enhance trust in health service encounters. Their cultural and language connections with community members are believed to engender trust and improve communication, which in turn has positive effects on health outcomes (Williams et al., 2014). Multiple studies also point to the role professionals who identify as bicultural or bilingual play in improving access to quality mental health support for recently arrived migrant and refugee populations (Cabral & Smith, 2011).

Bicultural and bilingual roles and practices

There is also literature that discusses bilingual and bicultural professionals, para-professionals, lay persons or volunteers and professionals and their practices in the provision of health, counselling and human services as well in international development and community development programs.

The field is complicated further by the use of terms that denote professionals or workers that explicitly or unconsciously distinguish those who hold tertiary level health psychology and social welfare qualifications from those who don't. Terms that are in use in relation to work with migrant and refugee communities in Australia include:

- Multilingual/ bilingual or multicultural/ bicultural therapist, clinician, case manager, counsellor advocate
- Cultural or culture broker
- Cultural consultant, informant, interpreter or mediator
- Cultural liaison worker, link worker or health navigator
- Bilingual community educator

Internationally, service and peer-reviewed literature also include references to

- Intercultural mediators (Verrept, 2019)
- Bridge people (Liu, Cook, & Cattan, 2017)
- Promotores de salud/ community health work (WestRasmus, Pineda-Reyes, Tamez, Westfall, 2012)
- Accompaniers/ or doing accompaniment (Watkins, 2015)

In this Study, I use the term *professional* or practitioner to mean anyone who applies *bicultural*, bilingual, multicultural abilities, sensibilities and perspectives. I assumed that these individuals adopted *culture-oriented* or culturally sensitive and inclusive practices in

the context of providing a formal service, and set out to understand how they do so. My use of the term "culture-oriented practice" is consistent with the way Watkins and colleagues (2019) describe a "multicultural orientation". It refers to professionals interacting with clients while being self-reflective, attentive to the feelings that arise in interactions, and open to exploring cultural themes. More broadly "culture-oriented" practices are the ways of being, knowing and doing at work that are consistent with adopting a cultural lens.

This field of enquiry is further complicated by the extensive roles "lay people" also play as mediators between services and migrant communities. There are many individuals and groups who help people to find out about and contact services and who also run mental health promotion, mutual self-help and many other programs that support social and emotional wellbeing. These individuals are not the focus of this Study, however, as will become clear, the Study identified professionals whose volunteerism and activism blurred this distinction as well.

Across the range of roles and positions described in literature, bicultural professionals are associated with a number of benefits: improved rates of retention of migrant population clients in community programs, more client-service contacts, improved continuity of care and enhanced outcomes for individuals and groups (Ito & Maramba, 2002; Ziguras, Klimidis, Lewis, & Stuart, 2003). There is also an extensive body of literature that documents and explores the approaches, practices and concerns of bicultural professionals. For example, psychotherapy-focused transcultural and multicultural material – some from a psychiatry viewpoint, some informed by clinical or counselling psychology – holds rich insights about the roles culture and language play in the practitioner-client relationship (Gielen, Draguns, & Fish, 2008). Other sources consider this aspect of bicultural practice in the light of a universal call for all professionals to be reflexive about our own identity and relations with others and ties this to a broader conversation about ways to become a culturally competent mental health professional (Kirmayer et al., 2012). The relational aspect of service encounters has also been explored in depth in the context of psychiatric assessment and formulation (American Psychiatric Association, 2013), psychotherapeutic work related to acculturation (Akhtar, 2004), and trauma-informed and trauma-focused approaches with people who have refugee or asylum seeker stories (Jemmot & Krause, 2020).

Another set of relevant literature describes mental health programs that enlist the services of bicultural community members or professionals. These accounts describe these providing a direct service and facilitating interactions between individuals, families and communities and mental health teams. They include school-based, community-based or

family therapy-oriented programs where bilingual professionals offer incidental or practical counselling, psychoeducation, psychosocial support or group programs (Procter, 2005; Brar-Josan & Yohani, 2014, 2019; Yohani, 2013; Karageorge, Rhodes, & Gray, 2018; Riggs, Yelland, Duell-Piening, & Brown, 2016; McKinney, 2007).

The international literature regarding multidisciplinary mental health casework is more limited. One example is the work of Ziguras and colleagues' (2003) evaluation of a bilingual case management program implemented for a limited period in some public adult mental health services in Melbourne Victoria.

Bicultural and bilingual professionals also feature in studies and program reports about specialist cultural consultation services coordinated by mental health teams in Canada, USA, and The Netherlands (Miklavcic & LeBlanc, 2014; Ton, Koike, Hales, Johnson, & Hilty, 2005; De Jong & Van Ommeren, 2005). These roles characteristically involve individuals helping to "interpret the cultural meaning of illness and healing" in the context of a mental health treatment team (Miklavcic & LeBlanc, 2014 p. 115). Jarvis and collaborators (2020) have recently compared well-established cultural consultation services offered in three cities – Montreal, London and Paris. I have found no peer-reviewed accounts of services in Australia modelled on these kinds of programs where bicultural professionals contribute as cultural informants.

Matching and its effects

Matching immigrant or refugee background service users with mental health practitioners or counsellors of similar cultural or linguistic background has been proposed as beneficial. Numerous international studies have investigated the effects of matching professionals and clients on features including gender, cultural, racial or ethnic identity, and language spoken. Most of this work was undertaken in the context of providing counselling services in the United States. Some meta-analyses (Maramba & Nagayama Hall, 2002; Cabral & Smith, 2011) and narrative reviews based on this work have also been undertaken (Karlsson, 2005; Nagayama Hall, 2001; Farsimadan, Draghi-Lorenz, & Ellis, 2011). There is considerable dialogue in this literature about what matching means, and how the categories of "match" are defined. Ethical concerns, that these studies perpetuate racialised and gendered categories and reinforce ideologically informed discourses, are also part of this debate. The consensus among some researchers is that the sense of trust engendered in "matched" cultural encounters arise in the context of people intuitively perceiving a shared worldview and professionals capitalizing on this to form alliances (Nagayama Hall, 2001).

Some researchers have pointed to evidence that many clients prefer to not be "ethnically matched" with professionals, citing "political, social, historical or psychological reasons" (McKinney, 2007). The approach can also reinforce pre-existing tendencies in mental health care teams to essentialise conceptions of culture and ethnicity and privilege medical interpretations of distress. For example, McKinney (2007) cites two examples in the United States in the 1990s, where this occurred, one of a Hispanic inpatient psychiatric clinic and another of a clinic, also in the United States, for arrivals from Cambodia.

Contemporary discussions about the ethnic matching approach continue to warn that it is an approach that can "lead to unwarranted assumptions" of similarity between professional and client, and about the level of mutual understanding that exists between them. It can also be used to create "de facto segregation in the health-care system". Finally, in hyperdiverse multicultural societies, this is not a feasible way to organise widespread service delivery (Kirmayer & Jarvis, 2019, p. 16).

Current consensus among leaders in transcultural mental health is that services and systems that utilize the connections professionals have with service users or communities of similar background need to also have overarching cultural responsiveness policies and frameworks in place. These should support all professionals to be more reflective about their own identities, histories and privilege, for example through education and group supervision. They should also require organisations to implement strategies consistent with cultural responsiveness, for example active community engagement.

The unwarranted assumptions about people, professional peers and service users alike, that Kirmayer and Jarvis (2019) describe are perpetuated by static conceptions of culture and privileging medical and biopsychosocial explanations of mental health issues and emotional distress over culturally-informed narratives. In my experience, these ways of knowing can also persist in a policy and service environment that uses cultural responsiveness as its overarching framework.

The Australian context

Internationally, and to a more limited extent in Australia, people are employed, contracted or some way engaged by mental health services to assist individuals of similar cultural, linguistic or faith background to themselves who are experiencing mental health issues or emotional problems.

Two clinical consultation programs in Australia, each coordinated by state-based transcultural mental health services, currently utilise bicultural and bilingual professionals

of a range of disciplines. These programs interact directly with clients and offer cultural mental health advice to other professionals (Queensland Government, 2020; Transcultural Mental Health Centre, 2020). The practice of bicultural and bilingual professionals and their contribution to immigrant and refugee mental health outcomes as part of these programs remains unexplored. Bicultural and bilingual professionals are also employed as mental health specialists, counsellors and counsellor advocates at specialist services for survivors of torture and trauma that operate across all states and territories (The Forum of Australian Services for Survivors of Torture and Trauma [FASSTT], 2020).

Some service reports describe the range of tasks bicultural professionals undertake and some of the issues they face (Crisante, 1997; Tobin, Chen, & Edwards, 2000; Frkovic & Pip, 2001). The few studies that have been undertaken in Australia (for example, Ziguras, 2001; Karageorge et al., 2018; Tan & Denson, 2019) appear to be researcher driven. Separate work undertaken by Mitchell (1998) and Ziguras (2000, 2003) (and their colleagues) was attached to transcultural units; however, almost two decades have since passed and I am not aware of any recent attempts to develop related theory or evidence from intervention and implementation research. These kinds of sustained applied approaches and efforts are needed to guide and develop mental health policy and practice (Sanson-Fisher, Campbell, Perkins, Blunden, & Davis, et al., 2006).

There are suggestions in some national mental health frameworks that practitioners should seek out cultural advice and expertise (Australian Government, 2010a; 2010b; 2013a). However, I have not been able to identify any related discussion in Australian mental health policy and practice guidelines about who could provide such advice or how these individuals interface with service providers.

The proposal

My motivation for conducting this Study

My interest in this research arose from years working as a mental health clinician, and in the past decade as an educator and advisor to services and government in the area of transcultural mental health. At the time of starting this research I was aware, through my professional contact with mental health services in Victoria, of professionals employed in designated bilingual or bicultural positions. I was also aware of many mental health professionals with a direct personal or family experience of recent migration using cultural expertise to support people of similar background to them in relation to mental health or emotional issues they were experiencing.

As far as I know, the work of these professionals – regardless of title – has not been the focus of any recent studies. To my knowledge there are no recent, local accounts, or documented practice guidelines pertaining to bicultural work practices in mental health in Victoria's mental health service system. In my observation, no explicit consideration is being given at the level of mental health service policy or system reform to the benefits that would flow from greater workforce diversity. I am also not aware of any recent attempts to seek out the perspective of the professionals themselves. I concluded that people were offering a valuable service, that is largely undocumented, rarely discussed, and therefore under-acknowledged by service providers and government alike.

I was curious about the realities of being a bicultural professional assisting PeMH/EI in Victoria. How do colleagues and communities regard them? What's distinctive about their practice? What are their concerns? What are the costs and benefits for them as individuals and professionals? Has any regard been paid to providing the people who currently do this work with support, training, supervision and career pathways?

I concluded that I needed to understand more about what bicultural and bilingual professionals offer, and the systems in which they work. Designing a study around listening to their perspectives would provide opportunities to generate new knowledge that could benefit these professionals. The study might also help re-invigorate contemporary debates about cultural responsiveness and ways to address service access issues. Finally, knowledge generated by this Study could inform strategies aimed at diversifying the mental health workforce and developing a more equitable and social just mental health service system (Victorian Transcultural Mental Health [VTMH], 2020).

Research aims and questions

The overall aim of the research was to understand the practice of professionals who identify as bilingual or bicultural and assist PeMH/EI with whom they share similar a cultural background. The aim was to contribute knowledge that could be used by professionals, community members, policy leaders, and service providers who want to explore how developing a more culturally diverse workforce could improve the cultural responsiveness of mental health service delivery as a whole. I also hoped that this research would provide bicultural and bilingual professionals with a helpful resource, grounded in their experiences, that they could use when having conversations about the contributions they make to mental health service provision.

The Study enquired directly of professionals who assist people experiencing mental health

issues or emotional issues (PeMH/EI) with whom they share a similar cultural, linguistic or faith background. The objectives were to:

1. Describe their personal and workplace characteristics, the tasks they perform, the approaches they use, and the kinds of supervision, support and training they receive.
2. Explore how these professionals practice – their motivations, the roles and responsibilities they take on, their perspectives on culture and mental health, and how they interact with service users and colleagues.
3. Integrate the descriptive and exploratory aspects of this study in order to build a compelling theory that explains their culture-oriented practice. This would entail examining relations between personal, professional, workplace, and other societal factors.

The core research question guiding the inquiry was: What is the experience of professionals, based in Victoria, who identify as bicultural or bilingual and assist PeMH/EI with whom they share similar a cultural background? In particular the Study asked:

1. What characterises these individuals and their work?
2. How do they combine their personal experiences with expertise associated with their professional qualifications, training or discipline?
3. What theories explain how they practice and how others perceive them?

The Study

A grounded theory methodology was chosen with the aim of developing a substantive theory that explains bicultural mental health practice in Victoria. It was anticipated that this could contribute to understanding similar work undertaken by other professionals located in relatively economically developed, multicultural societies with complex mental health service systems.

The study used a mixed-method design and was conducted in two phases. The Study began with an online survey because little was known about these professionals, the tasks they performed and the principles and approaches that were important to them. The questions asked were mostly closed with some open-ended questions. The data collected in this phase informed the enquiry undertaken in the second phase. Interviews were used to go deeper and explore participants' experiences and perspectives. Data were gathered and analysed separately and integrated at the point of interpretation (Guest, 2012).

Overall the study was qualitatively-led. It gave these professionals an opportunity to share the concerns that were important to them. My own experiences and reflexivity also formed part of the study's exploratory analytic strategies (Clarke, 2015a).

Participants included people working in mental health services, other health and social support settings, or human service settings. That is, the sample was not confined to professionals working in designated mental health services. This decision was made for two reasons. Firstly, the current mental health service delivery environment across Victoria is extremely complex and dynamic. Mental health service provision encompasses more than the network of state government funded specialist tertiary services for children and young people, adults and older persons.[1] Secondly, service access and pathway studies conducted in Australia and elsewhere (Colucci et al., 2014; de Anstiss & Ziaian, 2010; Tarricone, et al., 2012) show that PeMH/EI who have recent personal or family migration or refugee stories often turn to non-health sectors, including ethnocultural community agencies for psychosocial mental health support. Based on these two considerations, eligibility criteria for the study were designed to include professionals who assist PeMH/EI regardless of the service setting.

Outline of thesis chapters

The Thesis is presented in the following way. *Chapter 2 Bicultural professionals and mental service delivery* explores service, policy and peer-reviewed literature to contextualise the work of bicultural professionals in Victoria, and identify common themes and assumptions. *Chapter 3 Methodology* outlines the Study's mixed methods constructivist ground theory methodology. All aspects of the study's implementation are described.

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[1] The system also includes programs funded exclusively by the federal government and those delivered by state funded or nongovernment entities using federal funds. There are varying criteria regarding whom these programs service; multiple approaches to diagnostic formulation and developing care plans; and workforces vary considerably across these settings as well, in terms of disciplines and qualifications. Some program examples include: psychiatry led clinical hospital and community programs provided by multidisciplinary teams or supervised by general practitioners; psychosocial recovery-oriented programs provided by allied health professionals, lived experience peer workers and certificate level trained workers; mental health programs that intersect with the alcohol and drug services and specialist programs for youth; private practice sessions including those subsidised by government funding; primary health, family relationship, and specialist trauma counselling services; mental health focused programs in other sectors such as schools, social services and migrant support programs.

Chapter 4 Description of participants and setting includes demographic and workplace information about Study participants; the whole sample and the nested sample of participants who were also interviewed. The relative socioeconomic status, career trajectories and the main mental health frameworks used are also outlined for the nested sample. *Chapter 5 Survey findings* reports data related to the activities of bicultural professionals, their perspectives on cultural responsiveness and the opportunities they have for training, supervision and support. Patterns in the quantitative data are presented. This chapter concludes with an analysis of the text-based reflections they offered on their work and work structures. Together, these chapters provide context for understanding the findings and analysis that follow.

The next five chapters, each discuss a category that features in the substantive theory developed to explain bicultural practice. *Chapter 6 Work* conceptualises bicultural practice in terms of activities, strategies and roles. *Chapter 7 Principles* discusses the culture-oriented underpinnings of what bicultural professionals do and suggests that these are consistent with wider cultural responsiveness discourses. In *Chapter 8 Recognition,* the dynamics that arise from how others regard bicultural professionals is explored. This discussion considers their location in social worlds of work and beyond. It also acknowledges participant experiences of exclusion and racism. *Chapter 9 An ethical predisposition* explores participant perspectives on identity and motivations, and focuses on the relation between a sense of personal freedom and obligation to extend care to others. *Chapter 10 Interacting* presents the many ways participants use conversations, intuitively read social signals and share experiences and stories in service encounters.

The next two chapters integrate these analyses and interpretations. *Chapter 11 Practice Pathways* presents three case examples to show the characteristic ways that bicultural professionals embody practices, consistent with their motivations and culture-oriented principles. *Chapter 12 The substantive theory* outlines the main findings and presents the grounded theory of the culture-oriented mental health practice of bicultural professionals as a metanarrative. It also relates the theory to other theories and frameworks.

Implications of the findings and the substantive theory and potential areas for future research are presented in *Chapter 13 Conclusion* and research strengths and limitations are also discussed. Additional material regarding human ethics approval for the Study, the survey instrument and interview schedules, as well as coding matrices and details of some quantitative analyses can be found in the *Appendices*.

Chapter 2 Bicultural professionals and mental service delivery

Introduction

The purpose of this chapter is to identify texts that help to locate the work of bicultural mental health professionals in Victoria. This includes a review of national and state level policies and practice guidelines, peer reviewed literature and books, documents developed by service providers and advocacy agencies, websites, and relevant observations based on the analysis of first-hand experience and reported internationally. It builds on themes raised in the introductory chapter (Chapter 1).

This chapter opens by outlining where bicultural professionals feature in national and Victoria State Government mental health and cultural responsiveness policy environments. It then identifies reports prepared by Australian agencies that discuss the work of bilingual and bicultural professionals in health, human services and other industries. A limited selection of reports created in other countries is also included. This is followed by an overview of a narrative review of qualitative studies that explores the perspectives of professionals who, similar to the participants in this Study, assist PeMH/EI of migrant or refugee background with whom they share a similar cultural, language or faith background. Common themes and assumptions in the literature are identified. Consistent with the grounded theory methodology, extant literature was identified throughout the Study period and rigorously considered during theoretical integration and theory building phases.

Mental health policies and workforce diversity

A review of Australian and Victoria State Government health and human services websites identified material focused on cultural responsiveness and mental health. Key documents listed by Embrace, Multicultural Mental Health (2020, p. 9) and VTMH (2020) are among those included below.

National

Guidance around including cultural practitioners when implementing diversity policies tends to be high level and generic. For example, standard four, *diversity responsiveness*, of the "Implementation Guidelines for Public Mental Health Services and Private Hospitals" (Australian Government (AG), 2010a, p. 20) advises service providers to seek "cultural input from cultural informants, bilingual workers and relevant others". The characteristics of these individuals and the particular tasks they could perform are not further defined.

"The National Recovery Framework for Mental Health Services: Guide for practitioners and providers" (AG, 2013a, p. 21) suggests organisational leaders "foster particular workforce positions and roles that will address the specific needs of the local population, for example, bilingual workers, [and] cultural liaison workers". This is included as part of a workforce capability that describes "responsiveness to people from immigrant and refugee backgrounds, their families and communities' (AG, 2013a, p. 51-52). Once again, no rationale for collaboration is offered, and there is no additional information how these individuals could assist.

The various documents that comprise the "Primary Health Network Mental Health Tools and Resources" (AG, 2020) make general statements that commissioned services should be inclusive, culturally safe and appropriate to the needs of people from diverse backgrounds including "culturally and linguistically diverse (CALD) backgrounds". A brief suggestion is made that peer workers who share a common culture could help people communicate their needs, feel more comfortable when using services and support recovery. Bicultural or bilingual professionals are not discussed as part of the psychological therapies description of these commissioned services. "The Fifth National Mental Health Suicide Prevention Plan" (AG, 2017) does not mention culturally and linguistically diverse populations. I also searched a new extensive Australia-wide mental health service government website for a community facing examples about bicultural or bilingual practitioners. I identified the following single negative commentary on a page called "culturally and linguistically diverse people":

> As a recent migrant, I saw a doctor from my own culture who told me that I couldn't have postnatal depression because it only affected Western women! I went to another GP who recognised my condition and was far more empathetic and understanding – Suchitra (Head to Health, 2020).

There are no other mentions of multicultural practitioners across this extensive site. There is no countervailing example of a competent, helpful bicultural professional. There are no comparable comments about poor practice by mainstream service providers.

Victoria

Some major shifts in approaches to cultural responsiveness and a bicultural workforce have occurred in Victorian policy documents over the past two decades. The last reference to bicultural mental health professionals by the Victoria State Government was in "Cultural Diversity Plan for Victoria's Specialist Mental Health Services, 2006 – 2010" (VG, 2006). It references the bicultural case management initiative described by Ziguras and colleagues

(2003). By 2009, this program had formally ended; although a small number of tertiary mental health services continued to employ the individuals recruited as part of the initial project.

In 2009, the state government released "Cultural Responsiveness Framework for Victorian Health Services" (VG, 2009), a whole-of-organisation strategy "to embed CALD issues into the strategic planning process" of publicly funded health service (p. 8). The document is still "live" and was cited in a major report of a review of safety and quality of hospitals across the state (Duckett, 2016). However, my desktop review did not identify any other recent references to it by state government or public mental health service providers.

The framework is based on ensuring "equal access to, and the provision of, quality health care for the whole population" (p. 10). It is an all-of-health services plan that consolidates policy and reporting across health, disability services and community-based aged care and became the main strategy for addressing migrant and refugee community encounters with mental health services. Developing an *effective workforce* is one the framework's four key domains. It promotes improving the capabilities of all health staff through education, information sharing, and ensuring cultural awareness is included in position descriptions and recruitment practices. However, unlike similar documents developed in other countries, the Victorian framework does not consider the diversity of the workforce (Seeleman, Essink-Bot, Stronks, & Ingleby, 2015).

Current Victorian state government mental health policy statements – "Victoria's 10-year Mental Health Plan" (VG, 2015), "Mental Health Workforce Strategy" (VG, 2016a), "Victorian Suicide Prevention Framework" (VG, 2016b) – mention earlier commitments to cultural responsiveness. These contemporary documents also include references to cultural safety, talk about the importance of community service relationships and informal sources of support, and some pledge to develop community-controlled mental health services.

Continuing the trend, these current plans and strategies do not include any plans to harness the cultural and language skills and knowledge of a culturally diverse workforce to enhance service responses to diverse communities, either by building organisational capacity, or making connections with communities. In Victoria, a diverse workforce is not seen as integral to developing the culturally safe team and service environments that these policies frameworks also seek.

Bicultural and bilingual professionals in Australia

While workforce diversity in mental health service delivery is an underdeveloped

government policy area in Australia and Victoria, a number of Australian services and systemic advocacy agencies have created materials regarding bicultural and bilingual work, and most of these agencies are based in Victoria. None of these are specific to practising in mental health settings or with people experiencing mental health challenges or emotional distress, although they consider the importance of emotional and social wellbeing when working with recent migrant and refugee communities.

One document relates to *bilingual* professionals based in a range of industry sectors (Federation of Ethnic Communities Council of Australia [FECCA], 2017) and another to health and human services (Centre for Culture Ethnicity and Health [CEH], 2008). Both contrast the skills and roles of bilingual practitioners with professional interpreters and note that bilingual professionals are bound by the legal and ethical frameworks of the settings in which they work, for example children's' services or aged care.

Other material describes *bicultural* professionals who may or may not use community languages as part of their role. These materials describe individuals working in health and human services sectors, such as migrant, refugee and community support programs. This includes: a report produced by a multicultural youth agency (Centre for Multicultural Youth [CMY], 2011); discussion papers prepared following consultations with bicultural practitioners (Tyrrell, Duell-Piening, Morris, & Casey, 2016; enliven, 2018) and a dedicated bicultural hub website developed by a primary health care provider (cohealth, 2020).

The FECCA report also describes education and training approaches across Australia. Some are associated with particular programs, and some are connected to Australia's national accredited training framework. One such qualification delivered in Victoria is "Bicultural Work with Refugees (CHCSET002: Undertake Bicultural Work with Forced Migrants in Australia)" and it is designed for people from a refugee background who are working or want to work with refugees (AMES Australia, 2020).

The FECCA paper notes a "plethora of approaches across sectors and locations" and attributes this to a lack of training and accreditation opportunities for this workforce (FECCA, 2017, p. 6). Terminology and definitions coined by CEH and CMY are referenced in other documents. Bilingual professionals are characterised by their communication skills while bicultural professionals undertake a broader range of activities roles that may include engaging supporting individuals and groups or delivering programs. The notion that bilingual and bicultural practitioners "bridge" service encounters is a recurring image throughout. CMY (2011, p. 4) asserts that a culturally and linguistically diverse workforce brings "different perspectives and creative ideas to solving problems".

These documents discuss the linguistic and/or cultural competence of this workforce and ways to recognise and build these competencies. They also note that these practitioners are often multicultural and multilingual, both in their identities and in the knowledge and skills that they bring to service encounters. In addition to describing the range of activities they could perform, required professional attributes, and potential for positive outcomes for individuals and groups there are universal calls for appropriate recruitment, supervision, support, expectations, workloads, training and career paths for individuals in these roles. The issues associated with their practice include:

- Managing the expectations and assumptions of colleagues, and senior staff (CEH, 2008)
- Their presence can enhance or undercut the commitment of other professionals to improving their own cultural competence (FECCA, 2017).
- Ethical implications that arise from being accountable to agency structures, and unreasonable expectations to be impartial (FECCA, 2017).
- Maintaining community facing relationships, knowing their expectations of them, and understanding assumptions held about the organisations in which they work (CMY, 2011).

Research notes that the demands on bicultural practitioners differ from those experienced by professional peers, because they occupy positions "both inside and outside the community" (McKinney, 2007, p. 490). The risks this work poses to these professionals' own emotional wellbeing and interpersonal relationships is a strong and recurring theme across service literature.

Other documents, originating outside Australia, describe health and human services roles that are largely consistent with those described in the above Australian documents. A report prepared by the National Centre for Cultural Competence [NCCC] (2004, p. 5) in USA discusses *cultural brokering*, as acts of bridging, linking and mediating performed by those with cross-cultural capacities, who "may not necessarily be members of a particular cultural group or community" but who have necessary knowledge, history, experience and credibility with cultural groups and health care providers. Other interrelated documents from Europe adopt the term *intercultural mediation* and survey language and cultural roles across a number of predominantly European countries. Varying multicultural and migration policies, histories and societal contexts are discussed in documents prepared by Bennegadi and colleagues (2010) and others (Theodosiou & Aspioti, 2016). More recently Verrept (2019) completed a comprehensive systematic review for World Health Organisation of workforce initiatives designed to improve the health care accessibility and

quality of care for refugee and migrant populations. Roles undertaken by intercultural mediators across European Union countries include cultural brokerage, providing mental health support, service liaison, and advocacy in response to institutional discrimination.

Accounts of bicultural professionals assisting PeMH/EI in peer-reviewed literature

I undertook a search and narrative review of peer reviewed literature relating to bicultural professionals who assist people of migrant or minority ethnic background who are experiencing mental health or emotional issues. The review approach is summarised in Box 1 and the selection process, based on PRISMA guidelines (Moher et al., 2009), is outlined in

Figure 1.

As others have noted, variation in the range of mental health services and programs designed for immigrant populations across multicultural industrialised societies reflects countries' particular histories, modes of recognising indigenous nations, waves and patterns of migration, approaches to multicultural citizenship, as well local variations in how mental health services are organised (Kirmayer & Minas, 2000; Carrera, Lévesque-Daniel, Radjack, Moro, & Lachal, 2020). In line with the objectives of this Study, I searched for studies that included qualitative data about bicultural professionals' experience, including their interactions with service users, colleagues and community members, and their perspectives on organisational and professional development structures.

Thirteen qualitative research papers were identified: 11 single methods studies – which used descriptive, phenomenological, grounded theory, single case study or ethnographic methodologies – and two mixed methods studies, one qualitatively-led and the other quantitatively-led.

Table 2 outlines some details about the 13 articles and includes a classification of the kind of cultural roles described (using one of the three categories that I outline below). Publication dates range from 1998 to 2020. Eight of the articles provide a separate statement of findings. One notes that the researchers and authors were bilingual professionals; this information is not provided in the remaining studies. Varying levels of information is included about the recruitment of participants, data collection, analysis and approach to addressing ethics.

Box 1 Approach to the Narrative Literature Review

Scope of the search: Any study design reported in a peer-reviewed journal (excluding discussion papers, conference papers) and also excluding theses and non-peer reviewed newsletters, reports and practice guidelines.

No start date limit was set on the literature, and searching continued to mid-2020.

Inclusion criteria for searches included:

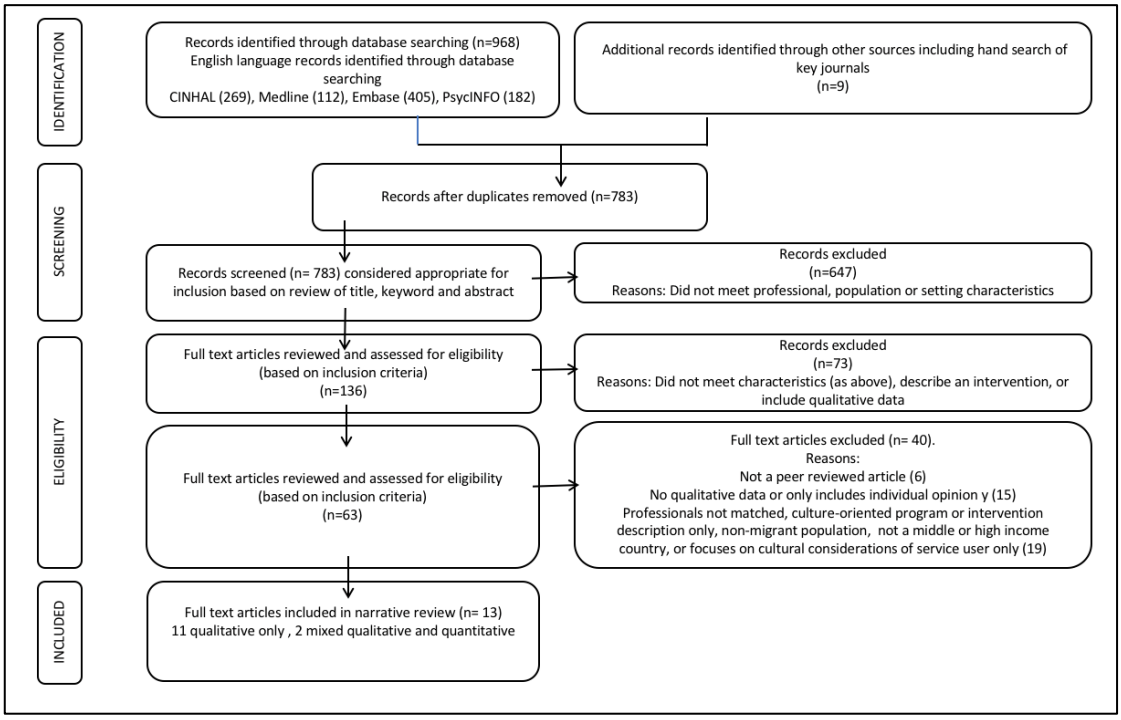
- professional characteristics: some or all study participants described as migrant or refugee background or by ethnicity, language or religion; any mental health discipline; 'non-professionals' collaborating with professionals
- population characteristics; people experiencing mental health issues or emotional distress including mental illness, substance use issues, or the effects of past trauma; some or all study participants are of migrant or refugee background or their ethnicity, language or religion is described
- setting: any service setting; middle or high-income country
- interventions: any culture-oriented intervention that assists PeMH/EI, including direct care, brokering understanding, service development or community development
- study type: includes qualitative data collection and analysis

Exclusion criteria included:

- professional and population characteristics: no report of similarity between professional and service population based on culture, language or religion
- intervention: do not involve a bicultural professional; bicultural professional conducts research; purpose is to explore community health beliefs or help-seeking

Four main concepts were used to guide the searches of databases and a hand search of relevant journals: mental health disorder or illness; immigrants; culture; and health professional.

Figure 1 Selection of Sources for Review



The narrative review is based on 13 studies. Three are from Australia, six from USA, three from Canada, and one from UK. The same two authors are represented across the Canadian references. Eleven of the studies are qualitative studies and two are mixed methods enquiries. Data collection methods included semi-structured interview, open-ended interview, participant-observation, survey, focus groups, critical incident and document review.

Study aims included: to evaluate a program within a service (Karageorge et al., 2018); to explore the activities, roles and practice approaches of a professional cohort (Mitchell, Malak, & Small, 1998; Brar-Josan & Yohani, 2014, 2019; Ito & Maramba, 2002; McKinney, 2007; Verdinelli & Biever, 2009; Kokaliari, Catanzarite, & Berzoff, 2013; Liu, 2013; Ramos, Brookman-Frazee, Kodish, Rodriguez, & Lau, 2020) and identify their training and supervision needs (Tan & Denson, 2019); and to explore how a professional group enhances a populations' service access (Liu et al., 2017).

An outline of roles, activities and practices

Across the studies, participants were described as multilingual and multicultural therapists (Mitchell et al., 1998; Ito & Maramba, 2002; Verdinelli & Biever, 2009; Kokaliari, et al., 2013; Ramos; 2020), bicultural workers and bicultural brokers who provide some

counselling and facilitate service and community engagement (McKinney, 2007; Yohani, 2013; Brar-Josan & Yohani, 2014, 2019; Karageorge et al., 2018), and "bridge people" who included both professionals and informal supporters (Liu et al., 2017, p. 667). Two studies focused on the work of a single discipline; in one case social work (Liu, 2013) and in another, psychology (Tan & Denson, 2019). Participants were based in public health or mental health settings (Mitchell et al., 1998; Ramos et al., 2020), public family therapy services (Karageorge et al., 2018), or worked across youth mental health programs and schools (Yohani, 2013; Brar-Josan & Yohani, 2014, 2019). Others were based solely in a refugee torture and trauma support agency (McKinney, 2007) or worked as private practitioners (Verdinelli & Biever, 2009; Kokaliari et al., 2013).

The studies focused on service encounters between professionals and a range of groups: members of populations with complex migration histories that are mainly non-English speaking communities, such as people of Chinese or Latinx heritage, former refugees, family members and subsequent generations who have become permanent residents or citizens. Ethnicity and racialised terminology were used. These include non-English speaking backgrounds or NESB (Australia) and black and minority ethnic or BME (United Kingdom). A United States study included "Black American" populations and newcomer migrant groups in the same investigation (Ramos et al., 2020).

Participants worked directly with individuals and families (Mitchell et al., 1998; Yohani, 2013; Karageorge et al., 2018; Brar-Josan & Yohani, 2019), sometimes providing specialised interventions and counselling and sometimes in collaboration with others who did so (McKinney, 2007; Karageorge et al., 2018; Brar-Josan & Yohani, 2019). Some were involved in developing the capacity of teams and clinics to be more culturally responsive (Ito & Maramba, 2002) and some were involved in community education and providing supportive group programs (McKinney, 2007; Yohani, 2013; Brar-Josan & Yohani, 2014, 2019; Karageorge et al., 2018).

Some studies (Mitchell et al. 1998; Ramos et al., 2020; Verdinelli & Biever, 2009) involved heterogenous professionals (as this Study does); for example, individuals who provided basic counselling, as well as others who offered comprehensive psychological interventions. The three reports discussed bilingual mental health professionals: Mitchell and colleagues (1998) and Ito and Marama (2002) discussed how bilingual practitioners use core cultural competencies that are applicable to all mental health practitioners while Tan and Denson (2019) focused on the issues that arise when professionals offer psychological interventions in languages other than English. The characterisations of culture brokers were consistent across studies and involved individuals working under the clinical

supervision of more senior mental health professionals. The dynamics of this hierarchical relationship was the explicit focus of Brar-Josan and Yohani's (2014) exploration of a framework that teams, supervisors and services can use to address power imbalances and develop relationships based on collaboration.

Themes identified in the qualitative literature

The qualitative findings of these studies described the experiences and concerns of these professionals. I identified four main themes across these studies:

(1) Using identity, experiences and personal attributes

(2) Complex relationships with service users and communities

(3) Ways to provide culturally responsive mental health care

(4) Relationships in the workplace and structures of support

(1) Using identity, experiences and personal attributes

Professionals across these studies saw positive links between offering services and support in language or from a place of cultural similarity and understanding. None of the studies explicitly discussed religious similarity. Professionals surmised that their presence increased opportunities for people to connect with and receive services (Liu, 2013). They also believed that their deep knowledge of the circumstances facing individuals and groups was a source of comfort to service users (Liu, 2013).

All studies stressed the importance of conceptualising the identities of bicultural and bilingual professionals in complex terms. Some of the variation noted across studies included whether the professionals were born overseas or born to overseas born parents and whether they attended primary or secondary schooling or undertook tertiary studies in another country or in the country where they now live and work. The language in which they gained professional qualifications was also seen as important. These factors were believed to influence how bilingual professionals use knowledge, practice and interact with different client groups.

The connections that professionals and clients might share included cultural and linguistic heritage, and a recent personal or family history of migration and settlement (Karageorge et al., 2018). Professionals and clients might have also both experienced learning to function in everyday life in more than one language and living in two worlds (Verdinelli &

Biever, 2009).

The studies made frequent references to the personal attributes of these professionals. For example, Karageorge and colleagues (2018) emphasised the importance of having compassion, and a keen desire to share cultural knowledge. Professionals themselves placed a high value on speaking a LOTE, being helpful and willing to serve their community (Verdinelli & Biever, 2009; McKinney, 2007; Tan & Denson, 2019).

The studies described participants wanting to do this work out of a sense of obligation. Many studies reported that their multilingual practice started at the behest of others, unintentionally. Some carried some self-doubt and anxiety about whether their LOTE was up to the challenges that a bilingual practice demands (Tan & Denson, 2019) McKinney (2007) described the emotional issues that could arise for professionals when working with refugees who had similar traumatic life trajectories to their own.

(2) Complex relationships with service users and communities

All studies mentioned the capacity of these professionals to engender trust among service users. Ito and Maramba (2002) described this as a form of professional-client relationship that deviates from Western conventions. Bicultural professionals were aware that they established rapport with some clients with greater ease than their mono-cultural or monolingual colleagues (Liu, 2013).

Ito and Maramba (2002) discussed the way clients might treat professionals like a family member or close friend and that this can go hand-in-hand with being regarded as a professional with authority and prestige. The professionals involved did not find this contradictory, explaining that family structures themselves can be hierarchical, and it is natural for communities to embrace respected individuals outside the immediate extended family. Ito and Maramba (2002, p. 53) saw these relationships as dynamic, citing a professional who stated: “It takes a while to develop trust but once we do “break through” they treat staff as a family member”. Some professionals were concerned about clients becoming overly reliant on them, and how to manage unrealistic expectations (Liu, 2013). A professional in Liu’s (2013) study noted the need to remain alert to implications that similarities and differences between professionals and clients have on the therapeutic relationship. This included reconciling the gift giving tendencies of clients with organisational guidelines and professional ethics. One study (McKinney, 2007. p. 496) was critical of the way cultural brokers were commonly told “to establish ‘boundaries’ with their clients”. These professionals saw organisational rules about gift gifting and keeping to rigid appointment time as “illogical, dehumanizing, rigid, culturally insensitive and

therapeutically undermining" (p. 496). Some professionals described turning requests for personal information into opportunities for limited meaningful self-disclosure, constructive interactions and humour (Liu, 2013; Verdinelli & Biever, 2009).

This proximity intensified relationships, with professionals finding that some clients idealised them, and some devalued. These responses arose in same culture and cross-culture encounters (Kokaliari et al., 2013). Examples include professionals realising that clients of similar background suspect they breach confidentiality, or sensing that clients saw them as an "exotic creature" (Kokaliari et al., 2013, p. 112).

Professionals also offered some reflections on their own practice, noticing they might find themselves investing more energy with clients of similar background, or feeling angrier if they didn't engage (Kokaliari et al., 2013). Working with people of similar background and using their mother tongue sometimes gratified the professional's personal need to connect with their country of origin (Kokaliari et al., 2013). The sense that, having gained an education, they were "giving back" to the community, could put them in a position of being beneficent and condescending (Kokaliari et al., 2013, p. 112).

Professionals also cared about the ambience of their workplaces. The ethno-specific agencies or services that took care to ensure the physical environment reflected multiculturalism felt more home-like to professionals and service users alike (Liu, 2013). The professionals in Ito and Maramba's (2002) spoke of preferring informal personal clinic settings to those with more neutral, professional atmospheres. A Chinese American therapist cited in this study mentioned: "[When clients come to the clinic] they see Asian faces, posters, announcements, materials, decorations. It's like coming home. It's the right place for them. Not foreign. They feel comfortable" (p. 54).

(3) Ways to provide culturally responsive mental health care

The studies described the many ways these professionals respond to clients' mental health concerns. Examples included: interacting with sensitivity so as to keep clients engaged in care (Ramos et al., 2020); making cultural adjustments to evidence-based therapeutic interventions (Ramos et al., 2020); negotiating mental health care and treatment plans with clients, family members and treating teams (Ito & Maramba, 2002); and offering practical support and case management through to specialised counselling as required (McKinney, 2007; Brar-Josan & Yohani, 2014).

Professionals made cultural interpretations in two directions (Yohani, 2013; Brar-Josan & Yohani, 2014, 2019). They explained service cultures and practices to clients; for example,

what confidentiality and counselling meant. They also explained the culture of clients and their families to professional colleagues. Speaking about the vital ways in which cultural brokers augment her practice explained, "there's simply things you cannot see from the outside" (Brar-Josan & Yohani, 2014, p. 90). Professionals also noted lack of training in cultural competency within undergraduate and postgraduate university programs. Enhanced levels of cultural practice across the professions would reduce reliance on bicultural and bilingual professionals to assist cultural communities (Liu, 2013; Tan & Denson, 2019).

Studies observed bicultural professionals working in organisations on different levels, for short-term and longer-term change, and across multiple service settings. For example, directly helping a young person and their family by liaising with a school, influencing how schools respond to refugee families overtime, and proactively reaching out to families, and connecting students, families and teachers with other support service (Yohani, 2013). They might be the scaffold on which other professionals build their relationships with clients, families and communities (Brar-Josan & Yohani, 2019).

(4) Relationships in the workplace and structures of support

Bicultural professionals felt that their work imposed additional and particular demands. Professionals spoke of their services being in high demand. Their work commonly also had a peer education component: informally explaining cultural issues in team meetings; and also leading cultural competence training sessions (Liu, 2013; Tan & Denson, 2019).

In settings where they saw clients of many backgrounds, some professionals had higher than average caseloads because they serviced the general population and also had contact with most of the clients from a particular cultural community (Liu, 2013). Some spoke of needing to repeatedly explain their role to colleagues (Liu, 2013). This could make them feel distant from mainstream professional peers, and clients (Liu, 2013). Brar-Josan and Yohani (2014) organised their study around applying models of team collaboration. They found all team members benefited when the roles and responsibilities, ethical standpoints, values, and priorities of different players were understood.

Professionals commented that their skills, knowledge, and additional efforts were not acknowledged in the work place. In response they suggested: services or systems offering financial or career incentives and providing opportunities to undertake further study (Ito & Maramba, 2002; Liu 2013; Tan & Denson, 2019); more opportunities to participate in networks and forums (Tan & Denson, 2019); attaching specialist cultural or linguistic competence practice standards to professional registration processes (Tan & Denson,

2019); assisting overseas trained professionals who struggle to have their qualifications recognised (Tan & Denson, 2019).

There were reports of professionals learning how to practice biculturally or bilingually through trial and error and private study (Verdinelli & Biever, 2009; Tan & Denson, 2019). Some bilingual professionals believed they lacked particular knowledge, for example adequate psychology terminology in other languages (Verdinelli & Biever, 2009; Tan & Denson, 2019). McKinney (2007, p. 496) observed that some of the individuals who became culture brokers in a refugee support program, "were never trained to be, nor did they ever dream about it..., they don't have appropriate training and self-care skills and they don't see their lives as being fulfilled by this job."

All studies commented on the complex ethical issues that arise for these professionals in working within organisations and with community members, and that these need to be acknowledged and explored. Supervision was raised across the studies in a number of ways. It was seen as a mechanism for addressing motivation and stress (Liu, 2013). Reflective practice models have been used with some success (Karageorge et al., 2018). Supervisors themselves needed to be aware of the organisational contexts that affect the status and roles of supervisees, and create relationships where supervisees can openly discuss their issues and struggles (Verdinelli & Biever, 2009; Liu, 2013). Culture brokers benefited from supportive supervision that acknowledged power dynamics and imbalances (Brar-Josan & Yohani, 2014).

McKinney (2007) also observed the asymmetrical subject positions that staff occupied – gender, race, ethnic, class, and national differences – were all relevant. While stated program values included "partnership", "participation", and "dialogue", the opportunities for bicultural professionals to meaningfully discuss their concerns with senior staff were limited. McKinney (2007, p. 498) saw workers pushed toward one of two extremes – becoming professionalised and assimilated into the "dominant culture" of the agency or relegated "to the lower rungs of professional hierarchies". The collaboration model proposed by Brar-Josan and Yohani (2014) addresses some of the team-based power imbalances observed in McKinney's study.

Bicultural professionals: descriptions and discourses

Based on these qualitative studies, bicultural professionals providing mental health care and support tend to be *described* in one of three ways. There are professionals who identify primarily as psychologists, medical practitioners and other disciplines who also use their language and cultural skills and knowledge in service encounters (Tan & Denson, 2019;

Ramos et al., 2020; Verdinelli & Biever, 2009). There are also accounts of mental health professionals who are aligned with culturally competent or responsive practices; they provide evidence-informed mental health care by exploring identity, beliefs about illness and treatment, psychosocial support, and the therapeutic relationship (Mitchell et al., 1998; Ito & Marama, 2002; Liu 2013; Liu et al., 2017; Verdinelli & Biever, 2009; Kokaliari et al., 2013; Ramos et al., 2020). Finally, some professionals are described as culture brokers or para-professionals. They help individuals and groups engage with services, lead community initiatives or work with other clinicians to provide direct mental health care (Brar-Josan & Yohani, 2014, 2019; Yohani, 2013; Karageorge et al., 2018; McKinney, 2007). Each of these descriptions connects with wider discourses about these professionals, which I term *professional-first, culture-inclusive, and brokering.*

The *professional-first* discourse tends to emphasise the technical aspects of bilingualism or adopt a fairly static understanding of culture. It describes professionals fulfilling their usual responsibilities in two or more languages, or providing standard care with culture awareness. These are professionals practising with fidelity and in another language or with cultural sensitivity. However, the logic of this discourse downplays the indeterminacy of language and cultural practices. This is internalised by individuals as a struggle to maintain legitimacy as professionals, and manifests in efforts to seek recognition for specialist skills and knowledge through certification or registration. This is expressed, for example in Tan and Denson's (2019) study, where psychologists were especially concerned about how to deliver quality evidenced-informed psychological interventions in a client's preferred language. It is also the focus of Ramos and colleagues' (2020) investigation of how bilingual professionals engage with evidence-based models of care.

The *culture-inclusive* discourse tends to use the terminology of holistic or person-centred care, cultural responsiveness and, more recently, safety and humility. The assumption here is that culture permeates every aspect of every service encounter – that is, culture is conceptualised as an expression of human diversity not something that racialised or ethnic communities have. Culture includes how mental distress is experience, expressed, and how people seek help, how services are delivered, and the knowledge paradigms of mental health, illness and recovery themselves[2]. The inherent logic is that if culture matters for everyone, every day and everywhere, then it structures mental health service delivery as

[2] The summary is mine, based on the topics identified in these studies, and uses the themes outlined for cultural assessment and care planning in "Diagnostic and Statistical Manual of Mental Disorders, 5th Ed" (DSM-5; American Psychiatric Association, 2013).

well. However, this discourse shows that it is difficult to keep this critical perspective conscious and visible in daily practice because practices such as cultural humility, cultural safety or multicultural orientation are seen marginal. This is true even within the more progressive person-centred care discourses that have been gaining momentum in mental health in recent years. When the professionals, featured in this literature, worked with migrant and refugee populations and racialised groups, they consistently encountered difficulties providing comprehensive care in systems that had underdeveloped cultural competency (Mitchell et al., 1998; Ramos et al., 2020; Liu, 2013; Ito & Maramba, 2002). This led them to redouble their efforts to respond to particular needs and preferences of particular groups. Most had limited opportunity to affect any of the local service structures that reproduced inequalities.

The *brokering* discourse usually describes individuals who work in services and also have strong community connections. These accounts commonly stress their personal attributes, such as empathy, and motivations. Lacking an emphasis on technicality, their practices are portrayed as experiential and intuitive. Hence this discourse consistently discusses the informal relationships these professionals have with communities, the hierarchical relationships they have with other professionals and the supervision and training that these professionals need. They sometimes include accounts of individuals seeking freer rein while supervisors and agencies set limits and moderate their ambitions (Brar-Josan & Yohani, 2014, 2019; Yohani, 2013; Karageorge et al., 2018; McKinney, 2007).

This discourse analysis entailed reading texts with a view to uncovering the "unstated implicit assumptions within them" (Cheek, 2004, p. 1144). The above brief exegesis identified some of the power dynamics that are at play in the working lives of bicultural professionals (Foucault, 1975). The analysis revealed some of the ways bicultural professional practices are minimised, marginalised and regulated. It also shows the ways in which bicultural professionals experience the objective structuring forces that organise their work and mental health service delivery (Bourdieu & Nice, 1997). These are issues to explore when thinking about how bicultural professionals could gain a stronger foothold within mental healthcare delivery.

Summary

Australian and Victoria State Government statements continue to note that people of culturally and linguistically diverse backgrounds, refugees, and asylum seekers are among the groups who experience lower levels of emotional and social wellbeing relative to the wider population. Cultural responsiveness frameworks, policies and plans have been

developed to address this. Bilingual or bicultural professionals do not feature in these documents. Some bicultural professional programs continue in some states under the auspices of transcultural units.

Several Australian agencies have produced resources that describe what bilingual and bicultural professionals do and discuss opportunities to develop this workforce. For the most part, they refer to culture broker or paraprofessional roles that have been described in international literature. None of these resources focus explicitly on professionals who assist people experiencing mental health or emotional issues. Bilingual professionals who offer mental health expertise in a language usually develop their own professional development plans in liaison with accreditation bodies and professional networks. I have not identified any Australian resources that focus on how bicultural and bilingual professionals, working in private practice or in publicly funded health and human services, use and apply culture-oriented practice principles.

There is limited research related to multicultural professionals and mental health service delivery. One study attempted to build theory relating to these professionals' practice. Liu and colleagues (2017) explored how public-sector professionals (social workers and staff at community-based Chinese ethnocultural organisations in a region of the United Kingdom) assist a particular ethnic minority community (older people of Chinese cultural heritage experiencing mental health and other health issues) to engage with services. No studies that considered professionals from a range of cultural backgrounds, who work across many settings, were identified.

There is very limited discussion at government policy and service delivery levels about how bilingual professionals contribute to the mental health and emotional wellbeing of individuals and families and communities, and the various roles they play. A discourse analysis based on qualitative peer-reviewed literature identified how power affect bicultural professionals and their practices.

This Study was designed to gather first-hand information, generate explanations and stimulate conversations.

Table 2 Studies Included in Narrative Review of Qualitative Studies

Author, country	*Type of Study and aims*	*Design & presentation*	*Position and program*	*Type of professional described*
		11 Qualitative studies		
Brar-Josan & Yohani (2014), Canada	Intervention study: Explore bridging roles played by culture brokers working in a program to enhance school and family life for refugee youth	Single case study. Semi-structured interviews & thematic analysis. Statement of findings. Researchers identify as bicultural professionals	Counsellors & culture brokers working with refugee youth	Bicultural and bilingual professionals and para-professionals who focus on community engagement
Brar-Josan & Yohani, (2019), Canada	Intervention study: Explore bridging roles played by culture brokers working in school settings.	Part of a larger study, single case study. Semi-structured interviews. Statement of findings.	Culture brokers & mental health professionals working with refugee youth	Bicultural and bilingual professionals and para-professionals who focus on community engagement
Ito & Maramba (2002), United States	Practice study: Explore perspectives on their own practices and clients' beliefs	Preliminary investigation, descriptive. Open-ended interviews & participant-observation. Statement of findings.	Professionals who speak numerous Asian languages and dialects working at a clinic for Asian Pacific families that provides outpatient and community outreach	Bicultural and bilingual professionals using culturally inclusive approaches
Karageorge et al. (2018) Australia	Program evaluation: Management and bicultural staff perspectives	Interpretive description methodology. Interviews & thematic analysis. Statement of findings.	Family therapy service that includes a refugee-focused program	Bicultural and bilingual professionals and para-professionals who focus on community engagement
Kokaliari et al. (2013), United States	Practice study: Explore professionals understanding of their role	Semi-structured interviews. Statement of findings.	Multilingual therapists based at a community centre, of varying cultural heritage using Spanish, Korean, Italian, Croatian, Tibetan, and Hebrew	Bicultural and bilingual professionals using culturally inclusive approaches
Liu (2013) United States	Practice study: Explore the lived experience of being bilingual social workers	Phenomenological. Interviews. Combined presentation of findings and discussion	Social workers who speak Chinese languages and are based at a community centre	Bicultural and bilingual professionals using culturally inclusive approaches

Author, country	*Type of Study and aims*	*Design & presentation*	*Position and program*	*Type of professional described*
Liu et al. (2017), United Kingdom	Access study: Identify how migrant group accesses formal care services	Grounded theory. Interviews. Statement of findings.	Chinese heritage identifying professionals based at a community-based Chinese organisations, other services, and family members and friends	Bicultural and bilingual professionals using culturally inclusive approaches
McKinney (2007), United States	Practice study: Explore role of bilingual and bicultural workers	Case study. Ethnography. Combined presentation of findings and discussion.	Bicultural workers, including those with Middle Eastern, North African, East African North Central American, Eastern European heritage who provide practical assistance and counselling, at a centre that supports refugees	Bicultural and bilingual professionals and para-professionals who focus on community engagement
Mitchell et al. (1998), Australia	Practice study: Explore role of bilingual workers	Phenomenological. Interview. Combined presentation of findings and discussion	Bilingual professionals – psychology, social work and nursing – based in numerous community mental health teams	Bicultural and bilingual professionals using culturally inclusive approaches
Verdinelli & Biever (2009), United States	Practice study: Explore the language capacities and use	Phenomenological. Interview. Combined presentation of findings and discussion. Researchers identify as bicultural professionals.	Spanish-speaking psychotherapists in community settings	Bicultural and bilingual professionals using culturally inclusive approaches
Yohani (2013), Canada	Practice study: Explore bridging roles of culture brokers	Case study. Focus groups, critical incidents, document review, and semi-structured interviews. Combined presentation of findings and discussion	Cultural brokers working with refugee families in school settings	Bicultural and bilingual professionals and para-professionals who focus on community engagement
		2 Mixed Method studies		
Tan & Denson (2019), Australia	Workforce study: Describe training and practice experiences, rate competences, develop recommendations	Qualitatively-led inquiry. Survey & interviews. Statement of findings.	Bilingual psychologists identified through professional networks	Clinical specialists who are bilingual

Author, country	*Type of Study and aims*	*Design & presentation*	*Position and program*	*Type of professional described*
Ramos et al. (2020), United States	Examine the experiences of therapists implementing evidence-based practices.	Quantitatively-led Survey & interviews. Statement of findings.	Therapists who identified as Asian American or Pacific Islander or African American in community health settings	Clinical specialists who are bilingual

Chapter 3 Methodology

Introduction

This chapter presents the choice of methodology in relation to the research aims and my connections to the field of transcultural mental health.

It opens with an overview of mixed methods research, grounded theory methodology, and key epistemologies from critical social theory, as well as the rationale for aligning the study with these approaches.

The research process is described, beginning by detailing sampling and recruitment, followed by data collection and analysis, with particular attention to how findings were meshed to develop an integrated understanding of the culture-oriented mental health practice of bicultural professionals that explores their perspectives, and situates the work in time and place and in relation to diversity and mental health discourses.

The chapter concludes by discussing strategies and mechanisms applied to ensure the Study's rigour.

A qualitatively-led mixed research methodology

This Study used quantitative and qualitative methods to meet largely qualitative interpretative goals: that is to describe, explore and conceptualise culture-oriented mental health practice of bicultural professionals. The Study was qualitatively (rather than quantitatively) "led" because it was, at its core, an in-depth exploration of participants' personal experiences and perspectives (Creswell, 2014, p. 43).

A background review (Sandelowski & Barroso, 2007), undertaken in the early phase of the Study used selective searching in order to make an assessment of existing knowledge and research gaps, and to develop and design the Study. There is limited research related to how bilingual professionals contribute to the mental health and emotional wellbeing of individuals and families and communities, the roles they play in supporting communities and enhancing the care provided by formal service providers. There is some consensus in the literature (as discussed in Chapters 1 & 2) about the valuable contributions that professionals who are themselves of recent migrant or refugee background make when assisting people experiencing mental health and emotional issues with whom they share a similar cultural, linguistic or faith background. However, little has been documented about

how they practice. Further, my experience as a mental health professional, including in transcultural mental health, and the knowledge of the enduring patterns of inequality in terms of service use and wider social opportunities, informed my decision to tap into the knowledge this important, yet under- acknowledged workforce. A motivation to better understand these professionals in the context of contemporary approaches to providing culturally responsive mental health care informed the decision to undertake this qualitatively-led enquiry.

Addressing the Study objectives

As outlined in Chapter 1, the Study aimed to enquire directly of professionals who assist people experiencing mental health issues or emotional issues (PeMH/EI) with whom they share a similar cultural, linguistic or faith background. The Study objectives were to:

1. Describe their personal and workplace characteristics, the tasks they perform, the approaches they use, and the kinds of supervision, support and training they receive.
2. Explore how these professionals practice – their motivations, the roles and responsibilities they take on, their perspectives on culture and mental health, and how they interact with service users and colleagues.
3. Integrate the descriptive and exploratory aspects of this study in order to build a compelling theory that explains their culture-oriented practice. This would entail examining relations between personal, professional, workplace, and other societal factors.

The Study was designed to develop descriptions of these professionals and their work, explore various elements of their experiences and circumstances in more depth and develop an integrated, contextualised theory that explained their practice.

Developing a grounded theory is primarily an iterative process that emerges from generating data, coding and categorisation. Hence prior knowledge and theoretical understandings should be scrutinised, as they can potentially threaten proper data collection and analysis (Charmaz, 2014). Researchers have taken different stances as to when and how to use pre-existing experience or literature in a Study. In this Study, I used reflective strategies to make a break from what I already knew of the social reality of the health settings and psychiatry and the social theories familiar to me as a long-term student of culture via the disciplines of anthropology and sociology. I also used grounded theory data generating and analytic procedures promoted by Charmaz (2014), Birks and Mills

(2015) and Clarke and colleagues (2015). I considered the work of some social theorists during the phases of theoretical integration and developing the substantial grounded theory. In support of this approach Albert and colleagues (2018) argue that inductive reasoning and narrative interpretations are not a sufficient basis from which to build compelling social theory. In summary, my approach here, to evoke the work of Bourdieu, Levinas and others, does not constitute a "private reflection" and is not based on my believing they held "innate wisdom". These theoretical perspectives offered ways to verify social facts that were emerging in the study, and to think about relations between structures, mechanisms and processes social theories (Albert, Mylopoulos, & Laberge, 2018, p. 8).

Constructivist grounded theory research method

Conceptual underpinnings of constructivist grounded theory methodology

Conceptually, Charmaz's (2014, p. 266) constructivist grounded theory (cGT) methodology elaborates on the "symbolic interactionism" articulated in the 1960s by Blumer, who responded to the work of early twentieth century American pragmatists. Blumer described how, in a given social context, interactions between actors, shape future actions. Key premises of Blumer's symbolic interactionism include: human beings act in the world of things, because things already possess meaning for them; meaning is derived from interacting with others; and the processes by which one responds to the people and things that one encounters are synonymous with interpreting their meaning (Charmaz, 2014, p. 270). Symbolic interactionism "takes into account the subjectivity of social actors as they engage in practical actions in the world" (Charmaz, 2014, p. 269). Charmaz sees a close alignment between symbolic interactionism and cGT methodology. Symbolic interactionism offers a conceptual rationale for the methodology's iterative approach to data gathering and analysis, the focus on exploring dynamic social processes, and capacity to explain the ways social structures manifest within particular contexts.

Co-construction

A core tenet of using cGT methodology to let empirical data drive further data gathering and the conceptual analysis, and to set aside rather than impose pre-conceptions that the researcher may have about what the study will find (Bryant & Charmaz, 2007).

The methodology acknowledges the researcher's involvement in a Study, especially the part that their subjectivity and circumstances play in generating and interpreting data. That is, enquiries entail the 'mutual construction' of knowledge, by researchers and participants.

Researchers' standpoints, priorities, choices and negotiations are integral to the world they study, the data generate, the analyses undertaken and the interpretations they make (Charmaz, 2014; Fram, 2013).

This theoretical approach is compatible with the relational and structural worldviews that I hold. Even so, I made pragmatic decisions when designing this Study that limited the opportunities for participants to be explicitly involved in knowledge co-construction: this occurred during data collection to the extent that the interviews were conversational, and later interviewees offered their reflections on the emerging analysis. I have documented decisions made throughout the Study period as well as reflections on the process and my own standpoints.

My past and present involvement with people and perspectives throughout the life of this Study includes the range of encounters I have had with bicultural professionals in particular and multicultural mental health more broadly, outside the bounds of the Study activities. Namely, I have professional connections with a state-wide transcultural unit that provides opportunities to connect with bicultural and bilingual practitioners working in health and human services and also those based in multicultural and small community ethnocultural agencies. We have encountered each other in workshops and reflective practice sessions which I have facilitated, as an external evaluator of capacity building community mental projects, and during professional development sessions and network meetings that bring together professionals with an interest in refugee health, diversity issues transcultural mental health.

Applying a constructivist grounded theory methodology

The methodology uses a set procedural approaches described by Charmaz (2014) as well as Birks and Mills (2015) that are designed to derive abstract understandings by exploring the subjective understandings of participants, their experiences, and their interactions and identifying, exploring patterns to develop explanations (Fram, 2013). The aim of a cGT study is to explicate "an abstract grounded theory of a substantive area of enquiry" (Birks & Mills, 2015, p. 97). Characteristically, the methodology is associated with adopting coding techniques, and using a constant comparative approach and memo writing to create a compelling interpretation of the data (Charmaz, 2014). The researcher begins by engaging directly with the data to define what is happening and what it might mean, and later identifies the more significant codes and compares them with other data and other codes (Charmaz, 2014).

The terms *codes* and *categories*, *coding* and *categorising* are at times used interchangeably in the grounded theory literature and defined differently by different authors. Charmaz tends to reserve *categories* for the codes that acquire "overriding significance" or analytic concepts that arose by "abstracting common themes and patterns" (Charmaz, 2014, p. 341). I also adopt this style in this Study.

Birks and Mills (2015, p. 108) define a grounded theory as "an explanatory scheme comprising a set of concepts related to each other through logical patterns of connectivity". The theory I propose in this study is less structured than that definition implies. It is not structured around a "core category", that is, I have not posed a unifying concept that integrates all the main categories that emerged (Birks and Mills, 2015, p. 97). The practices are characterised as multifaceted pathways, embodied and actioned in varied settings. The theory developed in this Study applies in a local social world (Charmaz, 2014, p. 17). It is a meta-narrative (Albert et al., 2018), an interpretation of the overall analysis, and an account of how the categories and sub-categories meshed (Mason, 2006).

Applying a critical lens and using critical theories

Critical theories have been variously used in grounded theory research (Gibson, 2007; Bryant & Charmaz, 2007; Fram, 2013; Clarke, 2015a) to explore injustice and inequality.

I intentionally drew on my pre-existing knowledge of social theories during the advanced stage of analyses and theory development in this Study, although I was also mindful of their potential explanatory power for me much earlier in the analytic process. I acknowledge that this breaks with cGT priorities: that developing a grounded theory is primarily an iterative process that emerges from generating data, coding and categorisation; and the appropriate time to include the researcher's preferred categories is after the Study's substantive theory has been generated.

Making these moves could be seen as instances of me giving "priority to researcher's analytic categories and voice" (Charmaz, 2014, p. 136). However, others, such as Albert and colleagues (2018) argue that inductive reasoning and narrative interpretations are not a sufficient basis for theorising about social life. They argue that applying theoretical frameworks in qualitative research is an advantage. External theories can suggest new ways to understand data, and bring to light information about relations between structures, mechanisms and social processes (Albert et al., 2018).

My experience was that exploring these critical perspectives was helpful. They deepened my understanding of the data, and helped me to see experience-near concepts and identify

patterns in the data (Fram, 2013). Drawing on external sources expanded my ability to explore multiple realities, in ways that acknowledged subjective perspectives and responded to the complexity. They made me more attuned to position taking (including my own) and expressions of power in the narratives of participants.

I was already familiar with Pierre Bourdieu's (Bourdieu & Nice, 1977) *theory of practice* and his work on symbolic violence. His sociology is populated with compelling ways to conceptualise the structuring power of social worlds and the socially constituted dispositions of thinking, feeling, and acting agents (Calhoun & Wacquant, 2002, p. 5). Other theoretical sources include work on the social expressions of affect, embodiment and the imaginary developed by Gilles Deleuze, including as interpreted by May (2005) and Clarke (2015a), the work of Emmanuel Levinas (1989a) on ontology, ethics and otherness and also Hannah Arendt's (1998) use of concepts of labour, work and action to discuss the human condition. I am aware that that throughout the Study, more people and writers have been living in my mind than this list suggests. They include countless seekers of justice for Australia's First Nations and internationally, and the voices of feminist and anti-racism.

For example, when exploring the properties of bicultural mental health practice, applying elements of Bourdieu's theory of practice gave me the conceptual tools I needed to clarify other component parts of the theory. I zoomed out from the many accounts in literature about their talents for building trust in relationships and revealing cultural insights, as well as common observations about an ethos of service and propensity for self-sacrifice. First person voices and allies explained that these professionals were functioning in health care service ecologies that sometimes recognised them but, more often than not, ignored their contributions. This led me to regard bicultural mental health practices as more than the collective outcome of personal trajectories, community preferences and local service priorities. Their culture-oriented practices were responses to the needs and preferences of migrant and refugee populations; they exist due to the efforts of particular people but they also arise from points of weaknesses in the health service system and broader societal failures of collective action.

Mixed method research

Mixed method research approaches are particularly suited to addressing research questions about social experience and lived realities. While debate continues about combining quantitative and qualitative research there is consensus in public health research that using multiple diverse approaches within a single study often leads to richer

analyses and ways to triangulate findings (Fehenbacher & Patel, 2020).

In mixed method research "mixed" can refer to the types of data collected, techniques for collecting data, as well as approaches to sampling, analysis and interpretation (Collins, Onwuegbuzie, & Jiao, 2007). Combining qualitative and quantitative data enables exploration of "different types of questions" and the relationships between items and themes (Creswell, 2014, p. 43), and can illuminate the "different layers of a phenomenon" (Feilzer, 2010, p. 7). The mixing of methods should deliver an explicit purpose to a study (Guest, 2012); this can include one data set informing or explaining another, serving to triangulate findings, or allowing exploration of the relationship between data sets (Mason, 2006).

Since the pioneering work of Glasser and Strauss, grounded theorists have adopted mixed methods designs (Johnson, McGowan, & Turner, 2010; Gasson & Waters, 2013). Charmaz agrees that the "inductive, iterative process" of grounded theory complements "moving between methods and mixing results" (2014, p. 324) and that cGT methodology can accommodate using "more than one type of data", and more than one type of analysis. Similarly, Creamer (2018a) argues that mixed methods grounded theory methodology can support the development of creative explanatory frameworks and theoretical models.

Study design

This Study has a qualitatively-led mixed methods design. The overall approach to data gathering, analysis and building theory in this study was guided by the grounded theory methodologies described by Charmaz (2014), Birks and Mills (2015), and Clarke (2015a). The main features of the mixed methods design are outlined in Table 3.

Adopting two modes of enquiry allowed the Study to explore different dimensions of bicultural professionals and their practice – to learn about their roles and approaches to culturally-oriented work as well as their experiences at work and relationships with professional peers, service users, and communities. This resulted in richer information that explored these different aspects and generated a more holistic picture than would have been possible, if I had relied on only one source of data (Creamer, 2018a).

Table 3 Features of the Mixed Methods Design

Aspects of mixed methods design	Design elements used in this Study
Modes of enquiry	*Two modes:* Pre-determined, as survey closed questions consistent with post-positivist attempt to collect objective and value-free data. Emergent, as interviews conducted in line with adoption of constructivist tenets.
Data collection	*Two methods.* Online survey and semi structured face-to-face interviews. *Sequential*. Survey conducted before interviews commenced.
Data types	*Mixed*. The survey included closed and open questions (generating quantitative and qualitative data). Interviews were audio recorded and transcribed, and memos and field notes were made (qualitative).
Data sampling	*Purposive* sampling scheme. *Nested.* Interview participants are a subset of survey participants.
Data analysis	*Types.* Survey: descriptive, associations and correlations. Survey: structures in data, themes, social processes and actions and situations. Interviews: social processes and actions, and situations. *Mostly sequential, some concurrent*. Survey analysis completed before interviews commenced. Analysis of interview data concurrent with conducting later interviews. *Mostly separate, some integration.* Initial analysis of survey data informed content of first interview schedule. Participant specific information from survey informed conducting and analysing each interview.
Data interpretation	*Meshed.* Advanced coding of all analysed data was used to generate meta-narratives and explore underlying processes and mechanisms.

Data collection was undertaken sequentially: the survey, which collected quantitative and qualitative data, was undertaken before the more substantial qualitative data was collected by interviews (Guest, 2012; Creswell, 2014). This offered participants two different ways to participate.

The survey generated quantitative and qualitative data. Procedural questions about these professionals and their work were designed to elicit discrete detailed information, numerically measure phenomena, test the strength of associations between data items, and then make and refine claims (Creswell, 2014). Preliminary findings of patterns in the survey data related to the professionals' activities and approaches to culturally responsiveness, as well the issues they face in work settings, informed the focus of the

initial set of interviews. Contextual information from surveys about each participant became background information for each interview.

The survey provided an efficient and consistent way to gather background information, including personal and professional characteristics, work roles and disciplines and to identify themes to explore in the initial interviews. The survey familiarised me with the views of a larger group prior to engaging a smaller sample in more depth to "obtain their specific views and their voices about the topic" (Creswell, 2014, p. 50).

The sampling scheme was purposive. Participants were selected using eligibility criteria based on their capacity to "best help the researcher understand the problem and the research question" (Creswell, 2014, p. 239). A "nested" qualitative sub-sample was interviewed within a larger population of survey participants (Lieberman, 2005). Interviews were used to produce rich descriptions to support transferability and applicability of findings. Saturated qualitative data and allowed exploration of discrepancies between participants' survey and interview responses. The study did not seek a representative sample (Teddlie & Yu, 2007). The data sets were separately analysed in depth, and close in time, using a range of statistical and textual analytic techniques (Guest, 2012; Creswell, 2014). Everyone who volunteered to interview met the need for a broad sample.

The two data sets were integrated at the point of interpretation. The interview data was understood in the light of the information that individuals had also provided in survey responses. The qualitatively rendered survey data was considered alongside the abstract codes and categories that emerged from analysis of the qualitative interview data. As the study progressed, interpretations of survey, interview, memo and field note data were explored with the aim of developing a theory that could accommodate different dimensions of culture work practice.

The Study design was implemented in six phases, from design to development of the substantive grounded theory (see Table 4 for more detail).

Table 4 Study Phases

Phase	Description
Phase 1 Development and design (2014)	*Literature reviews:* For background and to develop survey questions; commence systematic search to prepare narrative review. *Study design:* Qualitatively-led mixed methods grounded theory methodology. *Ethics:* Complete formal procedures and address practical issues that may arise
Phase 2 Survey – collect data (2015)	*Quantitative enquiry:* What are the characteristics of people, positions and features of the work? *Qualitative enquiry:* How do professionals explain their practice? *Purposive sample:* 44. *Collect data:* Design survey - closed and open text questions; Emails with link to online survey.
Phase 3 Survey – analysis (2015-2016)	*Quantitative Analysis:* Describe personal, professional and job characteristics; Explore associations and correlations. *Qualitative Analysis:* Explore patterns across quantitative data & create visual maps; Thematic analysis of open text of data. *Grounded theory analysis:* Initial coding of open text data; Intermediate coding; Constant comparative analysis; Category identification; Theoretical sampling.
Phase 4 Interviews – Collect data & concurrent analysis (2015-2016)	*Qualitative enquiry:* How do professionals explain their practice? *Nested sample:* 19. *Collect data:* Prepare interview schedule; Semi-structured 1:1 interviews; Transcribe recordings. *Grounded theory analysis:* Initial coding of open text data; Intermediate coding; Constant comparative analysis; Category identification; Theoretical sampling; Select important categories and their sub-categories; Theoretical saturation. *Situational mapping:* Social spheres mapping; Position mapping; Situational abstract mapping. *Discourse analysis:* Explore extant literature
Phase 5 Theoretical integration (2016-2020)	*Grounded theory analysis:* Compare data sets and themes; Mesh the analyses. Advanced coding – identify social processes, situational features, and relations between themes and categories; Explore extant literature, including critical social theory.
Phase 6 Develop a substantive grounded theory (2016-2020)	*Outline categories and their connections:* State the connections between important categories and their qualities; Show the relations and interactions; Focus on the main category of "practice"; Present case examples that discuss three practice pathways; Conclude narrative literature review; Present all findings and develop meta-inference; Present theory as metanarrative and image; Explore extant literature.

Note. Using Birks and Mills (2015, p. 91) coding terminology of "initial", "intermediate" and "advanced" coding which correspond to Charmaz's (2014) terms "initial", "focused" and "theoretical" coding.

Ethics

This Study addressed ethics in terms of both necessary formal procedures and practical responses to ethical issues that may arise when conducting research (Phelan & Kinsela, 2013, p. 82). The former includes seeking approval from an ethics committee, seeking informed consent from participants and maintaining confidentiality with the individuals involved. The latter refers to the researcher anticipating issues that may arise in the course of the study and demonstrating reflexivity.

Ethics approval

Approval for the Study was sought from La Trobe University's Research and Graduate Studies, University Human Ethics Committee by making a low risk application in two phases: to conduct an anonymous online survey and face-to-face interviews. The Science Health and Engineering College Human Ethics Sub-Committee Reference number for this study is S15/15.

Seeking informed consent

Competence to consent was assumed as all eligible individuals were employed (in paid or unpaid roles) by health, social and community agencies. Respondents required a level of literacy to access the online survey.

The participant information statement that accompanied promotion of the initial phase of the study was downloadable from the first page of the online survey. Confirmation of having read the statement was required before that they had read the statement before proceeding to the survey questions. It included information about how data privacy and how to withdraw consent to participate. Respondents were invited to indicate their interest in being contacted for interview by providing contact details when submitting the survey. At this point respondents became identifiable.

They were also informed that the researcher would contact all who expressed an interest and that not all who expressed an interest would be necessarily be interviewed. Written consent to participate and make audio-recordings was obtained.

Participant privacy and confidentiality of information

As indicated above, the study design allowed individuals to participate anonymously in the survey. On completion of the survey questions, a final screen thanked respondents and invited further participation in the study. Individuals could indicate their interest in being

contacted by the researcher for interview by following a link to a new survey page where s/he could provide contact details. Only the researchers had access to this contact information.

Ethics approval allowed the researcher to identify the survey data that belonged to individuals who were also interviewed. This design element is consistent taking a sequential approach to data gathering and allowed the researcher to: identify and compare the characteristics of participants represented in the survey and interview databases; incorporate survey descriptive data into interpretations of interview discussions and; generally, integrate the analysis of findings across databases.

Steps were taken to maintain confidentiality: data files belonging to individuals who were not selected for interview was removed; and the contact detail material of participant data files belonging to individuals contacted for an interview were removed once these sessions were completed. All information gathered throughout the course of the study has been stored securely and treated as confidential.

The personal and work-related characteristics of survey and interview participants have been reported to the extent that their privacy can be guaranteed. Code letters (for anonymous survey participants), numbers (for interviewees) have been used to report data provided by particular individuals. The detailed case examples use pseudonyms. Care has been taken so as not to identify any agencies or other contextual information that might inadvertently identify participants. Any quotes used in reporting study findings will not be directly attributable to particular individuals (Glesne, 1999). Background details that could potentially identify participants have been detached from the reporting of some findings.

Reflexive ethical research practice

Demonstrating reflexivity is not only a way to increase a study's rigor; it is also a means of "enacting ethical research practice" (Phelan & Kinsella, 2013, p. 88). I addressed this by questioning myself throughout the course of conducting the research and documenting my reflection. These reflexive questions, adapted from the work of Phelan and Kinsella (2013) considered: each individual's assent to participate; the nature of the information they disclosed; the power dynamics between myself as researcher and study participants; and how individuals and groups are represented in reports arising from the study.

For example, I anticipated that *assent* or dissent to participate may be mediated by the degree of autonomy individuals have in scheduling their work or obligations to inform employees about engagement with external researchers (Glesne, 1999). With regard to

disclosure and *reporting,* I considered if interview participants may be concerned about the study's potential to reveal "dangerous knowledge" (Glesne, 1999, p. 27) such as criticisms of service providers and community agencies for which they work, or inadvertently offend or damage their own reputations by discussing ethnic and faith community groups with which they have close personal connections. When using quotes from written text and interview transcripts I have kept the original words and phrasing that participants used, only replacing words when I judged that the meaning was lost in transition to the page. Regarding *power dynamics*, I considered how participants were likely to relate to me personally and perceive my interests as a researcher given that I do not personally identify as being of an immigrant or refugee background and have been associated for some time with the transcultural mental health field in Victoria.

The range of ethical issues and reflexive questions that I anticipated would be important to consider throughout this study are outlined in Table 5 and adapted from the work of Phelan and Kinsella (2013).

Setting

The State of Victoria is ethnically and linguistically diverse, with considerable variation in the distribution of diverse populations within and between regions. Publicly funded mental health, health and social support services are delivered by a range of government and non-government agencies across operating in metropolitan, rural and regional areas (VG, 2020b).

There are designated child and youth, adult and older people's clinical and psychosocial mental health support, care and treatment services. Mental health care and support is also provided by community health centres (that is, publicly funded multidisciplinary providers of primary health care) and counselling services. In addition, there are agencies that provide newly arrived migrants, refugees and asylum seekers with psychosocial and settlement support; ethno-specific agencies that provide communities with health services, aged care or social support; agencies that provide people, who have refugee and refugee-like experiences, with specialised counselling services; multidisciplinary professional mental health networks focused on diversity responsiveness, transcultural mental health, or trauma-informed care (VG, 2020b).

Table 5 Ethical Issues and Reflexive Questions

Ethical issues and reflexive questions
Assent
In addition to obtaining written consent, do participants understand how their views will be disseminated?
Have I made a conscious effort to revisit assent throughout the research process?
What have I observed that leads me to believe the participant has assented or dissented?
Disclosure
Reflecting on the survey and the interview guide, what are the potential risks of unintentional disclosure?
Is the participant's dignity, emotional and cultural safety being preserved in the research process?
Have I allowed each participant to direct what s/he feels comfortable sharing?
Power
How have I presented myself to the participant and how do they perceive my role?
In what ways have I created a safe space?
What aspects of the research relationship are making me feel uncomfortable?
What aspects of the research relationship are flourishing?
How have I continued to offer opportunities for the participant to withdraw? Ask questions?
How do the methods used contribute to balancing power dynamics and individuals to influence on the research?
Have I considered the benefits and risks to each method?
Representation
Have I considered safety, dignity, and voice throughout the research and dissemination process?
What are my preconceived assumptions about individuals of immigrant and refugee background living in contemporary Australia? About people experiencing mental health and emotional issues?
What are my intentions? Have I identified myself in the research?
Whose voice is represented in reports arising from this study?

Recruitment and sampling

The Study population

I aimed to recruit a broad cohort of individuals. I anticipated that they may be assisting PeMH/EI by performing any of a range of tasks – including counselling and other therapeutic interventions, cultural liaison between individuals or groups and service providers, and cultural guidance and mediation between professionals – in varying capacities – as their main role or as part of a broader role assisting other groups, in an ongoing role or on request as needs arise, and in paid or unpaid role. That is, participants were *not* required to be working in designated bicultural or bilingual roles or limited to

providing direct client-care or therapy.

There was no target sample size as the population was unknown, however based on my knowledge of the sector I anticipated approximately 50 individuals would respond to the survey and 20 individuals would be interviewed.

Eligibility and recruitment approach

The Study aimed to include professionals working within and outside designated mental health services and programs. This was because members of immigrant and refugee communities, who are experiencing mental health issues, use publically funded tertiary mental health services at lower rates than the Australian born (Stolk et al., 2008; Minas et al., 2013). Anecdotally, it is known that individuals and families from these groups also turn to professionals working in general health, social support and multicultural services for mental health assistance.

Participants in the Study self-identified as having the following characteristics: employed in a paid or voluntary capacity, within the State of Victoria, by an agency that provides health, mental health or social support to individuals or families; are bilingual or bicultural; undertakes work that involves assisting individuals from immigrant or refugee background experiencing mental health or emotional issues; shares a cultural, language or faith background with at least some of these service users. Individuals who met all of the above criteria within the previous 24 months were included in the study.

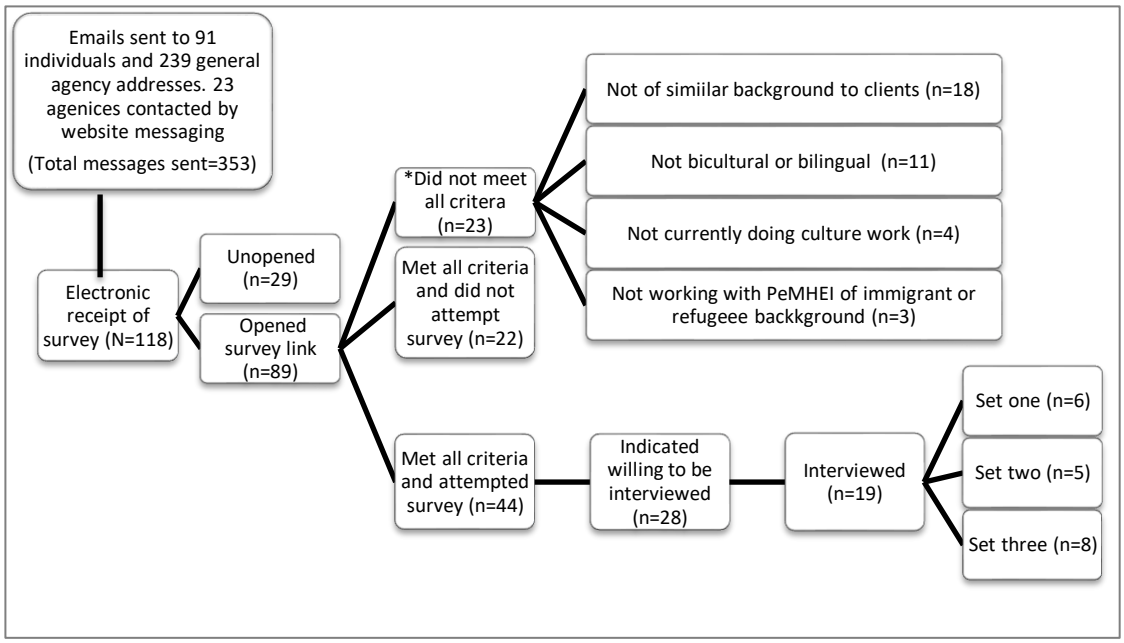
The recruitment strategy cast a wide net with the aim of capturing the interest of eligible individuals. This included individuals working in mental health, health, human services, and refugee and community health and multicultural agencies across Victoria. Contacts were identified via government and not-for-profit organisation managed service directories, and peak agencies for ethnic community organisations, settlement services, local government as well as mental health networks and professional bodies. A total of 353 messages were sent by email to individuals, general agency addresses and using website contact forms. The participation information statement was attached and a link to a survey was embedded in the email. This enabled anyone who was interested to access the survey.

Participants

A total of 118 individuals opened the survey (see Figure 2). Of these 89 attempted the survey. Some did not meet all the criteria for participation (n=23) or met the criteria but did not proceed to answer other questions (n=22). 44 participants attempted all or part of

the survey and provided information about themselves and their work. 28 indicated on the closing page of the survey that they would like to participate in an interview. Of these 19 individuals were interviewed in three sets. Participant characteristics are described in Chapter 4.

Figure 2 Recruitment Process



Note. *Some individuals did not meet more than one criterion.

Of the 23 individuals who did not meet all the criteria, all were based in Victoria and over 18 years of age: 18 were not of similar background to some or all of the individuals they assist; 11 individuals did not identify as bicultural or bilingual; 4 were not currently doing this work or had done so in the past 24 months; and 3 did not work with people experiencing mental health issues or emotional issues who are of immigrant or refugee background.

I could not know how similar the Study sample was to the bicultural practitioner population, who take a culture-oriented approach to assisting people experiencing mental health and emotional issues in Victoria, because research had not been done (or to my knowledge since) to identify a representative sample. To make claims about bicultural professionals in general from studying a portion of them, one needs to be able to confidently report the margin of error (Lois, 2012). To my knowledge, no such information exists about the personal and professional characteristics of these professionals working in publically funded health and human services.

Data collection

Survey and interview data were collected over a 17-month period, during 2015 and during 2016. I also made field notes following each interview and kept records of conversations I had with participants such as preliminary and follow-up phone calls and emails.

Survey

Surveys are an economical way to learn about a population by consulting a small group of individuals. They are used to develop "numeric descriptions of trends, attitudes or opinions of a population by studying a sample of that population" (Creswell, 2014, p. 42). Although I anticipated a relatively small sample size, the survey would be essential step toward clarifying what individuals, who identify as a bicultural professional do, as this information was not already available. An online survey platform enabled me to recruit from a diverse population of practitioners – in terms of personal and professional characteristics, their geographical location, types of positions and workplaces – with a rapid turnaround in data collection. Anonymity settings also made it possible for individuals to engage with the study while maintaining their privacy.

The survey was broad in its scope and was estimated to take twenty minutes to complete. We discussed the advantages and disadvantages of taking this approach. On the one hand, we risked people being put off getting involved, or losing interest and giving up part way through. Participants might find the numerous questions about their cultural background intrusive or irrelevant to their practice as a professional. By implication this could result in very low numbers of respondents. On the other hand, I had a strong personal sense (and a scan of the literature supported this) that bicultural work is rarely commented on or documented in mental health settings or policy discourses. Conducting a wide-ranging survey suggested a way to enquire directly about contemporary practice and contribute new information that might set the scene for further investigations. Further the survey would be useful in reducing the length of time need to conduct each interview session; I would be able to approach each individual already informed about many aspects of their personal and professional circumstances and use precious interview time, not to establish basic information, but to just clarify or extend information already provided and remain focused on listening to bicultural professionals describe their work and their concerns.

Overall survey design

The survey was developed in Qualtrics, an online survey program, and field tested with

three content/research experts, and then with two people who met the Study's eligibility criteria. Feedback from these five individuals led me to make minor adjustments to the contextualising information, modify the way qualification field and level questions were structured and change the age question from age groups to simple numerical response in years.

The survey was cross-sectional; that is, the data was collected at only one point in time. The survey was sent as a link by email to multiple mental health, primary health care, human services and multicultural agencies across Victoria. The email included a link that enabled anyone who was interested to access the survey and participate anonymously. A paper copy of the survey was available to send by post on request. When no more new responses had been received for 4 weeks, the survey was closed.

Eligibility to participate was established by seeking responses to a list of statements. Those who met all criteria could proceed to the main survey comprised of multiple choice and open questions. For an outline of the data items see Table 6 below. A copy of the survey instrument and other information is included in Appendix B.

The range of questions asked

Before proceeding to the questions, participants were provided with some information about the range of work roles and tasks that it would be relevant for them to consider.

Multiple choice questions and matrix tables sought detailed information from each individual – about his or her personal and professional attributes, positions held, and workplace, and work tasks and approaches. The survey included Likert scales. Some questions provided participants with a limited range of options or a text box in which to provide content that was later coded. A small number of open text questions were also included.

Developing the specific questions

A number of questions regarding personal and professional characteristics, positions and organisations reflect phrasing of questions asked by the ABS. I also reviewed relevant mental health and cultural diversity literature to develop the survey questions related to work roles, tasks and approaches.

Ethnicity was self-defined by study participants. Demographic information collected about participants was aligned with the questions and classifications used in the Census 2011 Household Form (ABS, 2013a). The ABS's multidimensional definition of ethnicity was adopted, based on self-perceived group identification[3], (ABS 2011a; 2011g).

Country, ancestry and language categories were based on ABS categories (2011b; 2011c; 2011d; 2011f; 2012). Information about country of birth, cultural heritage and languages spoken was collected using classifications at the most detailed level. In order to protect anonymity, the qualitative findings are reported using broad group classifications that aggregate geographically proximate groups.

The ABS's (2011e) convention to describe religious affiliation as also used. This includes broad categories for non-Christian traditions and distinct categories for Christian traditions within Christianity. I am aware of this bias, and acknowledge that all the major religious traditions are internally diverse.

Questions regarding professional qualification fields and levels were consistent with commonly used standard classifications (ABS, 2006) and the Australian Qualifications Framework (2013).

The survey questions asked participants to provide the following personal information: their gender identification and age; their country of birth, year of migration to Australia, and the country of birth of each parent; their self-perceived ancestries; their religious affiliation; and whether or not they speak a language or languages other than English, the name of these languages, and whether or not they spoke these languages at work. They were also asked to describe their tertiary level qualifications and highest level of educational achievement.

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[3] The distinguishing characteristics of one's "ethnicity" may include: "a long-shared history the memory of which is kept alive; a cultural tradition, including family and social customs, sometimes religiously based; a common geographic origin; a common language (but not necessarily limited to that group); a common literature (written or oral); a common religion; being a minority (often with a sense of being oppressed); being racially conspicuous" (ABS 2011a).

Information about positions held

Questions about participants' work positions and the organisations where they work were designed in line with the "Health Care and Social Assistance" division of standardised industrial classifications (ABS, 2006; 2013b). More specific categories were added, based on my prior knowledge of health and social welfare sectors and feedback received during survey testing.

Participants were asked to state the job title of up to four relevant positions held within the past 24 months and to indicate the following in relation to each; the type of industry or agency in which they work, whether the position is a paid or unpaid, the type and range of geographical area serviced and the name of the suburb, town or city from which the position operates. They were also asked to indicate number of hours worked, months or years in each job, and the proportion of time that they focused on working with people with experiencing mental health of emotional issues (PeMH/EI) who were of similar background to them.

Information about activities and approaches

Questions regarding what bicultural professionals do and the approaches that are important to them were designed following search of literature using key terms for the period 1995 to late 2014, as well consultation with professional peers and based on my own experience.

I explored grey and peer-reviewed literature for content that described the activities that bicultural and bilingual professionals undertake and mentioned the rationales that underpin their work. This analysis involved creating succinct descriptions and generating codes that entailed very little interpretation (Miles & Huberman, 1994). Details of the sources of the codes that became the basis of two sets of survey are listed in Table 22 in Appendix B.

A comprehensive list of prompts was prepared, with the aim of generating consistent and comprehensive data that did not rely on participants to generating their own descriptions and could be compared with extant literature.

As far as I am aware, the following five-fold characterisation of the work has not been identified elsewhere in health or mental health-related cultural competency literature. Namely, bicultural professionals: [4]

- directly assist by providing mental health treatment and care; therapy or counselling; and/ or psychosocial support
- advocate regarding health or other human rights
- facilitate intercultural interactions between service users and other professionals
- assist organisations and other practitioners to improve their responses to particular groups or diverse communities
- assist ethnocultural and multicultural groups or organisations to respond to mental health and emotional issues that are affecting their community.

Participants were asked to select which of the above five *general tasks* they do and then use prompts to select *specific tasks* by considering their work across all the positions that they had already described. The specific tasks totalled 30 items plus prompts to specify any tasks that were not captured in these lists.

Responses to these questions pertained to each participant, not each position. For example, a participant who indicated that they "assist services and other practitioners to become culturally sensitive", was prompted to indicate if, for them, this involved "educating the work force" or assisting in other ways that were also outlined. They may have had one or more position in mind when responding to this question.

I also discerned 21 separate descriptions from the literature related to the approaches taken by bilingual and bicultural practitioners. These were used to formulate statements about the potential rationales, beliefs about their consequences, and knowledge paradigms that underpin their work to assist PeMH/EI.

Participants were asked to indicate their level of agreement with each statement. Participants were asked to indicate the extent to which each statement resonated for them, not about their opportunities to apply them at work.

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[4] Mitchell and collaborators' (1998) Australian study of bilingual mental health workers developed a similar taxonomy. They initially distinguished individualised from community interventions, and then identified four categories (i) direct clinical service provision; (ii) mental health promotion and community development; (iii) cultural consultancy; and (iv) service development.

Information about other experiences

Open questions were included to generate data depth, produce quantifiable data (about supervision and training opportunities) and to identify issues that might supplement the closed questions (O'Cathian & Thomas, 2004).

These questions enquired about life experiences perceived as relevant to their professional role; opportunities for workplace supervision, support, and training; the issues that arise for them when assisting PeMH/EI; and their approaches to resolving these issues. Additionally, all participants had the opportunity to offer any other general comments before exiting the survey.

Table 6 Outline of Survey Data Items

Data item	Type of question	Response options
Personal and professional characteristics of participant		
Gender	Drop down menu (one option only)	Select 'Male'; 'Female'; or 'Other'
Age in years	Text box	Insert number
Born in Australian or overseas (OS)	Drop down menu (one option only)	Select 'Australia'; or 'Overseas'
Mother born in Australia or OS	Drop down menu (one option only)	Select 'Australia'; or 'Overseas'
Father born in Australia or OS	Drop down menu (one option only)	Select 'Australia'; or 'Overseas'
Country of birth (COB)	Drop down menu (one option only) and text box	Select from top 20 COB reported in Australia, and option to select 'Other 'and describe
(If born overseas) Year of migration to Australia	Drop down menu (one option only)	Select from list of years '1936' through to '2014', and option to select '1935 or earlier'
Ancestries	Drop down menu (option to select up to two options) and text boxes	Select from top 20 ancestries reported in Australia, and two options to select 'Other' and describe
Language other than English (LOTE) spoken	Drop down menu (one option only)	Select 'Yes'; or 'No'
(If LOTE spoken)	Drop down menu (more than one option) and text boxes	Select from list of 183 languages and option to select 'Other' and describe
LOTE spoken at work	Drop down menu (one option only)	Select 'Yes'; or 'No'
(If LOTE spoken at work)	Drop down menu (more than one option) and text boxes	Select from list of 183 languages and option to select 'Other' and describe
Religious affiliation	Drop down menu (one option only) and text box	Select from list of 15 affiliations, including 9 distinct Christian traditions, and option to select 'Other' and describe
Professional characteristics of participant		
Highest level of education	Drop down menu (one option only) and text box	Select 'Post-secondary education (e.g. TAFE, University)'; 'Senior secondary education (Year 11 or 12 or equivalent)'; 'Junior secondary education (Year 7, 8, 9 or 10 or equivalent)'; 'Primary school education'; or 'Other' and describe
(If has a post- secondary education) Qualifications held	Drop down menu (more than one option) Prompts to provide name in text box and select level of each qualification (no limit on number of specific qualifications described)	Select from 5 broad fields: 'Health, psychology or human welfare'; 'Social, cultural or political studies'; 'Education, including teaching or training'; 'Management or commerce'; and or 'Other field' and describe Name each qualification and select from 5 levels: 'Certificate level - I, II, III or IV'; 'Advanced diploma and diploma level'; 'Bachelor degree level and honours'; 'Graduate diploma, graduate certificate; or 'Post-graduate degree level, master degree or doctoral degree'

Data item	Type of question	Response options
Characteristics of culture work positions held by participant (option to describe up to 4 positions held in past 24 months)		
Position	Text box	Name of position
Industry type	Drop down menu (one option only) and text box	Select from list of 26 agency types and option to select 'Other' and describe
Location	Text box	Name of suburb, town or city
Paid or unpaid role	Drop down menu (one option only)	Select 'Paid'; or 'Unpaid'
Type of geographical area	Drop down menu (one option only) and text box	Select 'Metropolitan'; 'Rural'; 'State-wide'; 'National' and option to select 'Other' and describe
Hours worked in a typical week	Drop down menu (one option only)	Select number, 1 through to 40+
Months or years in role	Drop down menu (one option only)	Select '5 months or less'; '6-11 months'; '1 year'; '2 years'; '3 years'; '4 years'; '5 years'; '6 years'; '7 years'; '8 years'; '9 years'; or '10 years or more'
Culture work as a proportion of the role	Drop down menu (one option only)	Select 'Very small amount (less than 20%)'; 'Some (20-39%)'; 'About half (40-59%)'; 'Large amount (60-79%)'; or 'All or almost all (80-100%)'
Features of culture work tasks performed by participant		
General tasks	Multiple choice (multiple selections allowed)	Select 'Directly help individuals and families experiencing mental health issues or emotional issues (MHI/EI)'; 'Advocate on behalf of people experiencing MHI/EI'; 'Facilitate interactions between people experiencing MHI/EI and other health professionals'; 'Assist service providers and practitioners to be culturally sensitive'; 'Assist ethnic, faith and multicultural groups or agencies to respond to MHI/EI'; and or 'Assist in other ways'
(When select a general task category) Specific tasks	Multiple choice (multiple selections allowed) and text boxes	Select specific tasks pertaining to each of the 6 general task categories and option to select 'Assist in other ways' and describe
Preferred approaches		
Statements about culture work: rationales, beliefs, relevant knowledge	Multiple choice (one option only)	Select '1=Strongly disagree'; '2=Moderately disagree'; '3=Slightly disagree'; '4=Slightly agree'; '5=Moderately agree'; '6=Strongly agree'; or '0=Don't know' to respond to each statement
Factors that enable the participant to perform culture work		
Lived experience	Text box	Comment
Training	Text box	Comment
Supervision and support	Text box	Comment
Issues that arise for participant in performing culture work		
Issues that arise	Text box	Comment
Ways of resolving issues	Text box	Comment
Any other comments	Text box	Comment

Interview

Overall approach to the interviews

Interviewing is used extensively in grounded theory studies (Birks & Mills, 2015). Interviews can be used to focus on "'the meaning that the participants hold about the problem or issue, not the meaning that the researchers bring to the research of that writers express in the literature" (Creswell, 2014, p. 234-5).

Intensive interviewing was used (Lofland & Loftland as cited in Charmaz, 2014). Participants were asked open-ended exploratory questions, with the aim of maximising opportunities for them to discuss their experiences and perspectives. The sessions were purposeful yet conversational and not overly determined (Birks & Mills, 2015).

In-person interviews were chosen over telephone interviews because, I believed this was likely to be preferred by most participants, especially those for whom English is not a first or preferred language. Meeting face-to-face would generate more rapport and enable me to attend to subtle non-verbal cues of participants. I anticipated that the settings would be varied and be determined on a case-by case basis by the participant and researcher. Semi-structured interview schedules were designed to maintain broadly consistent open-ended questioning across the participant group and to pursue leads and new ideas as they were revealed (Charmaz, 2014).

Consistent with the 'emergent' grounded theory approach, the questions asked in the interviews did change as I gathered information in the field (Creswell, 2014). The Study design included the option to conduct one or two interviews, of one-to-two hour's duration, with each participant.

I anticipated interviewing between 25 and 30 individuals with saturation of emerging themes determining the final number. I interviewed 19 individuals; while this was the maximum number of individuals who were available, it proved to be adequate for the purposes of analysis and theoretical saturation. The interviews were conducted in three sets spread over a 12-month period; six interviews were conducted within six weeks of each other, followed by another five within one month, and finally another eight within three months. Settings varied at convenience of interviewee and included workplaces, cafes and participants' homes. While I anticipated that it might be necessary to meet individuals more than once to develop sufficient rapport, in reality I met with 18 individuals once and one individual twice due to time constraints that arose during the first interview.

The interview sessions

I sought permission from participants to make an audio recording and take notes of each interview. Recordings were transcribed verbatim, in most cases immediately following the interview, and the transcripts were checked against the audio recordings to ensure accuracy. I made audio recordings of 18 out of 19 interviews and took notes during all the interviews. I also wrote field notes within a day of conducting each session. These included comments about the setting, my own reactions and observations, and ethical reflections.

I allowed time between sessions and sets interviews sessions to make field notes, transcribe each interview, and undertake initial line-by-line coding and intermediate coding. I analysed the data as the interviews progressed (Simmons, Hadden, & Glaser, 1994). The questions asked of subsequent second and third sets of interviewees were adjusted based on the emerging analysis. That is, as the interviews progressed, interviewees were also asked to consider concepts and themes that were emerging from analysis of interviews that had already been conducted (Creswell, 2014).

The line of questioning

As described above, I had completed an early review of literature prior to conducting the interviews. This included meta-analyses, efficacy studies, and opinion pieces and service reports. Some of this literature spoke from the perspective of clinical supervisors (Owen & English, 2005) or service innovators (Ton et al., 2005). A small number of sources presented comprehensive accounts of the experiences of bicultural professionals (Ito & Maramba, 2002; McKinney, 2007; Liu, 2013). Several documents argued that service users of immigrant or refugee background implicitly place more trust in therapists and other professionals who are culturally or linguistically similar to them, or have had similar life experiences (Cabral & Smith, 2011; CMY, 2011; Farsimadan et al., 2011).

Some common themes had emerged across of various texts: service user engagement with services and improved client were attributed to the capacity of bicultural professionals to form meaningful alliances with individuals, families and communities. These sources also commented on some of the common challenges that bicultural professionals face: heavy workloads, lack of role definition, needing to reconcile professional peer and community expectations.

During this interview phase, I set these ideas aside, asked open questions, and paid attention to the patterns and generalisations that emerged (Creswell, 2014). That is, I did not introduce themes such as *trust* or *identity* or *boundaries*, which are prominent in the

literature, into the discussion; I was alert to the themes participants raised and followed these threads.

Outlines of the interview schedules used are included in Appendix C. In practice, I used these as memory aids, modifying the questions during the sessions as the interviews unfolded and between interviews as concepts emerged through analysis. Interviews lasted between 90 and 120 minutes.

Each interview session began with the consent discussion, followed by "descriptive questions" (Spradley, 1979). I explained: "I know some things about you and your work from your answers to the survey" then asked, "could you explain some more about ..." This signalled that I had absorbed the detail included in their survey responses, and invited them to share more about their current or past work experiences. Hence the interview sessions were an opportunity to elicit more background information about the participants and to clarify any survey responses regarding their personal and professional background and their work role. For example, after reminding one participant (#9) that she had mentioned working in several professional positions in recent years, in the survey, I invited her to speak about each of these roles in more detail.

I also used a "grand tour" question (Spradley, 1979), asking: "how have you come to be doing this work", to encourage interviewees to focus on their experiences, and signal my interest in broad themes, such as their life circumstances, personal ethics and motivations. Having noticed that some survey responses described the issues that clients and families face rather than those that arise for them when performing the role, I also used this question to indicate to interviewees that I was especially interested in their experiences and their practice.

The main purpose of these sessions was to listen to professionals describe how they perceived their role and the issues that they face in assisting people experiencing mental health and emotional issues, especially service users of similar background or who also had a migration or refugee story. I encouraged them to offer reflections on relationships with others, with colleagues and peers and any connections with ethnic or faith communities. I concluded each interview by inviting participants to ask any direct questions of me and to tell me how they experienced participating in the Study.

Taking a reflective, iterative approach

I reflected that I had opinions about mainstream mental health approaches to addressing cultural diversity and how bicultural practitioners could contribute more if they were

visible and supported in service settings.

I approached the interviews by setting aside my own views, focusing on establishing rapport and trust with participants, and creating an atmosphere where they felt free to offer their perspectives. I heard stories about achievements, complaints, suggestions and ambitions. I aimed to listen without joining in the criticisms or offering unreserved praise.

I used time at the beginning of each interview to explain why I was personally and professionally interested in the research questions. Even so in two early interviews individuals asked me why I –looking as Anglo-Celtic as my name suggests, and therefore assumedly lacking a recent migration family history of my own to draw on – was interested in this aspect of mental health. I realised that I had not paid enough attention to what following a line of questioning that highlighted our differences would evoke for interviewees and me (Dickson-Swift, James, Kippen, & Liamputtong, 2009).

I heard myself respond pragmatically – making claims about research knowledge gaps and asserting my interest in mental health workforce development and addressing inequitable service delivery. However, using memos to facilitate self-reflection, I realised that in those moments, I was attempting to present myself as a professional peer and an ally in system reform. I was playing down the fact that I was a researcher pursuing my own agenda. By attempting to ignore my own racialised identity, I was projecting that this had no bearing on the Study. And yet, it simply couldn't be true that these encounters were power-neutral. I was located in these encounters as a researcher, an interviewer, and as someone who is 'female', 'white' and aligned with majority culture. While I hadn't assumed that interviewees had more or less authority than I did, I hadn't clarified my knowledge perspectives or positionality. I had known that themes of power and social location or positionality (Clarke, 2015b; Foucault, 1975) were at the heart of the Study; I needed to embody this more during interview sessions. I may have been communicating my curiosity about bicultural professionals, but I wasn't demonstrating sufficient humility about the limits of what I could know about these participants, or about anyone else's experiences (Tervalon & Murray-Garcia, 1998). I subsequently took steps to explicitly acknowledge my social location, my history, personally and professionally, and the limits of my life experience, by making direct statements about this in later interviews. I noticed that from this point on interviewees seemed more forthcoming about their personal experiences. I was not directly questioned again about my motivations.

I also learnt, during the first group of interviews, participants wanted to discuss their work with culturally diverse populations and disadvantaged populations, and not just with

people who identified with them or had a similar cultural background. Interviewee responses to questions, about ways of working with particular groups, were following a similar path. They would begin by stressing the importance of professionals bringing a sense of humanity to any service encounter. They then commented on commonalities among the experiences facing immigrant and refugee communities regardless of cultural background. Only then did they discuss some of the particular considerations that apply when working with individuals who identify with them culturally. I decided to follow a similar approach when prompting subsequent interviewees, knowing that this would have implications for interpreting the Study findings.

Continuing reflexivity between interviews prompted my deepening consideration of perspectives, power and diversity. Consistent with grounded theory's iterative approach, this influenced how I collected and analysed the data and therefore shaping the overall theory.

Data analysis

Quantitative analysis – survey closed questions

An outline of the questions as they appeared in the survey, how they were transformed, and the analytic procedures used is provided in Table 24 in Appendix B. Quantitative survey data were analysed to address the descriptive objective of the Study and to identify preliminary patterns that could be qualitatively explored. Excel and SPSS (Version 24.0; IBM Corp., 2016) were used to conduct the analysis.

Analysis commenced once 30 completed surveys had been returned. I commenced descriptive analysis of numeric data items about individuals and their work characteristics, thematic analysis of professional development and supervision themes, and line-by-line initial coding of all other open text responses. This provisional analysis indicated that the sampling approach was effectively reaching individuals working in a range of work roles and settings.

Responses to questions regarding personal background – including country of birth, languages spoken, ancestry and religious affiliation – were matched to classifications used by ABS (2011b; 2011c; 2011d; 2011e) unless an individual offered an alternative category (such as 'African' and 'Jewish European' in the case of ancestry and 'Inclusive and nonspecific' in the case of religious affiliation). Country of birth, language and ancestry data was transformed to so that they could be reported as broad regional categories. Year of

arrival in Australia and the date the survey was completed were used to calculate length of time in years of living in Australia.

Responses to open questions that asked individuals to provide position titles and industry or agency information were coded for apparent similarity and used to create categories. Statistical analyses produced broad quantitative descriptions of the professionals and their work. Cross tabulations of responses with (chi square) explored whether there were associations between some variables:

- Some personal and professional characteristic and some job characteristics.
- A range of job characteristics
- LOTE capacity and carrying out general and specific tasks
- Receiving supervision or informal support and some personal and professional characteristics
- Receiving supervision or informal support and job characteristics

Pearson's correlations were used to explore relationships within two distinct sets of questions.

- whether or not bicultural professionals performed a specific task (binary)
- their level of agreement with statements related to preferred approaches (continuous)

Exploring patterns in the quantitative data

I used the Pearson's correlations to explore the patterns in the relationships between the survey questions in each of these themes. Strong correlations between questions were mapped using Mindnode (Version 1.7.3; 2015) free software, which offered a way to identify themes in the data. That is, quantitative findings were rendered qualitative by mapping patterns; explanations were developed based on the results of these quantitative analyses. This step was undertaken as part of the mixed method approach. The same approach was used to represent each set of correlation results.

I truncated the questions in order to express them as processes or actions and assigned a category that described the associations. Analysis of questions about specific tasks led to identifying five sub-categories. Analysis of questions about preferred approaches, beliefs and knowledge led to identifying another sub-six categories. I returned to these abstract codes as part of the analysis of the interview data and when developing a meshed

interpretation of survey and interview data.

Qualitative analysis – survey – thematic analysis of open text

All open text was analysed for themes that provided contextual information. Responses regarding training, and supervision or informal support, were coded using NVivo (Version 10; QSR International Pty Ltd, 2014), a software program that enables one to identify themes and group textual information for later interpretation.

I created theoretical memos for each participant regarding training (such as session based and other forms of learning) and supervision (such as methods and regularity of sessions) as well as different forms of informal support. The proportion of survey participants (and the nested interview sample) who have training opportunities or receive supervision or informal support was also calculated.

Qualitative grounded theory analysis – survey and interview

Both open-text survey and interview responses were regarded as "elicited texts"; texts produced by participants in which they told "as much or as little about [the topics] as they wish[ed]" (Charmaz, 2014, p. 47). They were analysed with a view to identifying concepts, processes and categories that would explain bicultural practice as a social process (Holton, 2007). This involved "breaking data up into component parts or properties", "defining the actions on which they rest", "looking for tacit assumptions" and "explicating implicit actions and meanings" (Charmaz, 2014, p. 125). This entailed applying initial line-by-line codes, and carefully attending to how they account for the data (Breckenridge & Jones, 2009; Charmaz, 2014). Making comparisons between data and between codes allowed construction of more focused, abstract (Charmaz, 2014) or intermediate (Birks and Mills, 2015) codes. This analysis occurred as data gathering continued.

Text and visual memos were used to define codes and categories, record the data gathering and analytical processes, and track my decision-making (Birks & Mills, 2015). They were also used to record my emerging ideas, attempts to explain the main categories, and to note what I was learning about the associations between them (Birks & Mills, 2015; Charmaz, 2014). They document the unfolding analysis and how sampling decisions related to the iterative process of theory development.

The data gathering and analysis process outlined below continued until I had obtained qualitative data of sufficient richness and judged that additional interviews would not substantially enrich the analysis (Thorne, 2020). I also note that there is considerable

current debate about the utility of making "theoretical saturation" claims, given the real-life constraints on applied health research, and that to do so can seem forced or misleading (Thorne, 2020).

Survey data – open questions

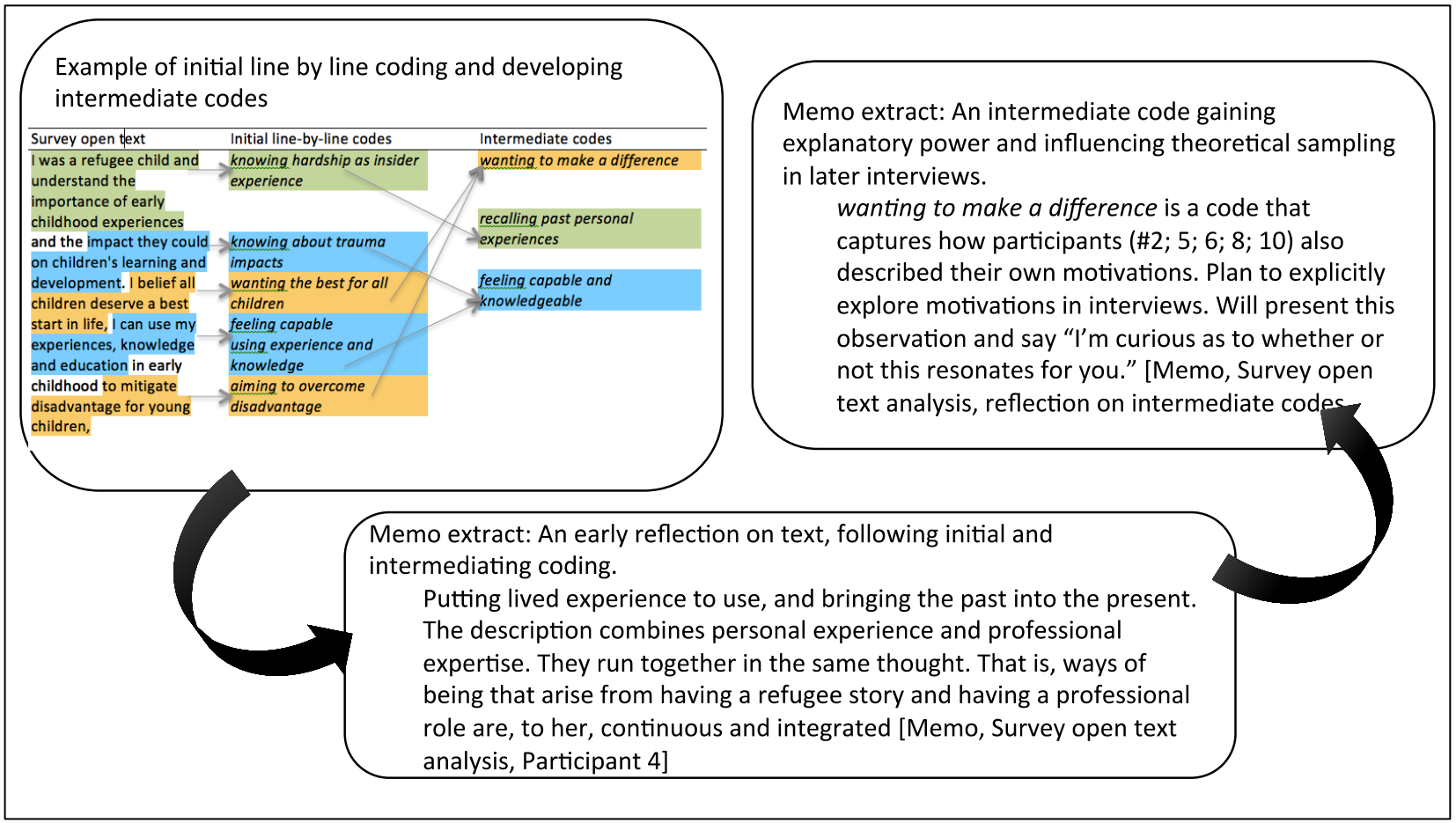
The open survey questions were coded line-by-line, and intermediate coding using grounded theory methods. An overview of codes and categories is provided in Appendix D, Table 25.

For example, Survey question 22 asked: "What kinds of LIVED EXPERIENCE have you personally had that enables you to do this work? For example: child of immigrant parents, lived for a time in a refugee camp, grew up in a country that was colonised, aware of holocaust stories in my family". Figure 3 provides an example of coding this text.

Participant 4's response is presented with line-by-line codes and intermediate codes and a memo extract, written during Phase 3 of the Study. This is an example of undertaking concurrent data collection and analysis of responses to open survey questions.

Another memo that document an observation that an intermediate code was gaining explanatory power is also included. This memo notes that the code was compared with survey data already collected and plans to theoretically sample in upcoming interviews.

Figure 3 Data gathering and analysis: Example of Coding, Memoing and Comparing



Interview data – transcripts and field notes

The more substantial phase of gathering and analysing qualitative data used individual interview session transcripts and related researcher field notes. During phase 4 of the overall research process, this was characterised by data collection and concurrent analysis.

I created a data memo for each member of the interview sample and used maps to consider the properties of categories and subcategories that pertained to each individual in the light of the patterns that emerged from analyses of the larger survey group. I developed numerous visual representations along the way, to consider the associations between codes and categories and identify patterns and variations in the data (Holton, 2007). Reflections on the research process were also recorded as memos. I recorded responses to the reflexive questions (outlined above) as they arose for me throughout the study to identify and examine my own biases and assumptions.

I revised the phrasing and meaning of codes categories, sub-categories and their significance in relation to each other many times throughout the life of the Study. I then used theoretical sampling – a process of re-engaging with the data following construction of the main categories in order to refine properties, "define new leads" (Hadden & Lester, 1994, p. 168) and explore how these dimensions and their sub-categories were expressed. Overall, I proceeded by asking questions of the data, such as "What is this data a study of? And What do the data suggest?" (Charmaz, 2014, p. 116).

Theoretical sampling was used to explore the data and notice seek statements, events and cases that illuminated the emerging dimensions of the theory. This form of sampling involved posing "tentative ideas about the data" and examining them through "further empirical inquiry" (Charmaz, 2014, p. 199), either in subsequent interviews or by reviewing the transcripts for new themes.

For example, a participant, who was among the first group of interviewees, offered some reflections on her motivations and how she goes about her work.

> [Researcher] I'd like to ask you, how you came to be doing this kind of work?
>
> [Participant] 'Um… well my original background is [a field of science], believe it or not, and I um, I just felt that I have too many people skills to be doing that kind of job. And being the first [world region] child or student that arrived here in [year], I saw that our community didn't have a lot of support and I had the opportunity to do a certificate course that was aimed at [world region] women to work in this field. So, I

> took up the opportunity to this course and then I studied further. I have a strong interest in families and children and wellbeing. Um, I'm really interested in people making the transition and starting over to a better life for themselves and especially for the children. So yeah, that's how I started off.

Her response expanded on comments that she had already made in the survey about taking up opportunities and re-establishing a professional career. This led me to consider the *trajectories* of participants and identify stories and patterns across the group.

Her interview also expanded on the theme identified in the survey of *wanting to make a difference*. She explained the pleasure she experienced in feeling competent, free to do this work in her own way, and make a valued contribution to the communities with which she strongly identifies. Much like the easy way she combined the personal and the professional in her survey responses about formative experiences, I noticed that she spoke of *human agency* and *responsibility* toward others in the same breath; these conditions of being human belonged together. I could see signs of the "intimate bond", that Deleuze describes (May, 2005) between how she thought about herself and they ways she was conducting her life at work and in other community settings.

She, like other interviewees (whom I was yet to meet), spoke of finding meaning in being free to meet responsibilities toward and on behalf of individuals and families and rarely about wanting to be released from such duties or obligations. This ethical stance seemed important. I re-considered data already initially analysed in this light and explored this theme with other participants in subsequent interviews. Table 7 includes some of the codes, categories and "relational statements" created by this iterative process (Birks & Mills, 2015, p. 96).

Table 7 Sample of Codes and Categories

Culture-oriented practices			
Analysis	*Sample of initial and intermediate codes from survey and interview data*	*Abstract codes*	*Category and relational statements*
(C)	*Enjoying dialogue with others*	*Seeking freedom*	*An ethical stance or disposition:*
(D)	*Seeing new perspectives*		Professionals aim to perform roles at work in ways that express who they fully are, and acknowledge their relationships with others
	Having a strong interest	*Expressing human agency*	
	Responding deftly		
	Choosing freely		
	'Going freelance'		They spoke of seeking the freedom at work to meet the obligations they believe they have in relation others
(C)	*Wanting to make a difference*	*Meeting obligations*	
(D)	*"Stepping into the fray"*		
	Showing solidarity with service users	*Responsibility to, as or on behalf of others*	
	Being all things to everyone		
	Adjusting approaches		
	Negotiating changes to service rules		
	Affirming human dignity		
	Wanting justice		

Note. Types of analyses used: (C) Qualitative grounded theory analysis; and (D) Situational and discourse analyses.

Here is another example of how the analysis progressed by theoretical sampling and increasingly abstract coding. The following brief extract, captures comments made just after this participant[5] described her own experience of exile, migration and settlement, and her interest in supporting newly arrived communities. She recalled times when service users notice an aspect of her cultural identity:

> Sometimes other people living in the [local area] either from the [world region] or other Muslim countries [in another world region], um also they say, [participant's first name] there? They don't know what [says her own name again] looks like. I always say, [Salaam Alaykum on the phone and they sometimes [they] say Ah, OK [expresses a sigh of relief].

I initially coded the above as *using unifying words and greetings,* and later also as an

[5] Participant identifier withheld to protect anonymity.

instance of *showing her involvement* with service users. I later linked these elements and interpreted this a form of *social signalling*. That is, she often found that using familiar meaningful words and phrases that elicited feelings of connection and safety in others. Coding and reflecting on these processes contributed to developing the category of *interacting,* an important feature of the substantive theory about culture-oriented mental health practice.

Situational and discourse analyses

Also during phase 4 of the overall research process, I used situational and discourse analyses to explore the forces that shape the social processes that participants were describing (Clarke, 2015a). The main purpose of these analyses was to acknowledge complexity and highlight the contextual elements that were important to developing theory.

As part of conducting a grounded theory study, Clarke and colleagues (2015) recommend preparing matrices, lists and maps to explore the more general, larger domains of social action or the situation of inquiry as it is broadly conceived (Clarke, 2003; Pérez & Cannella, 2015). This approach is based on an assumption that "everything *in* the situation *both constitutes and affects* most everything else in the situation in some way(s)" (Clarke, 2015a, p. 98) and *"the situation itself* [is a] *fundamental unit of analysis"* (p. 99). Different conditions – internal and interpersonal, proximal and distal, local and global – are all part of the situation that is examined. In this Study, I applied three mapping techniques developed by Clarke (2003) and elsewhere by Clarke and colleagues (2015) to set out some of the key human, discursive and ecological elements relevant to the enquiry and map the particular social worlds in which participants were engaged. I plotted the relative position of interview participants with regard to three features: their status as a health professional, as a holder of linguistic or cultural expertise and reputation in communities for mental health know-how. I also used survey and interview data to map of participants' social worlds; where they worked, their connections and the mental health practice frameworks they used. I also prepared an "abstract situational map" (Clarke, 2015a, p. 101) to capture the main "human, nonhuman, discursive" and other elements of the situation that seemed important when commencing the study, and included ideas from literature, and other sources as the research progress. Some elements remained important, while others fell away. A version that reflects areas of interest during later phases of analysis is included below in Figure 4.

Figure 4 Abstract Situational Map: Elements Relevant to Making Meaning of the Data

Individual human actors
Bicultural and bilingual professionals
Professional colleagues that work in sector – team members, team leaders and managers, other professionals, community representatives
Friends and professional colleagues who provide informal support or supervision
Mental health service users (including families) who identify with bicultural professionals
Mental health service users who identify as "mainstream"

Collective human elements
Organisations where bicultural professionals work
Identification with mental health frameworks
Other agencies that provide health, mental health and human services
Agencies that provide education and supervision
Various providers of health, mental and human services
Agencies that provide systemic advocacy for mental health consumers and carers
Ethno-community agencies
Schools and universities
Police, courts and legal services
Language professionals (interpreters)
Faith communities and their leaders
Peer networks that offer professional development

Political/ Economic elements - migration
Multiculturalism, migration, refugee, asylum seeker policies and practices
Australian Government and Victoria State Government human rights legislation
International and internal criticism of Australian Government's treatment of asylum seekers in off-shore and on shore detention
Australia's involvement in international settings - armed conflicts, and humanitarian responses

Political/ Economic elements – health and multiculturalism
Health-related cultural responsiveness policies, frameworks, practice guidelines
Professional codes of ethics (national registration body, professional colleges and associations)
Universal responses and accommodating particular groups
Cultural responsiveness one priority among many
Raising levels of cultural competence across the workforce
Mental health workforce strategy and diversity
Australian Government and Victoria State Government health funding and policy environment
Inter sector responsibility for providing mental health care

MH knowledge paradigms
Bio-psycho-social constructions of mental health and cultural & faith specific paradigms of health and wellbeing
The dominant role medicine and psychiatry play in how mental health services are organised
The marginal status of social and cultural perspectives within psychiatry and mental health in Australia

Health and diversity concepts and discourses
Human rights and discrimination
Ethnicity, race, gender, nationality, language, and faith
Feminism, intersectionality, racism, sexism and power
Identity, diversity, "othering", belonging and plurality
Mental health and illness
Transcultural, multicultural mental health
Bicultural, bilingual workers or professionals, Cultural brokers and health navigators

Key social processes
Professionalism – status, ethics, expertise, qualifications, remuneration, recognition
Using lived experience – authenticity, voice, experience, proximity to community
Communicating in a language other than English or multiple languages
Sectors, organisations, team and networks – relationships, status, hierarchies
Negotiating boundaries, visibility, security, emotional safety
Professional and private lives

Temporal elements (unfolding during time of data collection)
Australian Government and Victoria State Government elections and policy announcements
Restructuring of community-managed mental health sector in Victoria and other systemic reforms
Changes in national government migration and humanitarian arrivals
Rise of Islamophobia

Spatial elements (population and geographic)
Variation in population characteristics across Victoria
Variation in health, mental health and human services available across Victoria
Local, national and global issues

It includes individuals and groups, and political and economic considerations related to this picture; they are evident in practice guidelines, frameworks and local organisational procedures. Some concepts, such as diversity, health and mental health have distinct and overlapping discourses.

The discourse analysis consisted of reading a selection of research texts with a view to uncovering the "unstated implicit assumptions within them" (Cheek, 2004, p. 1144). Knowing that texts describing health and health care practices only ever convey a "partial perspective of the reality being presented" (p. 1144), I identified some taken for granted assumptions, in order to consider the main constraints on bicultural professionals and their practice are "historical and contingent" (May, 2005, p. 9).

Theoretical integration

The main aim of phase 5 of the Study was to mesh the emergent analyses and develop interpretations that accounted for both systemic context and underlying interpersonal and social processes. My sustained focus during this stage was on addressing the question: what theoretical category is being suggested by this data (Holton, 2007)?

I deepened my understanding of all the categories by exploring relationships between them. This was consistent with using grounded theory's iterative approach to reasoning and generating explanations by speculating beyond the data. I also re-examined the thick descriptive interview data and my initial reflections and analyses. I had gathered sufficient qualitative data to develop a coherent explanation and on this basis assessed "theoretical saturation" had been reached (Charmaz, 1990; Holton, 2007; Thorne, 2020).

In the context of this Study, here are some examples of the comparisons I made and the questions I compared:

- 'incidents' described in the survey data and accounts of similar 'incidents' in the interviews at the level of an individual participant and across participants; for example, participant accounts of their own experiences of racism at work and those relayed to them by community member. What might this reveal about the continuity between how members of racialised communities experience symbolic violence at work and in the everyday?
- incidents with emerging concepts; for example, where interviewee accounts described the roles they took on at work or discussed the approaches they adopted, I explored these in relation to the sub-categories of 'tasks and roles' and 'preferred approaches' that emerged from qualitatively exploring parts of the survey

analyses using maps. To what extent were these participants describing ways of being, doing and knowing that are particular to their experience? Might some of these elements resonate with how other socially engaged and culturally attuned professionals also respond when working with migrant and refugee communities?

- recurring conceptual codes with other concepts; for example, interviewees negotiated interpersonal relationships during service encounters in many ways. Contrasting and comparing these helped to identify the relational aspects of their practice, and revealed some commonalities between participants and resonated with observations in extant literature.

An overview of categories and sub-categories is provided in Appendix D, Table 26. Continuing the theme introduced above, Table 8 presents the qualities of a main category that became part of the substantive theory.

Table 8 Sample of a Category with Corresponding Sub-categories

Culture-oriented practices	
Category	*Qualities*
Practice: An ethical disposition	***Integrating entails***
	Becoming more intentional
	Regulating requests demands
	Caring for self
	Seeking out more ethically-aligned workplaces
	Enacted when
	Locating practices within existing frameworks and program approaches
	Finding frameworks that resonate
	Choosing a career pathway
	Implicitly embodied as
	Being emotionally and cognitively attuned
	Standing alongside clients
	Empowering clients, families, and communities
	Going above and beyond

Developing a substantive theory

Researchers develop grounded theories by interacting with data, primarily through coding, defining the properties of categories and sub-categories, how they are situated, and exploring their relations to each other. "Grounded theorists", Charmaz (2014, p. 341) explains, "make their most significant theoretical categories into the concepts of their

theory".

In this Study, the interpretation is grounded in participant data and situational and discourse analyses (Fosket, 2015). It considers what the work itself involves, the principles that inform it and the personal and social forces that shape how individuals do bicultural mental health work. It was important to consider relations of power and how their work is regarded by others. Case examples were used to double-back, use the constructs that had emerged, and examine data with a renewed focus on what data were saying in regard to the research question (Charmaz, 2014).

Together these interpretations present what is meaningful in the data and constitute the "storyline" of the theory discussed in the Thesis (Birks & Mills, 2015, p. 114).

Assuring the study's quality

While there are various interpretations of and approaches to grounded theory methodology (Holton, 2007; Bryant & Charmaz, 2007), there is general agreement that it entails using a "package of research methods of concurrent data collection and constant comparative analysis, theoretical sampling and memoing", all of which should be considered when assessing the merit of a grounded theory study (Elliott & Lazenbatt, 2005, p. 48). Creamer (2018a) argues that studies that combine mixed method and grounded theory methodologies should ensure that the qualitative and quantitative samples overlap, that the qualitative and quantitative analyses are conducted on the same constructs and use standardized quantitative instruments where possible.

The quality of a grounded theory study relates to the thoroughness with which procedural methods are applied, the significance of the research questions and the perceptiveness of the researcher (Elliott & Lazenbatt, 2005). Charmaz recommends assessing research that uses a cGT methodology in terms of its *credibility, originality, resonance and usefulness* (Charmaz 2014, p. 337). She suggests that a study's credibility and originality paves the way for its resonance and usefulness. In relation to mixed method cGT in particular, assessing the effectiveness of a Study "rests on the analytic coherence of the research product, integrated findings, and illumination of the research problem" (Charmaz, 2014, p. 325).

Credibility is the extent to which the researcher establishes confidence in the truthfulness of findings and the account of study (Elliott & Lazenbatt, 2005, p. 48) It includes whether the data is sufficient to merit the claims that have been made and the extent to which analyses were logically and systematically applied. It also concerns the study's coherence of the

conceptual grounding and whether the researcher gained an intimate degree familiarity with the setting (Charmaz, 2014; Birks & Mills, 2015). The freshness of the concepts and categories presented, and the extent to which the work has social and theoretical significance and extends current thinking, are markers of a study's *originality* (Charmaz, 2014). A study's *resonance* pertains to how comprehensively participant experiences have been rendered and the explanatory power of the analyses and interpretations for similar populations (Charmaz, 2014). The findings of a qualitative study should be logical and sound as well as comprehensive and deep (Krefting, 1991). The study's *usefulness* refers how it develops knowledge, suggests areas for future exploration and could be practically applied (Charmaz, 2014). This is similar to the quality of 'transferability' described by Krefting (1991, p. 216) that is, "the degree to which findings can be applied to other contexts and settings with other groups". The following considers each of the four elements in relation to this Study.

Credibility

A number of strategies are recommended for ensuring the credibility of qualitative (Krefting, 1991) and/or mixed methods (Creamer, 2018a) research; those used in this Study are described below.

The "nested" study designed ensured overlapping of data samples. Participants provided information on one or more occasions (via an online survey and in one or two interviews) and in more than one way (in writing and in conversation with the researcher). The survey and interview questions and methods were discussed with supervisors and my research peers throughout the study period. There was no capacity in this study to involve co-researchers who could separately gather and interpret data, and make comparisons.

The Study design did not adopt a participatory research approach (Genat, 2015). This is a significant decision given the Study's focus on issues of power and discrimination and made firstly, because I was unable to identify any pre-existing groups comprised of bicultural mental health professionals in Victoria with whom I could form a research alliance and secondly, for practical reasons due to the limited resources available to graduate researchers. I did adopt, in Creswell's (2014) terms, a "transformative world view" but I did not use a collaborative design. I acknowledge that I am in a privileged position with regard to the way the data has been recorded, interpreted and represented (Genat, 2015).

In the absence of any pre-existing suitable research instruments, I created sets of questions, derived from a review of relevant literature, to enquire about activities and approaches as part of the survey. The interviews were of sufficient length to produce rich discussion. I

took steps to create information sharing environments that were conducive to participants offering frank accounts of their experiences. The interview schedules (see Appendix C) provided internal consistency between interview sessions. I participated in some qualitative methods workshops in the course of the study that included conducting mock interviews, which helped identify ways to improve my interview technique. I reframed and expanded questions in order to facilitate conversations and clarify meaning.

I was alert to the possibility that participants may respond with what they thought was a "preferred social response" and not their personal experience (Krefting, 1991, p. 216). The one-way nature of surveys makes it impossible to explore this aspect of the findings. However, when interviewees volunteered accounts of how they believed colleagues perceive them, or that told me that they were perplexed by my interest in the area, I was reassured that they felt somewhat at ease and that we were having a frank exchange.

I compared the personal, professional and job characteristics information derived from survey responses with what participants described in interviews. The phased study design provided opportunities to triangulate data and analyses.

As part of integrating interpretations of findings of the two study phases, and developing an account of the overall Study, I created and updated comprehensive data memos. For example, one set of memos pertained to each interviewee. Other memos included reflections on categories, concepts and the relations between these. I generated multiple diagrammatic memos that explored patterns in the data and the meaning of intermediate and theoretical codes.

A cGT methodology does not require the researcher to conduct member checking, to check if participants agree with the researchers' interpretation of the data. The progressive nature of the methodology means that the researcher moves on to involve other people who have different experiences to see if the findings hold as new data are collected (Elliott & Lazenbatt, 2005). As Charmaz (2014) suggests, I considered their comments as well as their reactions, whether that be enthusiastic or bland agreement, to assess whether I had gathered sufficient data to saturate themes.

My pre-existing experience, in clinical, service development and workforce education roles in mental health including transcultural mental health, and also being a social researcher with a theoretical grounding in anthropology and sociology, gave me considerable familiarly with the setting of the Study. However, I also needed to aware of what Krefting (1991) terms a "double role". I was mindful of the potential for bias, for example, by over-attending to data that supported my preconceptions. One example of noticing a bias and

making an adjustment occurred when I realised that the views I held about Western bio-psycho-social approaches to understanding mental health issues, care and treatment were more negative than many of the interviewees. I took steps to ensure my lines of enquiry on these topics were even-handed.

I aimed to make my contributions to the interpretive process explicit throughout the course of the Study; in developing the design, during data collection and analysis phases and also in preparing this report (Glesne, 1999, p. 33).

Originality

Several "new insights" (Charmaz, 2014, p. 337) are offered. These are new in the sense that documented research regarding bicultural professionals in mental health settings in multicultural societies like Australia is rare. The insights generated by this Study are also novel because the perspectives of bicultural professionals themselves were the primary focus. Further this Study extends thinking in the field by focusing on how these professionals practice, and developing a theory that explains the features of their practice that takes local context into account. Adopting a grounded theory methodology ensured that the Study was an open enquiry. This led to developing an account of a social practice where being a person and being bicultural were both significant. The substantive theory may be helpful in thinking about other "lived experience" informed roles in health care policy and delivery.

Resonance

This Study's was designed to collect both valid numerical information and "thick" descriptive data (Geertz, 1973). The use of mixed methods has deepened the interpretation of the findings. This is because consistent conceptual constructs regarding the conditions, activities and actions of bicultural professionals were applied to quantitative and qualitative analyses.

The Study aimed to make a full portrayal that would make sense to the bicultural professionals who perform similar roles. Presentations of preliminary findings regarding motivation, role and principle categories at an international conference and on another occasion in a mental health service setting were well received. Attendees at both events included bicultural professionals who confirmed that these were meaningful ways to explore the concepts and issues.

Usefulness

By presenting detailed accounts of where, when and how the research was implemented and offering insights into the structures and processes involved in creating findings (Mason, 2006), readers are invited to make connections between this small scale mixed method study and their own experiences and circumstances.

The findings offer a way to understand the culture-oriented mental health practice of bicultural professionals, and are therefore a window into what building the cultural responsiveness of mental health services entails. The characteristics of the heterogeneous sample were documented in detail. This increases the likelihood of readers understanding how the findings may apply to other populations and circumstances.

This Study also provides an indication as to why people and professionals who identify as recent migrants or have a refugee story are left out of and behind by current mental health system reform debates. People's experiences, an intersectional lens, and social theories have been explored. Ultimately the usefulness of the Study lies in its potential to contribute to contemporary mental health service delivery debates in Victoria and Australia. This research is particularly important given the continuing mental health inequities that migrant and refugee communities face. The Study discusses the role bicultural professionals in this context.

Summary

This qualitatively-led mixed methods study adopted the key features of constructivist grounded theory. The Study presents an in-depth understanding from individuals with relevant and significant levels of experience and presents the Study context. Future researchers will have the information they require to judge the degree to which Study findings apply to "other contexts and settings with other groups" (Krefting, 1991, p. 216).

Chapter 4 Description of participants and setting

Introduction

This chapter presents information about the study participants and the research setting.

I provide demographic information about the participants, their personal and professional characteristics and the features of their work. This includes some associations identified between participant demographics and work features. I also present information about the participants and their jobs by comparing the total and nested samples. The remainder of the chapter describes the nested sample with respect to their relative socioeconomic status, career trajectories, role designations, work locations and networks, and the mental health frameworks that they use.

Describing the whole sample

Characteristics of the participants

Most participants provided personal and professional information (see Table 9 to Table 12 below). An overview of the characteristics of the nested interview sample of 19 individuals is provided in Table 13, also below. The following summary pertains to the total sample.

More than half (64%) of survey participants identified as female (n=25) and the largest age group represented, 29% (n=11), was between 26 and 35 years.

Four-fifths (80%, n=31) were born overseas. Of the overseas born, the mean number of years living in Australia was 22 years; 32% (n=10) had lived in Australia for between 11 to 20 years and 29% (n=9) for 10 years or less. Both parents of all participants were born overseas.

Just over one-quarter (26%, n=10) were born in 'Oceania', the region that includes Australia and New Zealand. Of the 31 individuals born overseas, 22 countries were represented: 18% (n=7) in countries in the North Africa and the Middle East region; 18% (n=7) in countries in North East Asia; 13% (n=5) in countries in of Sub-Saharan Africa; 10% (n=4) in countries in Southern and Central Asia; 5% (n=2) in Southern and Eastern Europe; 5% (n=2) in South-East Asia; 3% (n=1) in the Americans; and 3% (n=1) in North-west Europe.

The group identified a total of 45 distinct ancestries; 32 individuals identified one ancestry, while 7 individuals identified two. The ancestries most frequently identified were

associated with the following regions: Southern and Eastern European (23%, n=9), North African and Middle Eastern (21%, n=8) and North East Asian (21%, n=8).

The majority (39%, n=15) of participants identified a Christian religious affiliation, followed by approximately one-quarter (26%, n=10) who reported having no religious affiliation, 13% (n=5) with Islam and 10% (n=4) with Hinduism.

The majority (85%, n=33) of the participants indicated that they spoke one or more language other than English (LOTE): across the participant group, 30 LOTE were spoken in work or non-work settings.

Sixty-four per cent (n=25) of participants spoke a LOTE when performing some aspect of their work role. The languages most commonly spoken at work among survey participants were: Arabic (10%, n=4); Mandarin (10%, n=4); Persian, excluding Dari (8%, n=3); Hindi (8%, n=3); Cantonese (8%, n=3); and Greek (8%, n=3). During discussions with interviewees, I realised that four individuals had under-reported their LOTE capabilities at work in the survey. The survey data for these individuals was adjusted accordingly.

All 39 participants held post-secondary qualifications: 87% (n=34) had qualifications in the field of health, psychology or welfare (HPW) with 38% (n=15) individuals holding more than one HPW qualification. Fifty-one per cent (n=20) had acquired a master degree or doctoral degree level qualifications in one or more fields. Social work was the most frequently reported qualification (44%, n=17).

Characteristics of jobs held

Survey participants could describe up to four jobs they had held in the previous 24 months. Eighty-two positions were described across the survey sample (see Table 14 and Table 15).

The nested sample of those who subsequently took part in interviews included 37 positions. The following description pertains to the total sample.

Some individuals performed a number of culture-related tasks within a single agency: for example, a bilingual counsellor may also be a cultural competency educator and represent the agency at a local refugee health professional network. Some individuals did bilingual or bicultural work as part of a more generic position: for example, the university-based student counsellor's client list includes some people who are of similar background to her. Some individuals held multiple positions at different agencies: for example, the professional who uses his language skills and cultural knowledge at a community health centre as well

as when volunteering at a local program that supports asylum seekers.

Across the survey population, seventy-one per cent (n=58) of positions entailed direct contact with individuals or families experiencing mental health or emotional issues. This included: 38% (n=31) direct care or support positions (where the discipline was unspecified by the respondent); 12% (n=10) medical, psychology or allied health practitioner positions (that is, the discipline was specified by the respondent); and 21% (n=17) counselling and advocacy roles). Of the remaining positions (29%, n= 24), 16% (n=13) were community engagement, education, or development roles, and 13% (n=11) were mental health sector program or team leadership or advisory positions.

Most of the jobs that participants described (66%, n= 50) were not located in mental health service providers. Participants worked in the following types of organisations: 34% (n=26) with mental health services or agencies; 20%(n=15) with agencies providing specialist services to people of migrant, refugee and asylum seeker background; 13% (n=10) with health centres; 11% (n=8) with counselling service providers; 16% (n=12) with social support agencies that provide a range of services including financial counselling, and assistance to find housing and employment; and 7% (n=5) with education institutions.

Most jobs (84%, n=65) involved assisting people living in metropolitan areas and were paid (82%, n=63). Six individuals described eight positions using job titles that either included direct reference to culture or language, or implied that the person was using their recent lived experience of migration. This includes one individual who provided an alternative title during an interview.

- Chinese speaking family services counsellor (#A)
- Chinese speaking alcohol and other drug community development worker (#A)
- Bilingual health educator (#B)
- Chinese access and support worker (#B)
- Multilingual counsellor (initially provided position title of “social worker and counselor”) (#8)
- Multicultural carer representative (#C)
- International student mentor (#T)
- Advisor, asylum seeker populations (#12)

The median number of hours worked in a typical week was 18, with participants describing jobs that range from 1 to 40 hours per week. The most frequently represented (33%, n=23) typically worked from between 1 to 5 hours per week in a role that entailed performing

culture work, followed by 21% (n=16) who did so for between 36 and 40 hours per week. The most frequent response regarding months or years the person had held a culturally-oriented position was 10 years or more (27%, n=21), followed by two years (18%, n=14).

Participants were asked to estimate how much the position's time focused on helping people experiencing mental health or emotional issues who are of similar background to the professional; the most frequently occurring response finds (34%, n=26) indicated about half the job focuses on bicultural work.

Associations between personal characteristics and work features

Based on the total sample, cross tabulations were used to examine the associations between some personal characteristics (Australian born and LOTE capability) and the proportion of the position's time focused on helping people experiencing mental health or emotional issues who are of similar background to the professional. No significant pattern of association was found between whether a participant: was born in Australia or not or spoke a LOTE at all or at work and the proportion of the time focus of the position that they held. The Spearman's ranked correlation between the proportion of the position's focus and hours worked in a typical week is approaching significance (r_s=0.23, p=0.055, n=73) More hours worked was associated with greater focus on performing culture work (Appendix E, Table 27 and Table 28).

Associations between the proportion of the position's focus on helping people experiencing mental health or emotional issues who are of similar background to the professional and other position characteristics were also examined. No significant pattern of association was found between the proportion of the position's focus and each of the following: job category type; agency or industry type; whether paid or unpaid; and geographical area.

Comparing the whole and nested samples

Participant features

Nineteen survey respondents took part in interviews. The demographic characteristics of the 19 interviewees are consistent with the larger cohort of 44 individuals who completed the online survey.

Reflecting the survey group, more women than men were interviewed. The mean age of the survey and interview samples was identical, 44 years and a similarly high proportion of interviewees were born overseas. Just over 60% of survey participants and interviewees

had lived in Australia for between one and 20 years. The groups were also very similar with regard to the proportion that spoke a language other than English (LOTE) and or did so at work, and how they described their religious affiliation.

Broad demographic categories are used in this report to indicate diversity while also protecting anonymity. The range of country of birth regions, ancestries and languages spoken in the nested sample is similar to the whole sample. The largest proportion of both samples was born in 'Oceania', the region that includes Australia, New Zealand and numerous Pacific Island nations. The most represented region of birth in the survey sample is North Africa and the Middle, and Southern and Central Asia for the interview group.

The top three ancestry regions identified in the survey are Southern and Eastern European (commonest) followed by North African and Middle Eastern, and North East Asian (both equal second), while interviewees identified Southern and Central Asian region (commonest), North African and Middle Eastern (second), and with Southern and Eastern European, Oceanian, and African (all equal third).

Twenty-three languages are spoken at work amongst the survey cohort, and nineteen among the interviewees. There are more speakers of Persian (excluding Dari) and Tigrinya, and no speakers of Cantonese or Mandarin among the interviewees.

The survey and interview samples are also similar in regard to the types of qualifications that they hold, the highest level held and whether or not they receive supervision or other more informal workplace support. All interviewees hold tertiary level qualifications. Nearly all interviewees hold a health, psychology or welfare qualification; the remaining three individuals hold community development, social science, or education qualifications. More than half interviewees hold post-graduate qualifications; all qualifications hold qualifications that are at least at the level of diploma or advance diploma.

Job features

The survey participants described 82 positions. The nested sample described 37 positions. An identical proportion of survey participants and interviewees provide direct care or support (discipline unspecified) to people affected by mental health issues (37.8%). Other job categories – direct care practitioner (discipline specified), counselling and advocacy, mental health leadership or advisory positions, or community leadership, education or development positions – are represented in both samples. In comparison with the survey sample, fewer of the interviewees work in designated mental health or alcohol and drug services, and more work in agencies categorised as providers of immigrant, refugee or

asylum seeker support. Both samples also include individuals who work in health centres, counselling services, social support and welfare services, and education.

The survey and interview samples are also similarly matched in regard to the types of geographical area served, whether their work is paid or voluntary, the mean hours worked in a typical week and their estimates of the proportion of a job's focus on helping people experiencing mental health or emotional issues with whom they share a similar background. Each sample described roles held for months, and others held for ten years or more; both samples, include more accounts of roles held for a period of two years or less than those held for longer periods.

Table 9 Total and Nested Samples: Gender, Age, and Migration History

	Total sample		Nested sample	
	N	%	N	%
	Gender			
Female	25	64.1	14	73.7
Male	14	35.9	5	26.3
Other	0	0	0	0
Total	39	100	19	100.0
	Age			
	M=44, Range 23 to 70		*M*=44, Range 23 to 60	
25 years or less	2	5.3	2	11.1
26 to 35 years	11	28.9	2	11.1
36 to 45 hours	9	23.7	6	33.3
46 to 55 hours	9	23.7	6	33.3
56 to 65 hours	5	13.2	2	11.1
66 years of more	2	5.3	0	0
Total	38	100.0	18	100.0
	Born Australia or overseas			
Australia	8	20.5	3	15.8
Overseas	31	79.5	16	84.2
Total	39	100.0	19	100.0
	Overseas born, years living in Australia			
	M=22, Median 15		*M*=21, Median 18.5	
1 to 10 years	9	29.0	5	31.2
11 to 20 years	10	32.3	5	31.2
21 to 30 years	3	9.4	1	6.3
31 to 40 years	3	9.4	2	12.5
41 to 50 years	4	12.9	3	18.6
51 to 60 years	2	6.5	0	0
Total	31	100.0	16	100.0
	Mother Born Australia or overseas			
Australia	0	0	0	0
Overseas	39	100.0	19	100.0
Total	39	100.0	19	100.0
	Father Born Australia or overseas			
Australia	0	0	0	0
Overseas	39	100.0	19	100.0
Total	39	100.0	19	100.0

Note. Percentages may not total 100 due to rounding.

Table 10 Total and Nested Samples: Birthplace, Ancestries, and Religion

	Total sample		Nested sample	
	N	%	N	%
		Birthplace (region)		
Oceania	10	25.6	5	26.3
North Africa & the Middle East	7	17.9	3	15.8
North-East Asia	7	17.9	2	10.5
Sub-Saharan Africa	5	12.8	3	15.8
Southern & Central Asia	4	10.3	4	21.1
Southern & Eastern Europe	2	5.1	1	5.3
South-East Asia	2	5.1	1	5.3
Americas	1	2.6	0	0
North-West Europe	1	2.6	0	0
Total individuals	39	100.0	19	100.0
		Ancestry (region) [a]		
Southern & Eastern European	9	23.0	3	15.8
North African & the Middle East	8	20.5	4	21.1
North-East Asian	8	20.5	2	10.5
Southern & Central Asian	7	17.9	5	26.3
Oceanian	5	12.8	3	15.8
African	5	12.8	3	15.8
European (so described) [b]	1	2.6	0	0
North-West European	1	2.6	0	0
South-East Asian	1	2.6	1	5.3
Total ancestries	45		21	
Total individuals	39	100.0	19	100.0
			Religion	
Christian	15	38.5	8	42.1
No religion	10	25.6	3	15.8
Islam	5	12.8	3	15.8
Hinduism	4	10.2	2	10.5
Buddhism	2	5.1	1	5.3
Judaism	1	2.6	0	0
Sikhism	1	2.6	1	5.3
Inclusive [b]	1	2.6	1	5.3
Total individuals	39	100.0	19	100.0

Notes. Percentages may not total 100 due to rounding. [a] Includes non-mutually exclusive response choices. [b] Term used by a participant that does not have a corresponding ABS (2011e) category or code.

Table 11 Total and Nested Samples: Language Abilities and Languages Spoken

		Total sample		Nested sample	
		N	%	N	%
		LOTE capability			
Other language spoken but not at work		8	20.5	4	21.1
Other language spoken at work		25	64.1	12	63.2
No other language spoken		6	15.4	3	15.8
Total individuals		39	100.0	19	100.0
Language region	*Language other than English spoken at work* [a]				
Southwest & Central Asian Languages	Arabic	4	10.3	2	10.5
	Persian (excluding Dari)	3	7.7	3	15.8
	Dari	2	5.1	2	10.5
	Hazaraghi	1	2.6	1	5.3
	Kurdish	1	2.6	1	5.3
	Pashto	1	2.6	1	5.3
	Turkish	1	2.6		0
Southern Asian Languages	Hindi	3	7.7	2	10.5
	Nepali	1	2.6	1	5.3
	Punjabi	1	2.6		0
	Sinhalese	1	2.6	1	5.3
	Telegu	1	2.6	1	5.3
	Urdu	1	2.6	1	5.3
Eastern Asian Languages	Cantonese	3	7.7		0
	Mandarin	4	10.3		0
African Languages	Amharic	2	5.1	1	5.3
	Somali	1	2.6	1	5.3
	Tigre	1	2.6	1	5.3
	Tigrinya	1	2.6	2	10.5
Southern European Languages	French	1	2.6	0	0
	Greek	3	7.7	1	5.3
	Italian	2	5.1		0
Eastern European Language	Croatian	2	5.1	1	5.3
	Total individuals	25		12	
	Total languages	23		18	

Note. [a] Variables includes non-mutually exclusive response choices.

Table 12 Total and Nested Samples: Qualification Fields and Levels

	Total sample		Nested sample	
	N	%	N	%
			Qualification field [a]	
Health, psychology or welfare (including social work) (HPW)	34	87.2	16	84.2
Social, cultural or political studies (SCP)	7	17.9	3	15.8
Education	6	15.4	5	26.3
Management or commerce	3	7.7	1	5.3
Creative arts	2	5.1	0	0
Information technology	1	2.6	0	0
Total individuals	39	100.0	19	100.0
			Qualification level [a]	
Level 5, Postgraduate Degree level (Master or Doctoral Degree)	20	51.3	10	52.6
Level 4, Graduate Diploma, Graduate Certificate	7	17.9	3	15.8
Level 3, Bachelor Degree Level and Honours	10	25.6	4	21.0
Level 2, Advanced Diploma and Diploma Level	2	5.1	2	10.5
Level 1, Certificate Level - I, II, III, or IV	0	0	0	0
Total individuals	39	100.0	19	100.0

Notes. Percentages may not total 100 due to rounding. [a] Variables include non-mutually exclusive response choices

Table 13 Nested Sample: Outline of Demographic Characteristics

#	Age in years	Speaks a LOTE	Australia or OS born	Years living in Australia	Qualification fields and highest level attained in each
1	46-55	No	OS	21-30	HPW Grad Diploma, EDU Certificate
2	36-45	Yes	OS	1-10	HPW Bachelor, EDU Cert
3	36-45	Yes	OS	11-20	HPW Bachelor,
4	36-45	Yes	OS	31-40	EDU Diploma
5	25 or less	Yes	OS	1-10	HPW Postgraduate
6	26-35	Yes	Australia		HPW Grad Diploma
7	46-55	Yes	OS	41-50	HPW Bachelor
8	not provided	Yes	OS	11-20	HPW Postgraduate, EDU Bachelor
9	25 or less	Yes	Australia		HPW Postgraduate
10	56-65	No	OS	41-50	HPW Bachelor
11	46-55	Yes	OS	41-50	SCP Postgraduate
12	26-35	Yes	OS	1-10	HPW Diploma, INF Diploma
13	46-55	Yes	OS	11-20	HPW Postgraduate, MAN Postgraduate
14	46-55	Yes	Australia		HPW Postgraduate
15	36-45	Yes	OS	11-20	SCP Bachelor
16	46-55	No	OS	11-20	HPW Bachelor
17	56-65	Yes	OS	31-40	HPW Postgraduate
18	36-45	Yes	OS	1-10	HPW Postgraduate, EDU Certificate
19	36-45	Yes	OS	1-10	HPW Bachelor

Notes. OS born: Overseas born. Speaks a LOTE: Speaks a language other than English. Qualification fields: HPW Health, psychology welfare; EDU Education; INF Information technology; MAN Management; SCP Social, cultural or political studies. Ancestries included Southern and Eastern European (3), Southern and Central Asia (5), South East Asian (1), North-East Asian (2), Sub-Saharan African (3), North African and Middle Eastern (3), and of Oceania (2). Most identified as Christian (8), with other religious affiliations including Buddhism (1), Hinduism 2), Sikhism (1), Islam (3) and non-specific, inclusive (1).

Table 14 Total and Nested Samples: Job Type, Industry, Location, Status, Hours worked, Period of Time in Job, Proportion of Focus

	Total sample		Nested sample	
	N	%	N	%
		Type of job		
Direct care of support position (general)	31	37.8	14	37.8.
Medical, psychology, allied health positions	10	12.2	3	8.1.
Counselling and advocacy positions	17	20.7.	10	27.0
Leaders or advisor within the mental health sector	11	13.4.	6	16.2
Community position (leader, educator or development)	13	15.9	4	10.8
Total jobs	82	100.0	37	100.0
Total individuals	44	100.0	19	100.0
		Type of industry		
Mental health or AOD treatment service provider	26	34.2	9	24.3
Migrant, refugee, or asylum seeker support agency	15	19.7	9	24.3
Health centre	10	13.1	4	10.8
Counselling service provider (non-specialist refugee)	8	10.5	7	18.9
Social support programs & service	12	15.8	5	13.5
Education provider	5	6.6	3	8.1
Total jobs	76	100.0	37	100.1
Total individuals	40	100.0	19	100.0
		Geographical location		
Metropolitan areas	65	84	30	81.0
State-wide	6	7.8	4	10.8
National	3	3.9	2	5.4
Rural and regional areas	2	2.6	0	0
Off-shore detention	1	1.3	1	2.7
Total jobs	77	100.0	37	100.0
Total individuals	44	100.0	19	100.0
		Employment status		
Paid	63	81.8	33	89.2
Unpaid	14	18.2	4	10.8
Total jobs	77	100.0	37	100.0
Total individuals	41	100.0	19	100.0
		Hours in typical week		
	M=18, Range 1 to 40		*M*=21, Range 1 to 40	
1 to 5 hours	23	29.9	9	24.3
6 to 10 hours	8	10.4	2	5.4
11 to 15 hours	4	5.2	3	8.1
16 to 20 hours	7	9.1	4	10.8
21 to 25 hours	8	10.4	3	8.1
26 to 30 hours	7	9.1	4	10.8
31 to 35 hours	4	5.2	3	8.1
36 to 40 hours	16	20.8	9	24.3
Total jobs	77	100.0	37	100.0
Total individuals	41	100.0	19	100.0

	Total sample		Nested sample	
	N	%	N	%
	Period of time in the position			
5 months or less	5	6.5	4	10.8
6 to 11 months	7	9.1	6	16.2
1 year	9	11.7	4	10.8
2 years	14	18.1	10	27.0
3 years	6	7.8	1	2.7
4 years	5	6.5	2	5.4
5 years	1	1.3	1	2.7
6 years	5	6.5	1	2.7
7 years	3	3.9	0	0
8 years	1	1.3	1	2.7
9 years	0	0	0	0
10 years of more	21	27.2	7	18.9
Total jobs	77	100.0	37	100.0
Total individuals	41	100.0	19	100.0
	Proportion of focus			
Very small amount, less than 20%	20	26.0	10	27.0
Some, 20 to 39%	8	10.4	6	16.2
About half, 40 to 60%	26	33.8	13	35.1
Large amount, 60 to 79%	12	15.6	1	2.7
All or almost all, 80 to 100%	11	14.3	7	18.9
Total jobs	77	100.0	37	100.0
Total individuals	41	100.0	19	100.0

Note. Percentages may not total 100 due to rounding.

Table 15 Total and Nested Samples: Gets Supervision or Informal Support

	Total sample		Nested sample	
	N	%	N	%
	Training			
Yes	24	61.5	14	73.7
No	15	38.5	5	26.3
Total individuals	39	100.0	19	100.0
	Supervision or support			
Yes	31	79.5	14	73.7
No	8	20.5	5	26.3
Total individuals	39	100.0	19	100.0

Socio-economic status

To add to this demographic picture, I developed an estimate of the socio-economic status (ABS, 2018) of interviewees based on survey data they provided and their accounts in interviews of the professional positions they had held in the past 24 months. I considered their qualifications, occupation and seniority (based on specific information provided by participants, and publicly available industrial awards). The relative socio-economic status of the interview sample was diverse; the implications are discussed in Chapter 8.

Careers and position designations

Responses to survey questions (numeric and text) and interview data were analysed to generate an understanding of how individuals came to be doing culture-oriented work. Being on a *life trajectory* – termed "conatus" in the work of Bourdieu (Fuller, 2008, p. 171) – is a taken-for-granted attitude of feeling oneself to be a person, moving forward in a social context. We experience this sense when we feel ourselves "held back", "burdened", or "pushed forward", "relieved"; our awareness of reacting to social conditions entails adjusting "subjective expectations" to match our "objective chances" (Fuller, 2008, p. 172). This sense of movement does not require any conscious forethought on one's part or declarations about the life course that one is on (Fuller, 2008).

Participants reflected this intuitive sense of moving forward in one's life in responding to the questions. That is, it is neither regarded as wholly chosen by them nor determined by external circumstances, but the result of interactive forces. Participants explained that local opportunities, confidence communicating in English, and recognition of existing qualifications also influenced decisions to take up this work.

Explanations of how participants came to be doing this work fell into one of two common career paths. One group began their professional careers at migrant-focused service providers. Having started out by working at ethno-specific, multicultural agencies or other services for migrants, some later moved on to mainstream service providers. This cohort included individuals who had migrated as adolescents or adults and had relatively low levels of proficiency in English at that time. Some gained work experience first, by doing casework, advocacy and workplace training, then gained qualifications. Others gained relevant tertiary qualifications and chose to start out their professional careers working in ethno-specific or multicultural agencies. A participant, who mentors recently arrived migrants, saw his own story mirrored in others:

> I am helping someone to start a professional life... someone has never been in a professional position ... and you take this person out and put [them] in a professional setting, and then a new cycle will start, which is a professional cycle. (#15)

Those following the other path started out working in mainstream health services. This group included those born in Australia to migrant parents, individuals who migrated earlier in life and were schooled in Australia, and former international students who gained tertiary qualifications at Australian universities, and those who migrated from mainly English-speaking countries whose prior tertiary qualifications were recognised in Australia. Some moved from mainstream services to ethno-specific or multicultural agencies or programs consolidating their professional experience over several years. Others remained working in mainstream services and joined initiatives intended to improve the responsiveness of the agency, develop stronger links with ethno-specific agencies or provide programs that targeted particular communities. For example, Participant 1 integrated culturally responsive principles into her everyday work as a mental health practitioner. She has worked in acute care settings and now works the phones to connect young people with mental health services. She has led diversity-related working groups, advocates for young people of migrant background including recently arrived refugees, and belongs to inter-agency transcultural professional networks. Her concerns had their genesis working in acute care with young people from [region] communities and reassuring families. She has become "the face of mental health" services at local [region] community-led initiatives.

It was rare for the job titles recorded by survey participants to indicate that they were involved in helping PeMH/EI of immigrant or refugee background with whom they shared a similar cultural background, or using their cultural or linguistic knowledge and skills.

Interviewees described their work in "main-stream" ways: as mental health or counselling specialists offering services to clients on a sessional basis; as members of multidisciplinary hospital based and community mental health teams that use case allocation and review processes while taking collective responsibility for supporting clients allocated to the team; as members of care or support teams where clients are also allocated to professionals, although the work is less collaborative and review processes are less frequent; as practitioners, service development and community development professionals who undertake projects or programs in liaison with other leaders.

Some interview participants explained that their jobs were specifically designed to respond

to people recently arrived in Australia with cultural ties to a particular region. Some had also taken the substantial step of creating new, small and independent agencies to assist the communities with which they identified – they enlisted volunteer community members and undertook holistic mental health initiatives with communities and groups.

Others described positions designed to support more recently arrived populations from a range of cultural or linguistic backgrounds. Some of these individuals worked in acute care and assessment settings with the aim of facilitating improved access for one or more minority populations. Other positions of this kind were fully integrated into the fabric of the service organisation, in particular teams or across many program areas within the one organisation.

Service locations, mental health practice frameworks, and networks

Bicultural professionals in this Study told me about their work roles and workplaces, and from this I categorised the types of organisations where participants work and networks that they were a part of, as well as the kinds of mental health practice frameworks use at work. These elements, based on qualitative and quantitative data, are represented in Figure 5. This "view from above", shows the horizontal connections with categories of sectors, organisations and groups. It draws on Deleuze & Guattari's (1987) rhizome (tuber) metaphor of spreading entwined underground networks that surface in visible structures, social process and the actions of people and groups (Clarke et al., 2015).

I do not know how particular to time and place this image is. A larger sample may show offshoots to other sectors, types of organisations and groups or stronger links to particular sites, for example support programs for older adults. If I'd initiated the Study from another point, for example, begun with the field of practising multicultural psychotherapists, I suspect that the scope and configuration of connections would have looked quite different.

Across the group, providing care and support to PeMH/EI meant many things, and this is evident in the positions held and range of mental health practice approaches (which I term "frameworks") that they used. For the most part participants adopted mental health approaches consistent with "Western" medical, psychological and behavioural perspectives. Some individuals focused on counselling in one job, and providing psychosocial support in another, and some held jobs that required then to intentional combining more than one approach. Four mental health practice frameworks were in use across the interview group:

- Mental health and alcohol and drug (MH-AOD) care and treatment approaches. These clinical and recovery-oriented interventions were usually provided by medical,

psychology, nursing and allied health practitioners and support workers located in specialist mental health agencies (eight individuals).

- Psycho-social support approaches. This entailed providing individualised, comprehensive interventions using case management or care coordination over an extended period (seven individuals).
- Counselling was delivered in primary health, counselling services, at education providers or through outreach, and usually by professionals with psychology, social work or another counselling qualification (six individuals).
- Community development approaches consisted of engagement initiatives with local groups or populations with a focus on talking openly about mental health issues or creating opportunities for mutual self-help and support (two individuals).

Service agency type was not always an accurate indication of the type of mental health practice framework that informed their work. For example, of the nine positions based in migrant or refugee support agencies held by seven interviewees, approaches consistent MH-AOD, psycho-social and counselling frameworks were all described. Further, among this group there were individuals whose practice was closely aligned with Western medical views about mental health disorders and others who held more holistic views and emphasised of social, cultural, and emotional wellbeing.

Some participants had adopted more than one of the above mental health practice frameworks. Four individuals described intentionally combining two of these approaches in their everyday practice. For example, Participant 16 undertook both community development and clinically informed psychosocial interventions while working in an ethno-specific agency. Participant 6 provided comprehensive psychosocial support as a caseworker supporting asylum seekers at one agency and provided trauma-focused counselling at another agency.

Utilising connections with people located at other formal settings, for example the police and courts, and in less formal ones, such as faith communities, fell within the scope of how they characterised their roles and responsibilities. Some held multiple positions in different places during the same period and some moved between organisations and sectors as their careers progressed.

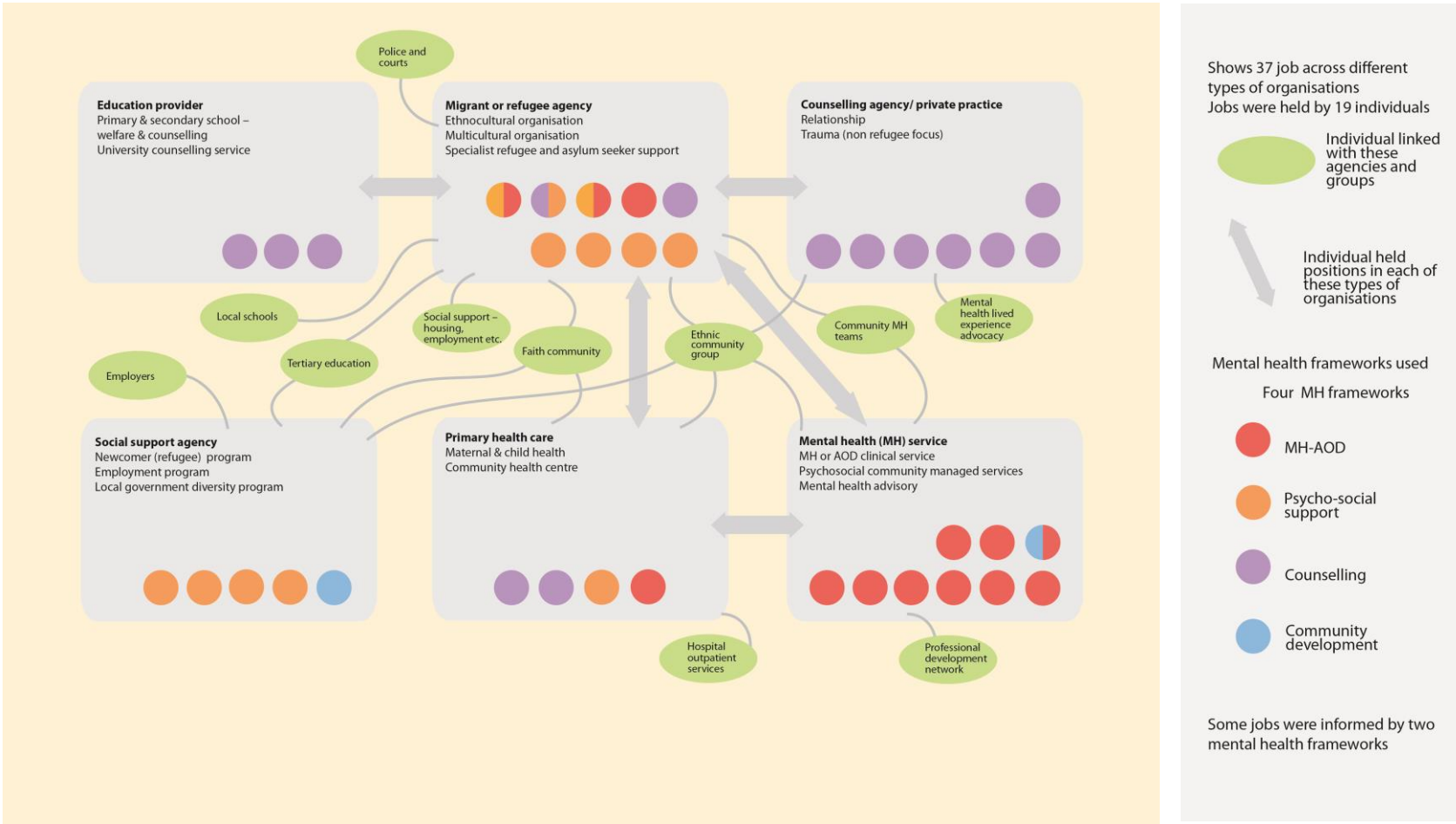
Individuals working in primary health care agencies had strong links with particular ethno-cultural and faith communities. They had developed longstanding relationships with other parts of the health system, including tertiary hospital outpatient clinics and providers of outpatient psychotherapy. These connections with formal services were founded on

personal relationships that participants had made with particular senior medical practitioners who were sympathetic to the service access issues facing newly arrived communities and acted on this, e.g. by co-facilitating health information sessions.

Professionals working in designated mental health services were connected with other providers of community mental health services. Some described voluntarily working with ethnocultural communities with whom they identified a shared a cultural heritage. This was in addition to the voluntary positions that had already been captured in the survey. Those providing casework in mainstream social support organisations seemed to have less extensive connections with other agencies and groups.

There was a commonly expressed conviction about the importance of cultural and religious communities in the lives of service users with some connecting with faith and ethnocultural community groups as part of their professional role. This sometimes involved liaising with religious leaders regarding the care of individuals experiencing MH/EI. There was nothing particular about their job – for example the type of organisation where they worked, or the mental health frameworks used – that seemed to distinguish those who did reach out in this way from those who did not.

Figure 5 Nested Sample: Location of Jobs Showing Type of Mental Health Frameworks Used. Networks and Movement of Individuals in These Jobs Also Represented



Summary

Based on the characteristics of those who participated in the survey, mental health bilingual and bicultural professionals in Victoria are diverse in their demographics, professional experiences and backgrounds, and in the professional work positions they hold and where they are employed. Across the whole sample, 45 distinct ancestries were identified. They included individuals born overseas and born in Australia to overseas born parents. Two thirds spoke a LOTE when performing some aspect of their work role. A large proportion (≥80%) had tertiary qualifications in a health, psychology or welfare field.

Their roles and responsibilities were consistent with those of bicultural and bilingual professionals working in other health, mental health and social settings and in other societies. Most described positions where they provided direct are or support to PeMH/EI. Over half were not located in designated mental service provider agencies.

Over a quarter had worked in the culturally-oriented job that they described for over 10 years. While 14% reported that their role was all or mostly dedicated to working with PeMH/EI of similar background to them, jobs that involved working with diverse populations were more common. Working more hours per week was associated with greater focus on performing bicultural work. Some were doing mental health culture-oriented work in a voluntary capacity.

Interviews revealed that there were two common career patterns. Some started out by working in ethnocultural or multicultural agencies and then took up roles in mainstream agencies. Others held positions in mainstream health and human service agencies and sought out opportunities to collaborate with cultural programs, transitioned to cultural agencies, or were active community volunteers. Across the group, 8/19 described practising in ways that were consistent with mental health clinical mental health or recovery-oriented approaches; roles that focused on providing psychosocial support or counselling were also common.

Across the group, a high value was placed on inter-sectorial work, especially in negotiating care and referral pathways on behalf of clients and communities. Those based in ethnocultural agencies, multicultural agencies and specialist refugee and asylum seeker agencies spoke a great deal about their connections with other agencies and groups, more so than those based in other organisations. Interacting with ethnocultural groups and faith communities was a feature of most roles.

Chapter 5 Survey findings and analysis

Introduction

This chapter reports the findings of the survey in three parts.

Firstly, it describes the activities professionals do to assist people experiencing mental health issues or emotional issues (PeMH/EI) with whom they share a similar cultural, linguistic or faith background. It also presents their responses to statements about cultural responsiveness. Opportunities for training, supervision and support are also described.

Secondly, the chapter explores emergent patterns about the purpose of what they do and underlying principles. This analysis includes mapping based on correlations of responses to questions about their activities and perspectives on cultural responsiveness.

Thirdly, an initial analysis of text-based reflections on their work and workplace structures is presented.

Describing the work and perspectives of bicultural professionals

The following section outlines:

- The tasks bicultural professionals do including exploring associations between the tasks they do and personal and professional characteristics (Australian-born, LOTE at work).
- The rationales, beliefs and knowledge paradigms they hold about their work. Includes associations between responses to statements and participants' characteristics (Australian-born, LOTE at work)
- Training undertaken and access to supervision and informal support. Includes associations between accessing supervision and informal support and position characteristics and participants' characteristics.

General tasks undertaken

Respondents were asked initially whether they performed any of five types of tasks, by responding *Yes* or *No* to each.

Approximately half (54%) of the participants (n=22) performed all five *general* tasks, with nearly all (93%, n=38) reporting "T3 Facilitating interactions between PeMH/EI and other health professionals" and two-thirds (66%, n=27) "T5 Assisting ethnic, faith and

multicultural groups or agencies to respond to MHI/EI" (Table 16). The distribution was similar for the nested sample.

Table 16 Total Sample: Performing General Tasks

General work tasks [a]	Total sample N	Total sample %	Interview sample N	Interview sample %
T1. Directly help individuals and families experiencing MHI/EI [b]	35	85.4	16	84.2
T2. Advocate on behalf of PeMH/EI [b]	35	85.4	17	89.4
T3. Facilitate interactions between PeMH/EI and other health professionals [b]	38	92.7	16	84.2
T4. Assist service providers and practitioners to be culturally sensitive [b]	36	87.8	17	89.4
T5. Assist ethnic, faith and multicultural groups or agencies to respond to MHI/EI	27	65.9	13	68.4
Total Individuals	41	100.0	19	100.0
Missing	3			

Notes. [a] Includes non-mutually exclusive response choices. [b] Response frequency of 80% or more

There was a strong significant positive relationship between T4 "Assisting service providers to work with PeMH/EI" and T5 "Assisting ethnic, faith and multicultural groups to respond to MHI/EI" (r(.518)= .001, n=41, 2-tailed) (see Table 17). None of the other correlations were significant. This indicates an association between bicultural professional working within agencies to promote the interests of particular groups and directly engaging with community-based groups and agencies.

Table 17 Total Sample: General Tasks, Pearson's correlations

General task categories		T1	T2	T3	T4	T5
T1. Directly help PeMH/EI	Pearson Correlation	-				
	Sig. (2-tailed)					
	N	41				
T2. Advocating on behalf of PeMH/EI	Pearson Correlation	.219	-			
	Sig. (2-tailed)	.169				
	N	41				
T3. Facilitating interactions between PeMH/EI and other professionals	Pearson Correlation	.149	.149	-		
	Sig. (2-tailed)	.354	.354			
	N	41	41			
T4. Assisting service providers to work with PeMH/EI	Pearson Correlation	.267	.267	.182	-	
	Sig. (2-tailed)	.091	.091	.256		
	N	41	41	41		
T5. Assisting ethnic, faith and multicultural groups to respond to MHI/EI	Pearson Correlation	.284	.138	-.005	.518**	-
	Sig. (2-tailed)	.072	.388	.976	.001	
	N	41	41	41	41	41

Note. **Strong correlation (Cohen, 1988; 1992).

There were no significant patterns of association between participants' LOTE capability – whether a professional speaks no other language than English, speaks a language other than English but not at work, or speaks a language other than English at work – and performing any of the five general tasks (see Appendix E, Table 29 to Table 33).

Specific tasks

Respondents were then asked whether they performed any of 32 specific tasks in each of the categories, answering *Yes* or *No* to each (Table 18). Tasks performed by four-fifths or more (≥80%) were:

1.2 Provide information about mental health, emotional issues and recovery.

3.1 Promote and facilitate contact with another professional, for example: explain how a social worker can help; attend an initial assessment with a case manager.

Two tasks were undertaken by one-fifth or less of respondents (≤20%). These options were not included as prompts and were identified from responses to "other" comments. They were:

2.5 Advocate on behalf of people in relation to managing finances, housing or social security payments.

5.7 Initiate discussion with communities in relation to "hot" issues such as 'Islamophobia'.

The pattern was similar for the nested sample.

Table 18 Total Sample: Performing Specific Tasks

Specific tasks	Total sample		Interview sample	
	N	%	N	%
T1. Directly help individuals and families experiencing MHI/EI [a]				
1.1 Provide information about services and make referrals	32	78.0	14	73.7
1.2 Provide information about mental health, emotional issues and recovery [b]	33	80.5	14	73.7
1.3 Be the primary person responsible for providing someone with individualised assistance	32	78.0	10	52.6
1.4 Do outreach to those at risk of developing problems	17	41.5	9	47.3
1.5 Work alongside other professionals to provide someone with individualised assistance	26	63.4	11	57.9
1.6 Coordinate services provided by other professionals	19	46.3	8	42.1
1.7 Mediate conflict within families	14	34.1	8	42.1
T2. Advocate on behalf of PeMH/EI [a]				
2.1 Ensure people get a good quality service	32	78.0	16	84.2
2.2 Assist individuals who are especially disempowered or vulnerable	31	75.6	14	73.7
2.3 Provide reports about individuals to courts or tribunals	9	22.0	5	26.3
2.4 Represent the interests of an ethnocultural group	13	31.7	7	36.8
2.5 Advocate on behalf of people in relation to managing finances, housing or social security payments [c]	3	7.3	3	15.8
T3. Facilitate interactions between PeMH/EI and other health professionals [a]				
3.1 Promote and facilitate contact with another professional [b]	35	85.4	15	78.9
3.2 Interpret information from one language to another to ensure accurate and meaningful communication between the service user and professionals	21	51.2	8	42.1
3.3 Explain service user and professional perspectives to each other	27	65.9	12	63.1
3.4 Build the relationship between a service user and professional	29	70.7	15	78.9
3.5 Advise health professionals about cultural issues related to mental health	24	58.5	9	47.3
T4. Assist service providers and practitioners to be culturally sensitive [a]				
4.1 Listen to health professionals' accounts of a person's issues and provide advice	27	65.9	12	63.1
4.2 Advise service providers about ways to be more culturally responsive to an ethnocultural group	31	75.6	15	78.9
4.3 Implement quality improvement programs that target service-users from an ethnocultural group	18	44.0	10	52.6
4.4 Inform service providers about the preferences and needs of an ethnocultural group	25	61.0	11	57.9
4.5 Support service user (consumer) representatives from an ethnocultural group	19	46.3	10	52.6
4.6 Mediate mistrust or conflict between service providers and an ethnocultural group	16	39.0	6	31.6
4.7 Educate a service provider workforce about cultural issues through shared case-work, mentoring, workshops or education sessions	25	61.0	11	57.9
4.8 Participate in partnerships and networks involving other services	27	65.9	14	73.7
T5. Assist ethnic, faith and multicultural groups or agencies to respond to MHI/EI [a]				
5.1 Build relationships with community groups and organisations	23	56.0	11	57.9
5.2 Inform groups and organisations about how mental health services can help	18	43.8	8	42.1
5.3 Advise groups and organisations about mental health issues	19	46.3	9	47.3
5.4 Implement community-oriented programs	16	39.0	8	42.1

Performing Specific Tasks (cont.)				
Specific tasks	Total sample		Interview sample	
	N	%	N	%
5.5 Mediate disputes within ethnic, faith or multicultural groups or organisations	9	22.0	4	21.0
5.6 Use mainstream, ethno-specific media or an agency's social media to discuss issues	11	26.8	5	26.3
5.7 Initiate discussion with communities in relation to 'hot' issues such as 'Islamophobia' [c]	1	2.4	1	5.3
Total individuals	41	100.0	19	100.0
Missing	*3*			

Notes. [a] All items non-mutually exclusive response choices. [b] Response frequency of 80% or more – total sample. [c] Tasks not included as prompts & created in analysis from "other" comments. Green highlight indicates tasks performed by 80% or more of the sample. Blue highlight indicates tasks performed by 20% or less of the sample.

Patterns in the data from the full sample were explored using Pearson's correlation. There were significant correlations between some of the items. The strength of the relationships between items with significant correlations ranged from moderate ($0.3<r<0.5$) to strong ($r>0.5$) (Cohen, 1988; 1992). Most were positive indicating agreement with one item was associated with agreement on the other item. The matrix was too extensive to include here; it is presented narratively in the Appendix E in Table 34.

A significant association was also found between speaking a LOTE at work and assisting service providers to work with PeMH/EI by mediating mistrust between a service provider and ethnocultural groups ($X^2=6.34(df=2)$, $p<0.05$) although the number of respondents who did not speak a LOTE at all was small (Appendix E, Table 35 to Table 38).

Approaches, beliefs and knowledge paradigms used

Forty survey participants responded to a set of 21 statements regarding approaches, beliefs and knowledge paradigms consistent with adopting a culturally responsive approach. Response options were *Strongly DISAGREE, Moderately DISAGREE, Slightly DISAGREE, Slightly AGREE, Moderately AGREE, Strongly AGREE*, and *Don't know/ Unsure*. The response options were scored 0 (*strongly DISAGREE*) to 6 (*strongly AGREE*) to calculate means and explore associations, with *Don't Know/ Unsure* responses excluded from analyses.

Means were consistently high, ranging from 5.9 (Q21.01, "When I do this work I aim to build trust with PeMH/EI") out of a maximum response of 6.0 indicating strong agreement, to 5.0 (Q21.20, "I use knowledge and practices about mental health and/ recovery that come from my understanding of the ethnocultural or faith-based traditions with which I

identify"), indicating moderate agreement.

Patterns in the data from the total sample were explored using Pearson's correlation. The matrix is reported with descriptive statistics in Appendix E, Table 39.

An example of a significant moderate relationship ($p<0.01$, 2-tailed r) between one statement and a number of other statements includes Q3.

Q3. When I do this work I aim to help PeMH/EI talk about stigma and negative beliefs about mental health issues' is positively correlated with four other items:

- Q5. When I do this work I aim to help PeMH/EI find out how mental health services can help (helpful services);
- Q12. When I do this work I aim to let service users know about the recommendations of other health professionals (co-workers' viewpoints);
- Q18. I believe that my work increases rates of mental health service use by PeMH/EI (service access); and
- Q19. I use knowledge and practices about mental health and/ recovery that come from my understanding of Western biomedicine and psychology ('Western' paradigms).

There were significant differences in responses to two items according to whether the respondent reported the capacity to speak a language other than English (LOTE) at work, compared to other groups (who do not speak a LOTE at all or speak a LOTE but not at work). Based on analysis of variance (ANOVA – for full results see Appendix E, Table 41), those who spoke a LOTE were likely to agree more strongly with the following statements:

(Q21.10) 'When I do this work I aim to help create services that value pluralism'. Mean for "other language spoken at work" =5.6 (SD=0.7) compared with "other language but not at work" mean=4.6 (SD=1.1), and "no other language spoken" mean=4.6 (SD=0.9). $F(2, 31)=6.04$, $p<0.01$)

(Q21.17) 'I believe that my work supports my ethnocultural or faith community'. Mean for "other language spoken at work" =5.6 (SD=0.6) compared with "other language but not at work" mean=3.9 (SD=1.5), and "no other language spoken" mean=4.8 (SD=1.5). $F(2, 35)=10.2$, $p<0.001$)

Crosstabulations of other personal or professional characteristic items and responses to each rationale/beliefs/knowledge paradigm statement did not identify any significant

associations.

Training, supervision and informal workplace support

The survey asked respondents an open-ended question about relevant training, supervision or support they had received. Themes were counted with a view to recognising patterns. Sixty-two per cent (n=24) of survey participants, and 74 per cent (n=14) of the nested sample reported having undertaken relevant training (Appendix E, Table 42). Three individuals mentioned other informal sources of learning such as self-directed learning or listening to the experiences of communities and mental health consumers. There were no reports of individuals participating in learning programs that specifically relate to performing a bicultural or bilingual role in a health setting.

Some respondents described receiving regular supervision in the form of individual sessions with a senior practitioner or team leader, and participating in reflective group sessions. They also commented on receiving informal workplace support from colleagues as part of their day-to-day work: they debrief with peers and managers or seek help to help resolve difficulties when needs arise (Appendix E, Table 43).

Some sources of informal support included attending education events sessions; participating in transcultural networks or groups forming collaborative or collegial relationships with practitioners in other agencies; and drawing on their connections with ethnocultural or faith communities.

No association was found between getting supervision or informal support and LOTE capability, the type of job that a professional held, or whether the person was in a paid or unpaid role. There also was no association between getting supervision or informal support and period of time working in a particular job or the number of hours they worked in a typical week.

The association between getting supervision or informal support and the type of industry in which a person works approaches significance when the analysis is based on two categories, either a mental health agency or another kind of agency. Individuals working in mental health organisations appear more likely to get supervision or informal support than those based in non-mental health organisations (61.3% compared to 38.7%; X^2=3.37(df=2), p=0.07) (See Appendix E, Table 44 and Table 45)

Of the 39 individuals who commented on their supervision arrangements in the survey, one individual received formal supervision from a senior staff member of “CALD [culturally and

linguistically diverse] background" (#E). There were no accounts of practitioners receiving supervision from individuals who are also experienced in performing bilingual or bicultural work. There were also no accounts of individuals participating in peer supervision groups that explicitly focus on the issues that arise when performing this kind of culture-oriented work.

Participant descriptions of supervision and support included incidental debriefing or discussing issues with colleagues when they arise (#7, F, 16); opportunities for reflective practice (#5, 19) working collaboratively (#7); and getting help and advice (#7, V).

While most participants have supervision, survey comments suggest that the types of supervision and support available may not be adequate. The suggestion of an association – between working in a non-mental health agency and a lack of access to supervision and agency-based support related to their work with PeMH/EI who are of similar background to them – could be explored further. The association is not explained by variations in the type of position held; that is, whether it entails direct care and contact or is primarily a developmental, leadership or advisory position. This suggests that organisational factors such as the value the agency gives to supervision or the internal structures in place to facilitate supervision were important.

Some respondents commented in the survey that supervision and support are especially important for bicultural professionals to look after their own wellbeing. There are risks due to vicarious trauma (#6) and this is especially challenging given the nature and severity of trauma some clients have experienced (#18). Supervision is also important in the context of professionals being subjected to overt and covert racism by clients and colleagues (#8).

Survey participants were also aware of the risk of becoming overcommitted to community members (#H) and that sharing the same cultural background with a client means raises the need for a practitioner to be especially aware of one's position and power (#18). Supervision and support can assist in managing competing client, family, community and service requests and perceived loyalties. Participants mentioned allies, supervisors or colleagues who: openly offer their support or understanding (#T); encourage them to be aware of their own needs as a person and professional (#J); and are also advocating on behalf of disadvantaged individuals and populations (#K).

Some individuals who receive formal supervision commented, nonetheless, that they are inadequately supported by their organisation or agency (#K, 17). One person mentioned

turning to external networks for support (#17), another emphasised self-reliance (#L).

Of the eight individuals from the full sample who had no supervision or informal support arrangements in place, one saw this as problematic, stating "bilingual workers do not receive adequate support", that they lack career opportunities and that dynamics between bilingual professionals and their team leaders can be strained (#12). This respondent felt that the range of knowledge and skills bicultural professionals possess is under-acknowledged by more senior staff. The "ability to speak a different language is [over]shadowing the other skills of a bilingual worker"; their deep understanding of migrant and refugee issues is not appreciated; their personal commitment to assisting people is much stronger than the senior practitioners (who are in the main, do not identify as bicultural) to whom bicultural and bilingual staff report.

One individual was unconcerned about supervision and support arrangements remarking, "[I receive] no help, I'm a brave person, my knowledge is even higher than those [of the] clinical team" (#C). Two individuals, who indicated that they received neither supervision sessions nor informal support, also mentioned *self-reliance*. One coupled this with a continued self-reflection: "it helps … on a personal level to reflect back and come up with new strategies to help" (#15). The other draws on non-agency sources of support: "using personal and social resources on a broad basis" (#10).

Identifying the purpose of their work and the underlying principles

This section that follows here presents the outcome of qualitatively exploring the correlation analyses reported above which showed significant associations between the 32 *specific task items*, and between the 21 *approach, belief and knowledge statements*. Implications of each of these analyses are explored further in Chapters 6 and 7 with interview data and in the light of extant literature.

It also reports analysis of open text responses to survey questions about the professionals' lived experience, the issues that arise for them at work, and how they resolve them.

Activities and purpose

The initial set of questions posed in the survey, designed to elicit what these professionals do, posed five types of work (referred to as general tasks) with examples (specific tasks) attached to each.

The original classification of items based on selected literature is outlined below in Table

19. The correlation analysis indicated that some items were associated with other items in the same a priori category, and some were not. As discussed above, there were multiple significant correlations across the 32 items.

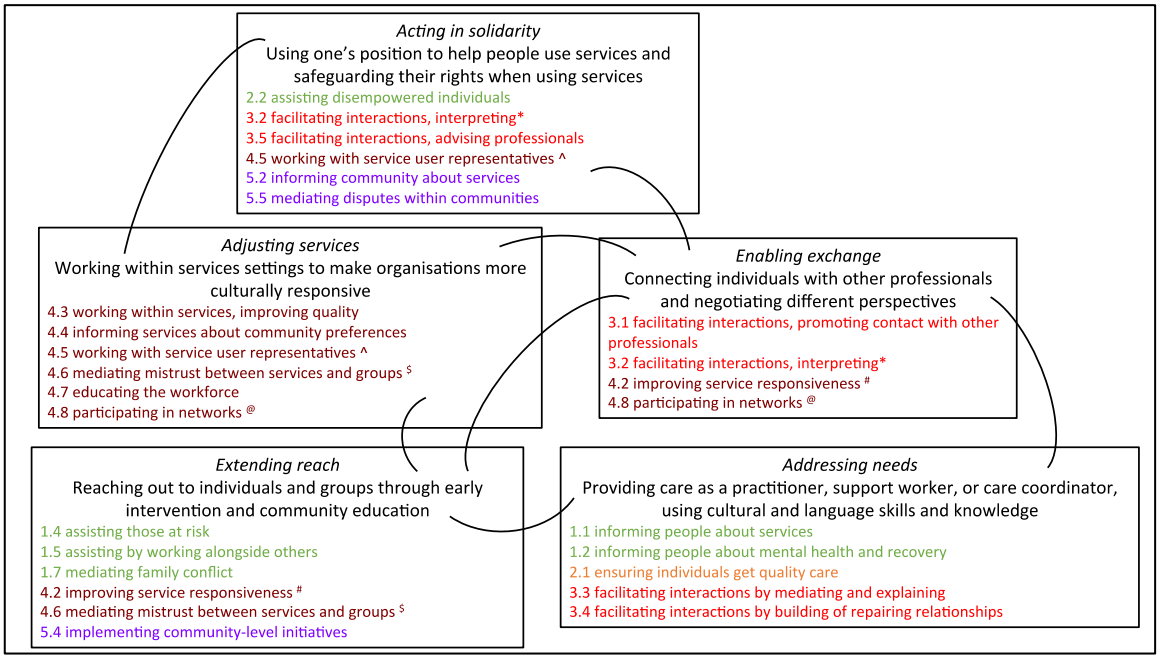
Figure 6 presents the new categories that emerged from mapping the magnitude of the correlations across the themes within these task descriptions. Five new categories explain how activities related to each other; each group of activities represents a main purpose. The detailed figure (see Figure 7) shows the mapping used to represent the correlation matrix and develop explanatory themes

Table 19 Total Sample: Identifying Patterns in Specific Tasks Items

General tasks	32 Specific tasks
1. Directly help individuals and families	1.1 informing people about services
	1.2 informing people about mental health and recovery
	1.3 being the primary practitioner [a]
	1.4 assisting those at risk
	1.5 assisting by working alongside others
	1.6 coordinating the services of other professionals [b]
	1.7 mediating family conflict
2. Advocate on behalf of individuals and families	2.1 ensuring individuals get quality care
	2.2 assisting disempowered individuals
	2.3 providing reports [b]
	2.4 representing group interests to government [a]
	2.5 providing individual financial advocacy [a]
3. Facilitate interactions between individuals and other professionals	3.1 facilitating interactions, promoting contact with other professionals
	3.2 facilitating interactions, interpreting
	3.3 facilitating interactions by mediating and explaining
	3.4 facilitating interactions by building or repairing relationships
	3.5 facilitating interactions, advising professionals
4. Assist service providers and practitioners	4.1 providing professionals with cultural consultation [a]
	4.2 improving service responsiveness
	4.3 working within services, improving quality
	4.4 informing services about community preferences
	4.5 working with service user representatives
	4.6 mediating mistrust between service and groups [a]
	4.7 educating the workforce
	4.8 participating in networks
5. Assist ethnic, faith, and multicultural groups or agencies	5.1 building relationships with community [a]
	5.2 informing community about services
	5.3 advising groups about mental health issues [a]
	5.4 implementing community-level initiatives
	5.5 mediating disputes within communities
	5.6 using media [a]
	5.7 initiating discussions about racism [b]

Notes. White text: item significantly correlated with other statement(s) and used to develop work categories. Black text: item not significantly correlated with other statement(s) and not used to develop work categories. [a] item correlated (but not strongly) with other statements. [b] item not correlated with other statements

Figure 6 Total Sample: Developing "Work" Category from Analysis of Specific Task Items



Notes. Numbers refer to survey questions. Each numbered statement strongly correlates with (an)other statement(s). Item colours represent how specific task items were initially presented in survey questions based on selected review:

Green text: Directly help individuals and families

Orange text: Advocate on behalf of service users.

Red text: Facilitate interactions between professionals and service users

Maroon text: Assist services and practitioners

Purple text: Assist ethnic and other groups and agencies

The boxes present five categories of "purpose" that emerged from analysis of responses: *Addressing needs; Acting in solidarity; Enabling exchange; Adjusting services;* and *Extending reach.* These are discussed in Chapter 6 Work

Some items appear in two categories:

3.2 facilitating interactions, interpreting * appears in *Acting in solidarity & Enabling exchange*

4.2 improving service responsiveness # appears in *Enabling exchange* & *Extending reach*

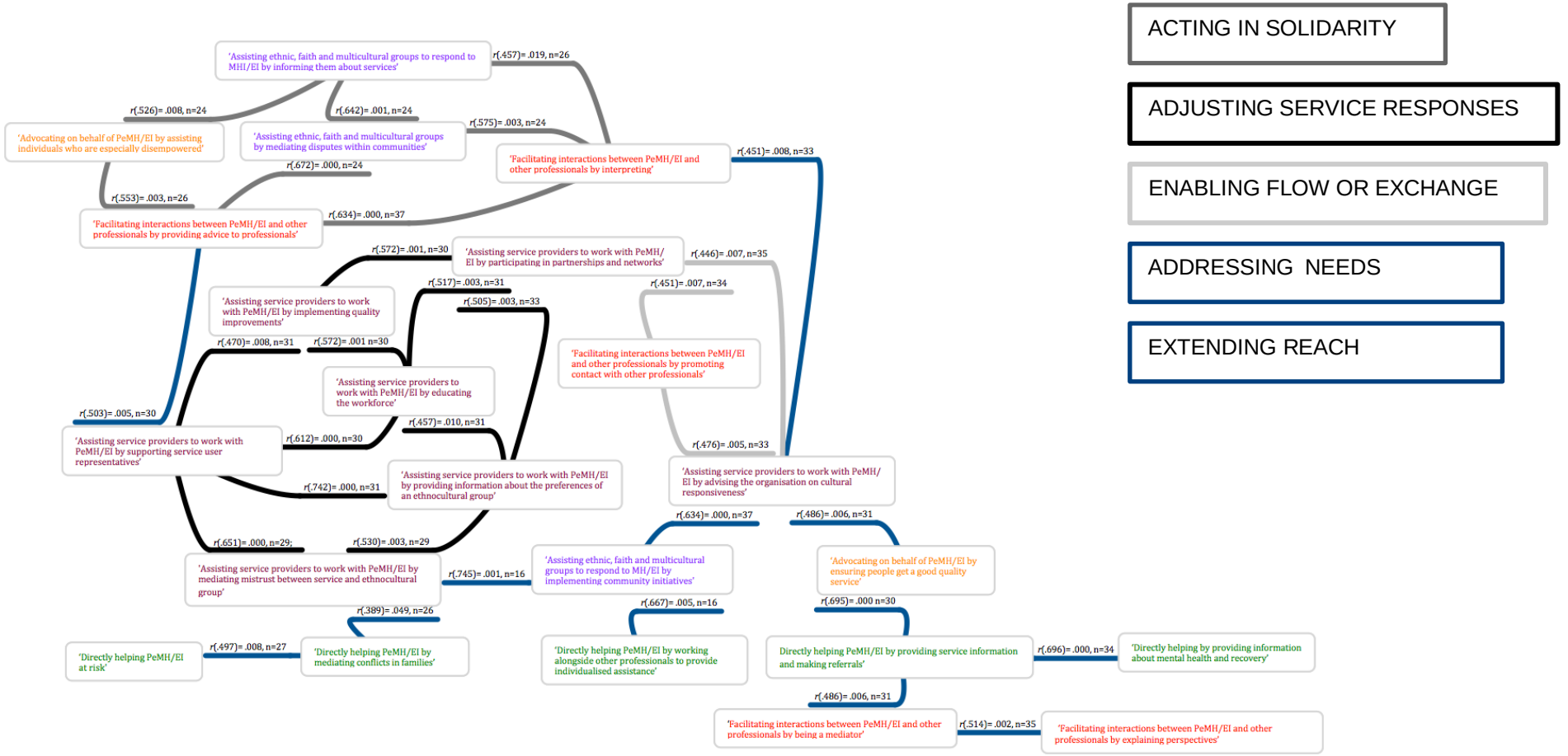
4.5 working with service user representatives^ appears in *Acting in solidarity & Adjusting services;*

4.6 mediating mistrust between services and groups $ appears in *Adjusting services & Extending reach*

4.8 participating in networks @ appears in *Enabling exchange & Adjusting services*

Lines reflect the points of connection between categories as shown on main map.

Figure 7 Total Sample: Developing "Work" Category by Mapping the Significantly Correlated Specific Task Items



Note. See Figure 6 for use of colours. Correlation is significant at 0.01 level (2 tailed).

Approaches, beliefs and knowledge in relation to cultural responsiveness

The statements that enquired about participant preferences regarding approaches, beliefs and knowledge paradigms related to cultural responsiveness are outlined below in Figure 8. This presents the categories that emerged based on mapping the magnitude of the correlations across the themes presented in these initial questions. The six categories capture these patterns. They each represent principles that bicultural professionals apply to their work with PeMH/EI. The multiple significant associations between these items were mapped. The detailed figure below (see Figure 9) shows how mapping was used to represent the correlation matrix and develop explanatory themes.

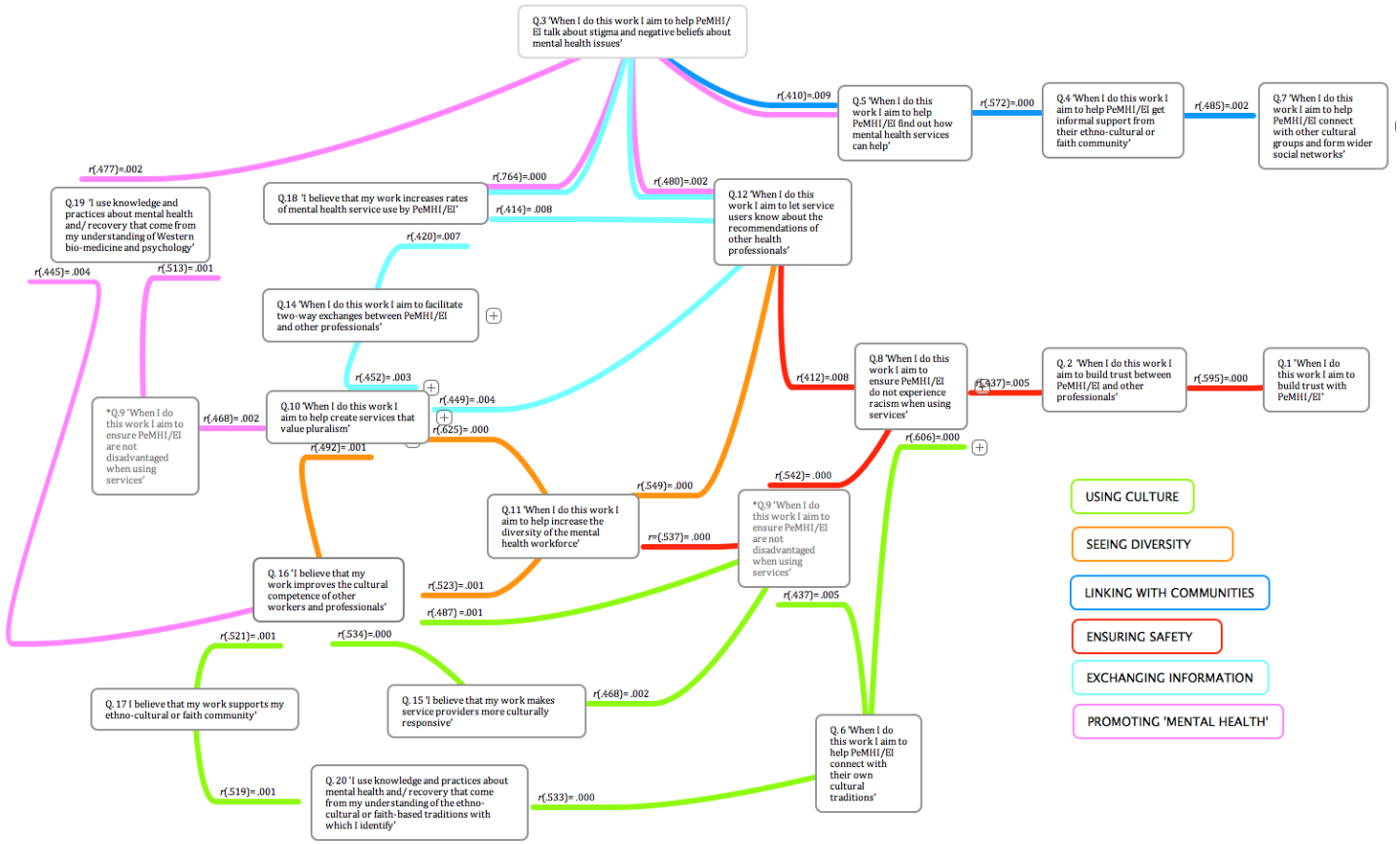
Figure 8 Total Sample: Developing "Principle" Category from Analysis of Statements about Cultural Responsiveness

Notes. There were 21 statements:

1. building trust with service users
2. building trust between service users and co-workers
3. discussing stigma and unhelpful beliefs [a]
4. enlisting community supports
5. explaining how health services help
6. connecting service users with their traditions
7. making community connections
8. addressing racism
9. ensuring equal treatment
10. valuing pluralism [a]
11. increasing workforce diversity
12. explaining co-workers' viewpoints to service users
13. explaining service users' viewpoint to co-workers [b]
14. facilitating two-way conversations
15. improving service's responsiveness
16. educating co-workers
17. supporting my [i.e. the participant's] community
18. improving service access
19. applying 'Western' knowledge & practice paradigms
20. using knowledge of 'cultural' or faith traditions
21. using understanding of social structures [b]

[a] statement part of more than one category; [b] not strongly correlated with another statement.

Figure 9 Total sample: Developing "Principle" Category by Mapping the Significantly Correlated Statements about Cultural Responsiveness



Notes. Q.9 "When I do this I aim to ensure PeMH/EI are not disadvantaged when using services" appears twice for ease of showing links with other items and not any other reason. Correlation is significant at 0.01 level (2 tailed).

Reflections: their experiences, concerns and how they respond to them

The survey ended by inviting participants to reflect on their experiences with three open-ended questions; "What kinds of LIVED EXPERIENCE have you personally had that enables you to do this work?"; "What ISSUES ARISE when you do this work?" and "What helps to RESOLVE ISSUES when they arise?" The main themes that emerged are outlined below.

Self and others

All respondents provided examples of some relevant experiences. No one questioned the premise of the question, either the relevance of asking it or whether personal and family experiences were enabling when it came to working with PeMH/EI who are of similar background to them. They offered comments on a range of ways that one's own life's trajectory may resonate with the personal and family histories of individuals whom one encounters professionally.

Recalling past personal experiences

Participants identified lived experiences from their own personal past, especially childhood or period of life when migrating and settling in new country, or encountering the experiences of other family members, especially parents and friends. They could *use their first-hand experience* to *adopt an insider's perspective*.

Individuals identified surviving political violence and discrimination, including living with the consequences of colonisation and civil war (#2, V) and experiencing marked gender inequality (#3, 18). They also described coping with migration and settlement including moving from country-to-country as a refugee (#4, 8); arriving in a new country and being unable to communicate (#3); and being subjected to racial discrimination prior to migrating to Australia and since (#1, E). There were also instances of recalling, as a child of parents and grandparents struggling to adjust (#M) and coping with loss and bereavement (#E). Another noted the lasting impact of past political trauma on the lives of family members (#H).

Other relevant lived experiences related to facing other life challenges, such as helping friends who have experienced domestic violence (#9); advocating on behalf of a family member with a disability (#2, K); and coping with a long-term caring role (#2, C).

Wanting to make a difference

In addition to describing events or life circumstances, participants affirmed the value of lived experience to their practice by directly connecting past personal experiences with current motivation to perform a culture work role. Participants claimed that, for them, wanting to make a difference was founded on their own familiarity with adversity. For example, Participant 4 explained:

> like all migrants I experienced trauma, cultural shock, language problem etc. ... Because of [name of country] government policies I had many negative experiences... My previous experience and being migrant in Australia help me understand my client's problem properly.

Several participants described drawing on past experience so as to make a difference in the lives of others. One described feeling compelled to do so: "I've had to deal with [issues affecting family members] that have pushed me to help others" (#C). Others mentioned getting overcommitted (#H, L). Participant L explained: "work can get too much at times but the... passion that I have in helping people overrides this issue".

Feeling 'capable' and knowledgeable

Reflections on experiences included identity-related themes, such as feeling adrift and disconnected from others (# 1, 3). For example: "I experience disconnection, racism, lateral violence and the internal conflict of identity and belonging" (#1). Others claimed identities, such as "I am an immigrant" (#2) "a child of migrants" (#6, 9), "bicultural" (#P) or "multicultural" (#C).

Participants saw links between having personally experienced adversity and their capacity to do culture-orient work. For example: "I can use my experience, knowledge and education in early childhood to mitigate disadvantage young children" (#4). Another participant asserted: "I am a brave person" (#C) and; "my knowledge is even higher than those [in a] clinical team" (#C). In contrast, another admitted to "a lack of experience in certain situations" (#5). Several participants' comments balanced self-belief with awareness of the need to also reflect on their practice (#A, J, H). This was evident in comments about maintaining an "awareness of personal competency and limitations" (#H) and "being self-aware so I can identify issues before they become a problem" (#J).

Encountering others

Participants described viewing relationships with clients as opportunities for life-long

learning (#10) and valuing the knowledge that comes with developing close ties with clients, families and communities (#2, 7, 10).

In their work with clients and families, participants described empathic encounters with the trauma of others (#6, J). One participant mentioned experiencing racism at work, noting "some people don't intend to be racist but they are" (#8).

Managing relationships

Relationship issues arose for participants at work. These were described in general terms, such as "personal values conflict" (#5) and managing "occasional boundary issues" (#H). On working with clients, families and community members of similar background to them, one participant noted that this requires practitioners to "be mindful of position and power imbalance" (#18). When interacting with colleagues, participants noticed disparities between their own approaches and those of others, for example: "a shared understanding of the patient amongst colleagues working with a patient may be challenging to develop" (#P). They also spoke of attempting to influence co-workers by "checking [their] understanding" (#M) and by working alongside colleagues for extended periods (#7).

Looking for recognition

Some participants described working in settings where they felt supported by their organisation and colleagues. They were particularly appreciative when those in leadership roles openly expressed their support for or understanding of culture-oriented work (#T) and encouraged bicultural professionals to care for themselves, become more aware of their own needs as a person or professional (#J) or championed the issues facing service users (#K).

Participants believed diversity responsive organisations create environments where bicultural professionals are accepted, can safely express their ideas and receive ongoing support (#2). Some described battling for acceptance and recognition in their workplace and questioned their organisation's "commitment to meeting the diverse needs of their clientele" (#1).

One participant commented at length that the range of knowledge and skills bicultural and bilingual professionals possess is being under-acknowledged by more senior staff, and claimed that the deep understanding bicultural professionals have of migrant and refugee issues is neither appreciated nor remunerated within organisations (#12).

Other comments

Survey participants also mentioned particular activities and actions in response to these open questions. For example, when (#4) spoke about advocating for "young children by educating their parents about the importance, the early years, the first step is often to make sure that parents' mental health is appropriately addressed and [they are] socially engaged." Survey comments on these themes were considered when gathering and analysing interview data as part of developing an integrated interpretation of bicultural practice.

Reflections on cultural and social themes

While they were *not* directly asked to do so, some participants also offered information about the societal issues facing clients, families and communities, and structural barriers to service use that they believe clients are facing.

Seeing the cultural and social aspects of clients' personal problems

Participants commented that clients are *facing social disadvantages* including: financial hardship (#3); struggling to communicate in English (#11); and experiencing racism (#10).

Culturally specific factors among some groups are *hindering help seeking*: the prevalence of unhelpful or stigmatising beliefs about mental illness (# 5, 7, Q, R,) that may lead to rejecting or blaming the person with the problem (#7) or not being open about the range of problems facing members of a family or community (#7). Pre-existing conflict within communities, for example along religious, historical and political lines, can hinder community-level responses (#7).

Noticing the limitations in service provision approaches

As professionals operating within the constraints of an agency or service provider, some respondents believed organisations do not understand the issues facing disadvantaged individuals and communities (#4, A, C, T) and that poor organisational responses increase levels of distress for clients (#T). Some observed *'lack of interest from staff to learn about how to work with people from ethnic specific background because they do not believe there is an issue [with their] practice'* (#17). Many practitioners are *lacking cultural awareness and capabilities*, for example working ineffectively with interpreters (#7).

Recommending service reforms

Observing that agencies and service providers are *failing to prioritise the needs* of groups

with high needs (#Q), some participants are *bringing to light* otherwise ignored community perspectives (#2). Respondents recommended organisational responses including *designing services that are easier to access* (#9); providing culturally appropriate mental health resources (#10); directly engaging with communities about mental health (#Q).

Summary

Five categories accounted for patterns in the activities these professionals undertake as part of their professional responsibilities in supporting PeMH/EI individuals, families and communities. These strategies involve directly *responding to needs* by using their discipline specific or cultural expertise. They may also be *acting in solidarity*, to advocate on behalf of people who are feeling overwhelmed by their circumstances and disempowered by contact with formal services. They e*nable flow or exchange* between service users and other professionals and within services and sectors by collaborating with others. They also *adjust service responses* by working within agencies and networks to improve service user access and experiences. Finally, their efforts also involve *extending the reach* of services to more vulnerable individuals and groups.

Six categories explained their approaches to cultural responsiveness: *seeing diversity, creating sanctuary,* and *using culture*. They also included *promoting mental health, linking communities and exchanging information*.

There was a high level of consensus among participants regarding the broad rationales that inform cultural practices. Those who spoke a LOTE at work believed more strongly (than those who did not speak a LOTE at all or did speak a LOTE but not at work) that their work is making services more pluralistic. The group who spoke a LOTE at work were also more likely than these other groups to believe that their work supported the ethnocultural or faith communities with which they identify.

When reflecting on their own issues at work, and how they respond, thoughts about self in relation to others seemed important to many participants. They described *recalling past personal experiences* while working with individual, families and communities. They were motivated by *wanting to make a difference* in the lives of individuals and groups who are disadvantaged in a range of ways. They were acting from a *sense of feeling capable and knowledgeable* about how to assist others. They were also reflective about the processes that unfold when *encountering others.* In particular they were *managing their relationships* with colleagues, clients and communities. They were also *looking for recognition* from

professional peers and supervisors for the work they do and the contributions they make.

There were no reports of individuals participating in learning programs that specifically relate to performing a bicultural or bilingual role in a health setting. Individuals working in mental health organisations were more likely to get supervision or informal support than those based in non-mental health organisations. There were no accounts of practitioners receiving supervision from individuals who also do bilingual or bicultural work. None of the study participants described joining peer supervision or reflective practice groups that focused directly on the issues that arise when performing a bicultural or bilingual role.

Survey participants also offered reflections on structural themes that play out in the provision of mental health care. There were examples of *seeing the cultural and social aspects of clients' personal problems*, *noticing limitations in mental health service provision approaches* and *recommending service reforms*.

This element of the Study provided a description of the workplace and personal characteristics of the professionals who assist people experiencing mental health issues or emotional issues (PeMH/EI) with whom they share a similar cultural, linguistic or faith background, the tasks they perform, the approaches they use and the kinds of supervision, support and training they receive.

Chapter 6 Work

Introduction

This is the first of the five chapters that present the fifth phase of Study design – theoretical integration – as outlined in Chapter 3. That is, the next five chapters each discuss a feature of the substantive theory developed to explain bicultural practice.

Chapter 6, Work discusses the kinds of culture-oriented work that bicultural and bilingual professionals do to assist PeMH/EI. It builds on the analysis of responses to survey prompts about tasks reported in Chapter 5 by also considering individuals' direct descriptions in interviews. It discusses their activities, undertaken for five main purposes. These purposes are evident in the roles they assume to solve everyday problems and address equity and social justice.

Activities and their purpose

Bilingual and bicultural professionals assisted PeMH/EI while undertaking a range of jobs. More worked in non-mental health settings than mental health designated programs or services. Most of those working in non-mental health settings did not get regular clinical supervision.

Participants offered many services, with half of the total sample (20/41) doing tasks associated with each of the following five general tasks:

- directly assist by providing mental health treatment and care; therapy or counseling; and/ or psychosocial support
- advocating regarding health or other human rights
- facilitating intercultural communication between service users and other professionals
- assisting organisations and other practitioners to improve their responses to particular groups or diverse communities
- helping ethnocultural and multicultural groups or organisations to respond to mental health and emotional issues that are affecting their community.

There was an association between working within agencies to promote the interests of particular groups and directly engaging with community-based groups and agencies. With respect to bilingual professionals in particular, there was a significant pattern of association between speaking a language other than English at work and facilitating interactions

between PeMH/EI and other professionals, but only in respect of the specific tasks of providing language interpreting. A significant association was also found between speaking a LOTE at work and assisting service providers and practitioners to work with PeMHI/EI by mediating mistrust between them and ethnocultural groups.

The work of bilingual and bicultural professionals involved contact with:

- individual PeMH/EI, their friends and families, and community members, including community representatives and leaders who were seeking support to address mental health issues arising in communities
- professional peers internal and external to the agencies where they are located and other service representatives involved in making decisions about how regarding services are delivered

The following interpretation – of purposes – is based on the implicit connections between the various activities they do. They were involved in *addressing needs*, *acting in solidarity*, *enabling exchange, adjusting services* and *extending reach.* These sub-categories were developed using quantitative analyses to identify patterns and consider how activities related to each other and by making comparisons with conversational accounts. Each purpose is expanded upon below: information elicited during free-flowing interview conversations is presented in relation to each theme.

Addressing needs

Participants carried out their core responsibilities as practitioner, support worker or care coordinator and incorporated cultural considerations, knowledge and using abilities to speak a language other than English (LOTE). They were directly addressing the needs of PeMH/EI for treatment, care, advice or healing.

For example, Participant 4 worked as part of a community team and undertook developmental assessments of children of recently arrived families and helped them to connect with formal support services. She sometimes incorporated prayer and other healing rituals into contact sessions if the family practised a [particular] faith.

Another participant described introducing clients to a recovery-oriented approach:

> For me as a worker to be aligned with my practice and my organisation and let them know, this is why we take this approach, and this is very different from what you used to be back home, but this is what works for people, because we believe in it.

(#5)

Participant 17 worked in a community mental health team and described using LOTE capabilities when conducting mental state examinations.

Acting in solidarity

Participants used their position to help people access services and safeguarded their rights when using services. These professionals sought out opportunities to promote the health rights of individuals and groups within the health care system. They want to "empower" clients, families and groups because, as one participant noted: "people need people in their community who are going to advocate for them and their family" (#7).

Participants also routinely took the time to discuss confidentiality and privacy with clients, helping them to understand their obligations to clients as individuals and to the wider community. For example, one participant explained:

> They used to worry about the confidentiality. That you are part of the community and you are going to and talk to everyone. What I always do is, I always say your story is your story and it stays here. It doesn't go anywhere and even if your sister or your husband comes here and asks and says, I saw so and so in your office what was she doing? I'm not obliged to tell them anything. You know and just repeating that all the time to make them feel comfortable. (#4)

Bicultural and bilingual professionals also spoke to individuals, families and communities about how mental health and other services can help. They wanted community members to regard formal services as "theirs". As Participant 1 explained: "we want everyone to be treated equally in a service, and [for services] to look at... strengths".

Showing solidarity also entails informing others about what matters most to an individual or a community. For example, Participants 3 and 18 each described times when representing clients' perspectives to treating mental health significantly changed clinical care and management plans. Even in work environments where bilingual and bicultural professionals doubted whether their professional peers understood or appreciated the cultural and structural aspects of mental health care, individuals were assiduously raising issues and asking colleagues to reconsider their assumptions and actions.

Enabling exchange

Participants connected service users and groups with other professionals and where

necessary helped to negotiate between different perspectives. Bicultural and bilingual professionals provided colleagues with cultural consultation advice, facilitated conversations between them and service users, and eased communication across agencies and sectors.

They were asked to share their cultural knowledge. For example, Participants 7 and 16 identified occasions when psychiatrists, general practitioners and other professionals requested their advice regarding culturally appropriate mental health care or treatment. They linked individuals and families with mental health service providers, kept them in touch with care teams, and therefore improved the quality of care that individuals received. One participant's intervention helped a young man because:

> I was able to establish what the issues were around the time when he suddenly started [to become mentally unwell] ... I can often relate that to the workers, to give them a broader picture of what's really going on. (#7)

Similarly, other mental health professionals have asked Participant 12's advice based on his knowledge of cultural or faith traditions. This informal expectation to educate other staff and supervisors felt burdensome at times, because, as this participant described, their cultural expertise was not consistently valued by the agency. This professional peer-educator role was largely unofficial.

These professionals used their cultural expertise and networks to enhance understanding between individual service users and providers. They wanted service users to form strong and helpful alliances with other professionals. This could entail countering taken for granted assumptions that each party held about the other. For example, Participant 1 has heard professional peers express stereotypical views about how ethnocultural groups address mental health concerns, observing: "too much of the information is about the negatives, and not... about what the communities are doing for themselves".

Participant 16 described using formal and informal networks to work across agencies and sectors: "I connect people with the services". Interagency networking was frequently described as essential for sharing information and fostering local cooperation.

Being the mediator between services and clients was emotionally demanding for these professionals because they could strongly identify with client's fears, sense of exclusion and preference for privacy. One Participant 11 offered this explanation of why opening up to outsiders can feel disloyal to one's loved ones and community:

> We don't want to air our dirty linen and we have no problems, and denial, until it reaches a tipping point, I think that's more of the issue. We should all be seen to be coping, and fitting in to the system and we shouldn't be having problems, that's shameful… And we may even get backlash. (#11)

Adjusting service responses

Professionals were also working within services settings to make organisations more culturally responsive. They were involved in developing and implementing organisational diversity responsiveness plans. This included: leading professional development and training of mental health practitioners (#8; 1); coordinating local community of practice networks of professionals who work with language communities (#13); supporting community groups to re-build relationships with services (#1); and creating forums where services could hear directly from communities (#1).

Extending reach

Finally, professionals reached out to vulnerable individuals and groups, often maintaining their involvement for extended periods. They talked in communities about mental health, in order to build trust. They scaffolded opportunities to explore issues in more depth, developed mutual self-help programs and provided information about how formal services might help.

Bicultural professionals understood that ethnic communities were often cautious about discussing mental health issues and using the formal services. In this context one participant (#14) opted to seek out people who were more accepting and open in the first instance, for example, religious leaders who were keen to discuss how mental health issues were expressed in their communities.

Professionals were also playing important roles by providing support early in episodes of distress. For example, Participant 7's regular group contact with parents and children enabled her to see when newly arrived families are struggling to provide young children with emotional care. Fellow team members trusted her to notice emerging issues and refer on. In another example, young community contacts would often let Participant 16 know when someone was disengaging from school or family and going through difficult times.

Tackling strongly held opinions is challenging in any community. Participants commented that explaining unfamiliar mental health concepts and service priorities could also be difficult. For example, "it's not just about simple translation, it's about how we can translate

the meaning of the approach behind it so it resonates" (#5). An even greater challenge lay in asking people to accept some of the premises that underpin formal mental health service delivery: "it's easy to describe [recovery-oriented approaches], but it's quite difficult for them to accept it, because they have not been used to it" (#5).

Professionals were aware just how unsettling it could be for members of recently arrived communities to have contact with formal health services. It helped to anticipate the possibility that offers of help might be declined (#7, 9). As one participant explained:

> I always tell them, you know, in the first meeting set up and say, some of the things I might say may seem strange to you or even controversial or contradictory to your culture. And often at the first meeting, I have an interpreter there and explain this is what this place does and this is the reason why we have places like this because people who are newly arrived haven't got a clue. [They are thinking] why are you interested in my family? Why do you want to help my family? And just explain, this is what we do, this is the philosophies and just take it down to basics. I say, this is voluntary, I can't proceed without your consent, and I can support your family with this, this and this and this is what we do. And some people might just say, No, no thank you, I'm OK. And eighteen months down the track we see them again and things are in a different situation, but you have to leave people to have their own momentum with stuff and to come to terms with it. (#7)

Other approaches included taking opportunities to talk about mental health at community events (#14), embedding mental health or alcohol and drug use themes in parenting sessions for families conducted in local schools in community languages (#13), and establishing volunteer-led programs in collaboration with other community members (#11; 16).

Roles and responsibilities

I compared the above sub-categories – that assign a purpose to a set of activities – with selected literature. The notion of "roles" (for example, as used by Erving Goffman) captures a sense of professionals assuming or adopting responsibilities in local settings in ways that are meaningful to them and which others can also recognise (Germov, 2009c). Five roles that reflect the categories and their relationship with the different roles in literature are described (Table 20). These roles are *providing mental health or wellbeing expertise*, *being a health advocate*, *mediating a range of encounters* (Mediator), *being a change-maker within teams and organisations* (Change Maker), and *offering guidance to communities* (Guide). The

data, codes and categories identified and compared to develop these role descriptions are summarised in Figure 10.

Participants in this study showed that while their work involves offering mental health, cultural and language expertise, the way that they do this has much in common with cultural competency expectations that apply to all mental health professionals. For example, cultural competency guidelines for psychiatrists in Canada developed by Kirmayer and colleagues (2012, 2020) with reference to the "CanMEDS Physician Competency Framework" (Frank, Snell & Sherino, 2015) sets out a list of roles. To the core competencies that come with being a "Medical Expert", the CanMED framework identifies additional roles, each has attitudinal, knowledge and skill components, and cultural competency is conceptualised as a component of each. The overall approach is characterised by Frank and collaborators (2015) as a paradigm shift because it explicitly orients practitioner education toward addressing personal and societal needs rather than meeting the interests and abilities of professional groups and service providers. The additional psychiatry guidelines embed cultural awareness in these generic roles. In the context of providing culturally responsive mental health care, this approach to building competency encourages professionals to become experts in using the "concept of culture", not experts in the language, ethnicity of culture of the client (Carrera et al., 2020).

The activities and intentions of bicultural professionals shared some similarities with individuals involved in facilitating social or organisational change. For example, material produced by Deepa Iyer (2020) for common use and distribution, outlines the range of possible ways one can (not necessarily as a professional) facilitate change in a "social change ecosystem". She explains:

> As part of movements and organizations, many of us play different roles in pursuit of equity, shared liberation, inclusion, and justice... This is a framework that can help individuals, networks and organizations align and get in right relationship with social change values, individuals roles, and the broader ecosystem (Iyer, 2020, p. 1).

The roles identified in Iyer's framework overlap with some of the purposeful work that participants in this Study described.

Frameworks designed to consider and plan the implementation of new programs or practices also identify some relevant roles. For example (Consolidated Framework for Implementation Research (CFIR), 2020) describes "opinion leaders" and "champions". These are individuals within organisations that "have formal or informal influence on the attitudes and beliefs of others" regarding how to implement a practice. The framework

also describes individuals who "dedicate themselves" to implementing changes in practice, including overcoming the resistance of others. Participants in this Study embodied some of these attributes, and took on some of these responsibilities. Some did so as program leaders; most attempted to informally influence and champion culture-oriented practices among their colleagues.

In summary, bilingual professionals directly assisted PeMH/EI their friends and families by providing mental health expertise, representing their interests in service settings through advocacy, facilitating intercultural communication involving other professionals, and by having contact with community members and representatives. They also helped indirectly by working within organisational and community structures. They worked with teams and organisations to improve they ways they respond to diverse individuals, families. They offered guidance to communities on ways to talk about mental health, offer support and connect with services. They are providing language and cultural expertise. Their work is also consistent with culture-oriented mental health practice, pursuing equity and inclusion goals on behalf of service users, and trying to influence and change how services responded to migrant and refugee communities.

Figure 10 Exploring the Category of Work: Activity, Purpose and Role Features

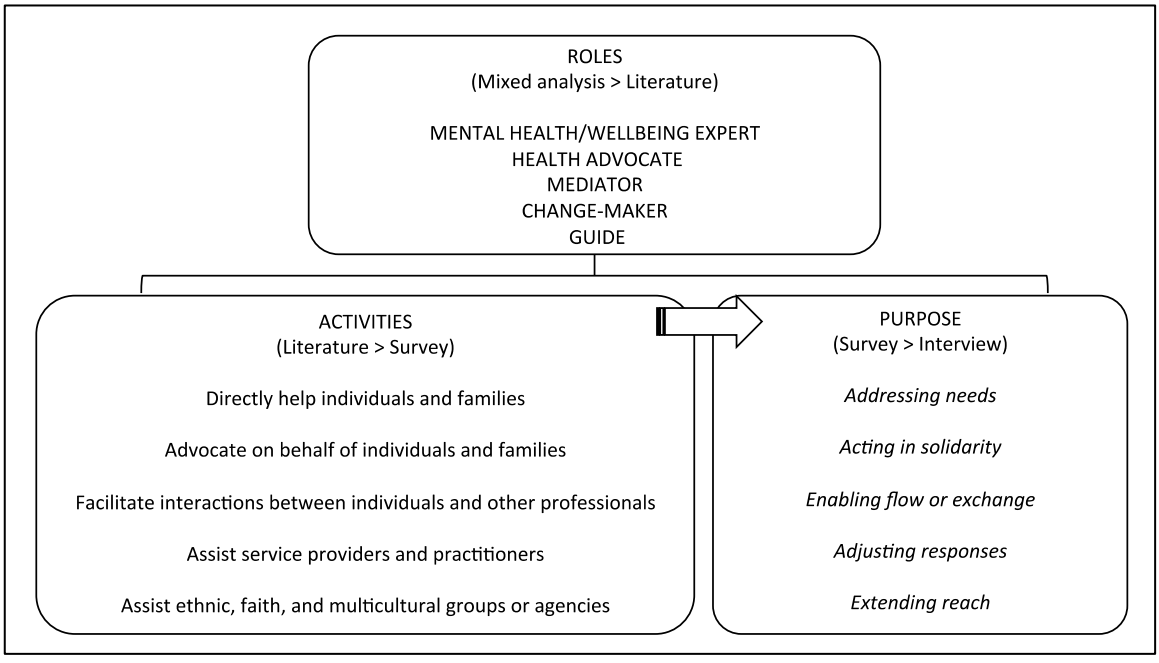


Table 20 Exploring "Work" Category: Purpose Descriptions with Selected Literature about Roles

		Bicultural work – Five "purpose" themes	Bicultural professional roles
		1. Addressing needs: Providing care as a practitioner, support worker, or care coordinator, using cultural and language skills and knowledge	
Roles	Expert [a]	- has self-awareness and knowledge about mental health problems, cultural expressions of distress, cultural issues that matter in therapeutic contexts and about relevant services. Skills include being able to engage people and develop an alliance, conduct assessments and provide therapeutic interventions	Mental health or wellbeing expert
	Professional [a]	- acting with integrity, respect for diversity, develop collaborate relationships, address ethical issues	
	Responder [b]	- addresses community crises by "marshaling and organizing resources, networks, and messages"	
	Healer [b]	- tends "to the generational and current traumas caused by oppressive systems, institutions, policies and practices"	
	Care-giver [b]	- nurtures and nourishes people around them "by creating and sustaining a community of care, joy and connection"	
		2. Acting in solidarity: Using one's position to help people use services and safeguarding their rights when using services	
Role	Health advocate [a]	- understands the impacts of racism and other barriers and has knowledge of advocacy approaches, provides educational talks to communities and advocates for individuals and families in service system	Advocate
		3. Enabling exchange: Connecting individuals with other professionals and negotiating different perspectives	
Roles	Intercultural Communicator [a]	- adapts communication approach to communicate with individuals and family, works with interpreters, uses translated material, bridges differences in understanding	Mediator
	Collaborator [a]	- recognises power differences and uses knowledge of community resources	
	Weaver [b]	- those who "connect the through-lines of connectivity between people, places, organizations, ideas, and movements"	
		4. Adjusting services: Working within services settings to make organisations more culturally responsive	
Roles	Builder [b]	-those who "develop, organize, and implement ideas, practices, people, and resources in service of a collective vision"	Change-maker
	Opinion Leader [c]	-has "formal or informal influence on the attitudes and beliefs of their colleagues" regarding implementing alternative practices	
	Champions [c]	-dedicates themselves to supporting and "driving through" new approaches and "overcoming indifference or resistance" to an intervention, includes front-line workers or managers who empower the front-line	
		5. Extending reach: Reaching out to individuals and groups through early intervention and community education	
Role	Guide [b]	-someone who "teaches, counsels, and advises" and use of "well-earned discernment and wisdom"	Guide

Note. Role descriptions sourced from [a] Kirmayer and colleagues (2012, 2020), [b] Iyer (2020), and [c] CFIR (2020).

Discussion

The varied forms of culturally oriented mental health work undertaken by participants in this Study resonate with the ways bicultural professionals are described in international and service literature – their activities, the range of people they work with to meet their objectives, the kinds of roles they assume, and the personal strengths and experiences they draw on.

A role framework, based on identifying what people do and why, is a counterpoint to the three-fold way bicultural professionals are usually discussed, that is as either "professionals first", "culture-oriented professionals", or as "cultural brokers". Participants who were senior mental health professionals in tertiary services described activities akin to cultural brokerage. Community-based recovery professionals discussed using evidence-based psychosocial models and translating their meaning for participants. Professionals with varying responsibilities in jobs across services and sectors were using the culture-oriented practices they had been exposed to through professional development and networks. Therefore, analysis based on the perspectives of professionals themselves suggests that many assumptions and stereotypes about these professionals and the scope of their practice do not hold. What this analysis offers, by first exploring activities and strategies and then considering their work roles, is a way to talk about the work as a "seamless whole" in a way that "reflects the daily activities" of these professionals (Frank et al., 2015).

Participants in this study believed that sharing language or ethnicity was a valuable starting point but it was the culturally informed work they did that made them effective. Carrera and colleagues (2020, p 13) confirm that cultural competence requires embracing the "concept of culture" rather than holding expertise in language or ethnicity, ideas explored in discussions about cultural competence (Sue, Zane, Nagayama Hall, & Berger, 2009).

The technical and tacit dimensions of this work are represented in discourses about the work in different ways. In Australia, Tan and Denson (2019) discussed technical linguistic considerations that inform the practice of bilingual psychologists. Ziguras and colleagues (2003) argued bilingual mental health case managers improved the quality of care community mental health clients receive. Mitchell and collaborators (1998) found professionals provided a great deal of individual direct client care, but could contribute more if their cultural consultation, community education, service development roles were more developed. Karageorge and colleagues (2018, p. 303) study in a family therapy

setting that involved bicultural professionals of refugee background [eg. the important of their "personality factors, such as compassion and deep cultural knowledge". This sample represents a sliding scale from emphasising the technical to the tacit, and where the tacit is asserted, as it is in the third example, the authors do so in the context of a model of care that contains these practices in structures of supervision.

A respectful reading of these studies finds the authors are well aware of the "art" of practising as a bicultural professional. This is evident whether they are describing relatively autonomous clinicians, members of a multidisciplinary teams and para-professionals working under the supervision of more senior clinicians. However, this small sample of Australian studies (and as Chapter 2 explained, the qualitative literature from Australia is extremely limited) suggests that researchers were also cognisant of the kinds of knowledge and practices that are more privileged in mental health service delivery and framed their discussions accordingly. Writers on healthcare dynamics have observed that less established professions tend to promote the technical components of their work, or how its less predictable elements will be monitored, over highlighting the more intuitive or interpretative aspects of the work (Traynor, 2009; Shim, 2010). This strategy may secure more acceptance for practices, such as the culture-oriented work of bicultural professionals whot are less established in formal service settings, yet seen by practitioners as valuable.

I found a reminder to not lose sight of this technical-tacit duality of the work when exploring other roles that rely on health competencies and the professionals' personal or family experience. In Genet and colleagues' (2006) report of a study with Aboriginal healthworkers in rural Australia, they observe:

> the provision of appropriate and effective health services for Aboriginal people is *not merely a technical exercise*... [emphasis added]. Health care in this context means establishing a trusting relationship with the client, assuaging their fears of the health system and bolstering their confidence so as to enable them to take control of their own health (p. 193).

From the perspective of participants in this Study, biculturality cannot be reduced to a matter of technicality either. They confirmed that biculturality is something one has – some saw it as an identity – and it can be performed – as demonstrated in the purposeful way the negotiate perspectives in their daily work. However, their perspectives turned time and time again to occasions when being bicultural was "useful" but not in a narrow or overly pragmatic sense of what it means to be useful (Hage, 2020). It is useful in the sense

that it is a way of participating in life. That is, biculturality is a mode of being that enhance experience and a way of being with other people that enhances "each other's being" (Hage, 2020, p. 666). It offers "a rich and varied set of experiences" that can be drawn upon "at different moments" (Butcher & Thomas, 2003, p. 32).

Genat and collaborators, continuing the argument above, believe their findings, "point to the necessity for healthworker practice to be defined clearly as either clinical extension or as client-centred holistic case work" (p. 193). This may also prove a useful strategy for bicultural mental health professionals to pursue in local settings. It may be extremely helpful for individuals and workplaces to agree on the elements and scope of their activities, purpose and roles. However, it would also be valuable to encourage further exploration of the experience of doing bicultural work in mental health settings and what "counts as the "art" of these practices" (Traynor, 2009, p. 505). The preliminary framework outlined here offers a starting point exploratory "empirical" studies about "the variability and contingency" of their everyday practice (p. 505).

Conclusion

Survey and interview data informed the above analysis of what bicultural professionals do, and the purposes around which their work is organised. Literature was used to show how this could be characterised as competencies and roles.

Much of the work that participants described was consistent with culturally responsive competencies and is not the purview of professionals of particular cultural backgrounds or those with recent experiences migration. These professionals were oriented toward helping people to achieve mental health outcomes and improve services accessibility. They were also pursuing access, equity and social justice goals on behalf of individuals, families and communities.

A focus on roles acknowledges that culture-oriented work requires particular skills and competencies and experiences. These professionals were not only applying mental health frameworks. They are required to be a *professional as a person* who thinks, listens, negotiates and reflects. Bicultural professionals bring specific perspectives to culture-oriented work because of who they are, their position mental health service settings, and what this may mean to the service users and marginalised communities they encounter. Their work is "integrated into a seamless whole" in the roles they perform (Frank, Snell & Sherino, 2015, p. 28) which capture the ways they respond to the everyday circumstances of individuals and groups.

Two dimensions of indeterminacy mattered to how they work – they are drawing on their life experiences and a bicultural way of being in the world and with others.

Chapter 7 Principles

Introduction

This chapter explores the culture-oriented principles that underpin the ways in which bicultural and bilingual professionals work. It uses interview data to build on the analysis of survey data related to cultural responsiveness statements about approaches, beliefs and knowledge. This chapter continues to integrate the analysis, as part of the fifth phase of the Study design.

"Principles" is a category that features in the substantive theory developed to explain bicultural practice. Three main principles are discussed, firstly with regard to how they are expressed at the level of bicultural practice, and secondly, their meaning at the level of service and systems policy and delivery.

Practice principles

The previous chapter explored patterns in what these professionals do. This chapter discusses how their work expresses three main principles associated with being culturally responsive.

Across the full sample, there was a high level of agreement in responses to survey questions about rationales, beliefs and knowledge pertaining to mental health responding to cultural diversity.

After exploring the conceptual overlap between data and analysis about participants' activities and the approaches that they adopted, three main practice principles that meshed the data into dialogic explanations emerged (Mason, 2006):

- Seeing diversity: paying attention to how people experience culture and societal structures
- Creating sanctuary: mitigating the disempowerment service users experience in mental health service encounters
- Using culture: finding ways to tap into cultural heritage and stories that promote mental health recovery and resilience.

Seeing diversity

This principle captures the way participants were attuned to the diversity of local populations, and the diversity within cultural groups and in their own workplaces. They

commented on variations related to languages spoken and faiths practised, as well as the ways in which class, political affiliations and other geo-political factors influence migration and settlement patterns.

For example, on learning to manage a diverse professional team that included bicultural practitioners, Participant 13 explained: “My knowledge of cultures has helped me in terms of understanding the importance of shame, in [work] setting, and seniority as well”.

Participants believed that they were more aware than many of their professional peers of the part cultural diversity plays in the lives of service users. This includes the effects socio-economic disadvantage has on health, how intersecting cultural and societal factors are experienced by people with recent migration or refugee experiences, and the ways these affect service encounters.

For example, Participant 12 shared the same country of origin with many of his clients and also speaks a number of the languages spoken in surrounding regions. He described the variation within these communities, in terms of ethnicity, politics, and migration stories, and saw differences between himself and clients with regard to education, class and socioeconomic status. He noticed and respected these distinctions and adjusted his interactions with clients accordingly.

In contrast, many spoke of the tendency of colleagues to generalise about ethnic groups and migrations or refugee experiences. They have seen how bias and stereotyping by professionals can lead to teams misunderstanding individuals and families with negative consequences for relationships building and the mental health care provided. Participant 1 commented: “I was astounded at considering the low percentage of population of [ethnocultural community] people, that they... had a high representation in the inpatient unit” and that they were routinely cared for in the most restrictive part of the inpatient psychiatric unit “rather than in just the open ward. And this just, didn’t seem fair”.

Participant 17 contrasted his awareness of diversity with that of professional peers who tended to see PeMH/EI from recently arrived migrant and refugee communities in fixed ways:

> Some, they are too demanding, according to my colleagues. [These colleagues] don’t understand why the way they speak in that language. [Service users] try to speak using very simple English, but for the Anglo-Saxon, find it difficult to accept, the demanding, [that’s] how they interpret... [that these services users] are very demanding, unreasonable. But if you understand... it could be a different

interpretation.

When colleagues do consider cultural aspects of care, their understanding of diversity may be underdeveloped, and this raises issues for bicultural professionals. For example, Participant 11 explained that:

> Sometimes you do get asked [by colleagues] about matters in relation to the [ethnicity] community. It's nice but also, I don't think I'm able to give all the information others want me to… It's quite a burden on your shoulders and you feel almost like a fraud because you can't represent the full diversity.

Creating sanctuary

Participants across the sample placed a high value on gaining the trust of service users. They spoke about making cultural connections and respecting cultural norms. The sanctuary principle emerged in the context of bicultural and bilingual professionals prioritising a sense of safety for individuals and families in the context of service encounters.

Participant 10 reflected:

> After [many] years you start realizing what works and what doesn't. OK, you're a [young] male, you're at this stage of your life, you're [ethnicity] so that means you're slightly different to the white norm, and because of that I start off from that point and work from there.

Participant 19 explained that he knows how to respectfully ask people about their personal circumstances: "Because I am [world region]. [I am aware] how to approach, using careful language, asking about life balance rather than asking about how do you experience".

The aim is to avoid evoking more stress or retreat, and this is seen as an essential part of meaningful engagement. For example, recounting the good practice of a colleague, who was also bicultural, Participant 16 explained: "One of our community representatives, she comes from [region], they are [faith tradition] people. And I've seen the ways she deals with the young [faith tradition] offenders. Really really good".

This principle underpins ways to discuss sensitive information. For example, Participant 5 uses judgement based on first-hand experience when discussing sensitive topics:

> A few things like… talking about sexuality or sex life, it's quite different to back in [country]. We don't really talk about it in public, whereas here, I would talk about it.... so yes, it's quite surprising for them as well, as well as me being comfortable talking about it.

Also, Participant 17 remarked that unlike many colleagues, he avoids direct questions about symptoms and emotions:

> What do you feel? What are you feelings? All of these things. [Service users] give answers that try to be more positive all the time, so it's very difficult for our system to detect whether this person recovery, or become better.

Using culture

Participants spoke of using their knowledge about populations, cultural and religious beliefs for the benefit of service users and communities, when working directly with PeMH/EI and directly by informing and educating professional peers.

Participant 15 explained:

> Understanding cultural background… does help you to understand where this person is coming from. So, for me understanding people from [regions] is not a problem because I came from the same region. So for me, that helps me to understand how they think... the way people in the West think is very, very different. Although we are the same human being, but the pattern of thinking is different.

Having a detailed knowledge of the geo-politics impacting populations, countries and regions was seen as essential (#6). So too was knowledge of the cultural and religious traditions, beliefs and practices that matter to particular communities:

> You know cultural traditions, ceremonies, beliefs and all that… the religion that they are talking about and that they believe in and even some of the [religious texts] that they are referring to and all that. I think I'm lucky that I've got all that, enough knowledge... so I could understand them, without saying, oh look, I don't believe in all that but I respect you (#18).

This principle goes beyond acknowledging diverse perspectives and experiences, or acquiring knowledge for its own sake, to understanding how particular clients, families and groups make sense of their distress. These professionals had integrated culture

awareness into their mental health practice, and this included using culture as a mode of healing.

For example, reflecting on what informed her work with clients and families of similar cultural background, Participant 1 recalled working with one young person and sharing the same cultural heritage as one of his parents, the parent with whom he no longer had contact, stating: “I really felt like he needed connection”. Participant 1 also described discussing family preferences for traditional healing and providing a non-judgemental space to consider how these approaches might dovetail with other mental health interventions.

Being able to discuss thoughts and feelings in familiar ways was especially important. This approach was used by practitioners who saw themselves as predominantly English speakers as well by as those who spoke a LOTE at work. They introduce words and phrases that were likely to be especially meaningful to an individual or group. As one Participant 14 described:

> There are times when I’m speaking to someone of second generation, the therapy is mainly in English, but there are times when there are some words that I might throw in, in [language]... like there are times when I’ve needed to be a bit more assertive in my counselling, or I’ve wanted to make a strong point, or provide guidance or advice.

Several participants saw recently arrived migrant communities placing an especially high value on family. Participant 17 explained that family is often fundamental to the sense of self of individuals who identify with particular cultures and this can be utilised in their recovery. Similarly, Participant 19 was familiar with the importance taking a family-oriented approach from his personal family experience; “family culture... it may be broken. Because they are isolated, so we need to restore these things with your clients”.

Several participants regularly explored the ethical and philosophical underpinnings of faith traditions with service users. Some evoked religious themes to encourage individuals and groups faith communities to support PeMH/EI. There were also instances where participants used the teachings described in holy texts to help a person make sense of their experience, such as when Participant 8 talked to women about healthy and safe intimate and family relationships. Participant 9, who practised another faith tradition, also sometimes introduced “something that might be a part of their religious reading” into conversations with clients.

Participants also described being able to quickly grasp the person's meaning when they used cultural or religious terms to describe their distress, for example (# 9): "because they can explain to me what's happening and I can say, yep, I understand". Some participants intentionally encouraged clients and groups to reconnect with their faith traditions. Participant 12 described himself as an atheist, but when he is with someone who is distressed, whom he knows to be religious, he will encourage them to pray.

Others routinely integrated faith-based healing practices into their work with clients. Participant 4, who in addition to her health professional role is a student of theology, described this in some detail. She brings spirituality into discussions about personal issues and self-care strategies:

> I do [pray and perform rituals] because I had to use it myself because, you know, my life is not perfect. There are times things arise and issues... and I find it doesn't help me to go to counsellor and have a chat or to talk. For me it's really early in the morning before dawn that I do that prayer and I read [holy texts] and I do [rituals]... So, it's more about that kind of sharing, that aspect.

She explained that many of these rituals are "sort of like mindfulness" and that she tells clients that "in times of your distress there are things that you do", for example "when your mind's racing". Knowing this, professional colleagues often ask her to contact women receiving other services at the same health centre, who seem distressed, "angry" or a "bit sad".

Other sources of knowledge about culture and regions included travel and living abroad (#6). One participant gained a comprehensive understanding of some refugee populations by working in international development (#17). Others mentioned studying political and social sciences at a tertiary level (#15) or engaging in community-based activism (#10). Some (#1, 5, 13, 17) spoke about developing their capacity to apply cultural and religious insights to mental health work by participating in professional development training and joining learning networks.

Discussion

These three principles emerged as especially important to bicultural and bilingual professionals supporting PeMH/EI. They are connected to broad principles that underpin culturally responsive mental health care. Bicultural and bilingual professionals apply and extend them in particular ways.

There was no indication that participants thought it was essential for them or clients to be culturally, linguistically or religiously matched. What mattered instead was the ability of these professionals to form meaningful relationships with service users. These professionals were comfortable with plurality, cared a great deal about being attuned to others and were not afraid to engage in some soul work.

Participants' reflection on their work with individuals and families has implications at the level of service and systems policy and delivery. For example, the principle, *seeing diversity,* is consistent with service provider obligations under legal frameworks to uphold human rights (Victorian Equal Opportunity and Human Rights Commission, 2020) and cultural responsiveness policy directives as they relate to health service access and use (VG, 2009). The marked inequities experienced by recently arrived migrant communities in relation to mental health care encounters in Australia have been documented for several decades (Minas et al., 2013). Recently, a stronger focus on cultural safety in multicultural mental health discourses internationally (Kirmayer et al. 2012, 2020) and Australia (Cheong Poon et al., 2020) is highlighting "the power differentials and vulnerability inherent in clinical situations involving dominant and subdominant groups in society" (Kirmayer et al. 2012, p. 4). Increasingly, research and leaders in social and cultural mental health are turning to feminism, post-colonial studies, and critical race theory to reshape this policy area and identify new solutions (Bennegadi, Acklin-Kalil, & Larchanché, 2010; O'Mahony & Donnelly, 2010; Kirmayer et al., 2012; VTMH, 2020).

The ways in which bicultural and bilingual professionals in this Study adopted the principle of *seeing diversity* was in step with these debates. They were sympathetic to the rights-based rationales that underpin policy approaches that have been promoted in Victoria in recent decades. In some respects, they went further than these documents: they saw cultural differences yet spoke a great deal about understanding the cultural and social contexts, of services, communities and their interface (powell, Menendian, & Ake, 2019)

The second principle, *creating sanctuary,* makes a lot of sense if one holds a "relational idea of personhood" and believes communities are "necessary to attain the full realization" of one's humanity and participation in society (Ogude, 2019, p. 3). Migrant and refugee communities around the world are known for their capacity to seek out and create communal "networks of mutuality": they build communities, find ways to re-experience a sense of common humanity, and create new opportunities out of ecological and social networks of support (Ogude, 2019, p. 5). At the level of service delivery, the moral and existential forces that drive this principle help to explain the marked contribution that local ethnocultural and multicultural organisations make to the mental health and

wellbeing of recently arrived communities across Victoria, by providing social support and in some cases directly providing mental health care.

The Study found bicultural professionals working in both publically funded and community-governed settings were intent on ensuring clients' emotional safety. They did so knowing that this principle is not central to the way formal mental health services are usually organised. In this sense, they noticed and held the psychological and cultural wellbeing of individuals and groups within a more hostile wider service system. This raises many questions for further exploration. For example, about the possibilities and limits of generating mutuality between service providers and service users in these settings, and also about the benefits of diverse community members rubbing shoulders with each other in health services versus programs specifically designed for people with refugee experiences or delivered by ethnoculturally defined agencies. This Study also did not gather data on the extent to which the services and programs where bicultural professionals work use participatory frameworks or have community governance structure in places. In any case, the sanctuary principle captures a sense of what bicultural professionals believe many individuals and groups are seeking from service encounters. This reinforces the need for policy settings to make cultivating safe mental health service environments a universal goal.

The principle of *using culture* captures the way bicultural and bilingual professionals put linguistic, cultural and faith understandings to work when supporting mental health recovery. These are areas of knowledge and skill acquired through experience, usually in the context of family and community life or political activism, and also by pursuing areas of interest or scholarship that held particular meaning to them. The professionals who exemplified this principle had been developing competence in culturally responsive practice for many years and included individuals who sought out opportunities for professional development and networking and to re-connect with their own cultural heritage and apply this in the service of clients.

There is an extensive literature that discusses how culture is central to identity and wellbeing (Kirmayer et al., 2012; Taylor & Usborne, 2010). In his work on migration, acculturation and psychotherapy, Salman Akhtar sees connecting with culture as a mode of self-actualisation that "helps reclaim one's soul" (Galdi, 2004, p. 215). A deeper engagement with social and cultural understandings of mental health offers practitioners and services creative ways to approach mental health prevention, early intervention and treatment (a claim also consistent with the premise of Johnstone and Boyle's (2018)

"Power Treat Meaning Framework").

In Australia, in response to the effects that "colonisation and other oppressions" have had on the wellbeing of First Nations people, an "indigenous mental health movement" has emerged in the context of broader demands to address history and for self-determination (Dudgeon & Bray, 2018, p. 97). It is "restoring and strengthening traditional therapeutic practices" (p. 97). In this Study, participants with heritages reaching from Oceania, Southern Asia, the Horn of Africa, and North Africa and the Middle East discussed the psychosocial and social harms wreaked by colonial and imperial ideologies. Without arguing equivalence, there are many lessons to learn from other multicultural societies and from indigenous professionals and communities in Australia and beyond about ways to support the health and wellbeing of migrant and refugee communities residing in Victoria.

Finally, participants had varying views on the extent to which bicultural professionals are central to providing culturally responsive care. Some believed bicultural professionals working with PeHI/EI of similar background are usually *best placed* to address the needs of migrant and refugee community members who otherwise "fall through the cracks" (#7). Most saw bicultural professionals as *one option among the many* that should be available to individuals and communities (#8, 10, 18, 19). These individuals cited examples where clients have preferred to connect with professionals who spoke their mother tongue but identified with a different ethnocultural group, and also individuals who preferred to not have any contact with professionals or services that were culturally similar or specifically designed for recently arrived migrants or refugees. Participants agreed that the reasons underlying such preferences are complex and need to be respected, and that other considerations such as gender and sexual orientation or identity are equally important.

The implications for service design include the need to weigh the relative benefits of specialised or integrated culturally responsive service models. It is important to understand service user perspectives on formal services. Knowing that minority populations often turn to ethnocultural or multicultural services staffed by people whom they share cultural connections or similar migration experiences, then mental health-related resources could be directed to these non-mental health agencies. Moves to develop ethnoculturally specific or multicultural service models also need to consider how individuals' intersecting social locations – migrant status, age, ethnicity, gender, sexuality, and so on – are also accommodated and respected. Finally, calls for more bicultural professionals or population specific services may be a reflection of mainstream service system limitations and failures; such as underuse of mental health trained interpreters,

underdeveloped workforce cultural competency, or lack of sustained attention to diversity, inclusion and cultural safety.

Conclusion

Most participants commented that they had not formally explored how they approach their bicultural practices in any depth, in their formal tertiary education, as part of their professional development or in supervision. Even so, three principles – seeing diversity, offering sanctuary and using culture – were evident across the participants' descriptions of practice.

This is new information and warrants further exploration with bicultural mental health professionals across a range of settings. It is a key category in the substantive theory that emerged from bicultural professionals' reflections on their own practice and about culture-oriented mental health.

These principles also resonate with wider mental health system and society discussions about diversity and racism and universal and targeted approaches to addressing inclusion.

Chapter 8 Recognition

Introduction

Chapter 8, Recognition, continues to explore and integrate key categories as part of the fifth phase of the Study design. “Recognition” is a category that features in the substantive theory developed to explain bicultural practice.

This chapter considers the relative socioeconomic status of participants and their social standing at work and in local communities. The analysis focuses on how participants described the ways they are regarded by professional colleagues and community members and implications for their wellbeing and practice.

Position mapping

When bicultural professionals interact with others at work and in other informal settings they perform and exchange *symbolic forms of power.* This includes:

- different kinds of labour, e.g. possessing insider knowledge, using language skills, creating links and forming relationships
- being seen among professional peers and community members to hold some degree of influence e. g. by smoothing referral pathways or harnessing additional resources
- holding symbolic power in the form of prestige or honour
- being the object of symbolic violence in the form of racism

In addition to their socio-economic status – characterised by their professional background, qualifications and authority – they may be known in the workplace for their cultural or language expertise. They may also have standing in the community as someone who understands mental health and is helpful to others. The combination of possibilities based on these properties is summarised in Figure 11. Using the information available to me, I placed each interview participant along the abstract capital continua, from low to high levels and considered the relationships between these forms of labour, influence and prestige.

Figure 11 Exploring the Nested Sample: Economic and Social Capital

CAPITAL	LOW ⟷ HIGH	
Economic capital (qualifications, field of expertise, seniority)	Position held has relatively low income and status, e.g. certificate level qualified community support worker	Position held has relatively high income and status, e.g. senior registered nurse or consultant psychiatrist
Social capital in work settings	Professional's culture-oriented practice is rarely acknowledged, e.g. senior social worker's cultural advice is not sought by the team that they lead	Professional's culture-oriented practice is often acknowledged e.g. community support worker's perspective is commonly sought during team discussions
Social capital in community spheres	Professional has low levels of visibility within a community for their ability to help PeMH/EI, e.g. a trauma-focused psychotherapist who maintains social distance from ethnic community groups outside sessions	Professional has high level of visibility within a community and reputation for ability to help PeMH/EI, e.g. bilingual counsellor who is a member of a faith community responds to direct approaches by community members or faith leaders for assistance

Across the nested sample of 19 individuals, eight were regarded highly at work and in the community for their culture-oriented mental health work, five had high standing at work and not in the community, and two believed they were well regarded for their mental health work in the community and less so at work for their cultural expertise.

There were four individuals (4/19) who did not believe they were especially well known in their workplaces as having cultural expertise and had no wish to integrate the personal connections they had with cultural and faith communities into their bicultural role. They did want more recognition within their teams and organisation as professionals with cultural knowledge and language skills though. They worked in community health centres, a clinical area mental health service, and a trauma counselling service. Of these four individuals, the three non-medical professionals were especially disappointed by their lack of acknowledgement at work. Their sustained interest in cultural approaches to providing mental health care – that is to work with people who experience social exclusion, whatever the cause – grew out of their personal and family stories of migration. They felt that their insider knowledge and language skills were under-utilised. They had not been given the authority to "speak", and others did not seek out their advice or listen to their guidance. They nonetheless maintained links with transcultural mental health networks, developed their professional practice, and quietly used culturally responsive practices in their direct work with clients and families. These individuals had tertiary level qualifications – including in medicine, psychology and social welfare – and therefore were

of middle to high levels of socioeconomic status relative to the whole sample.

Of the 19 interviewees, only three (3/19) held a position with relatively high socio-economic status, were held in high regard by professional peers and agency structures for their culture-oriented practice, and were well known among migrant or refugee communities for their ability to help people who were experiencing forms of mental or emotional distress. They were: a senior mental health practitioner with a private practice with extensive past public mental health experience; a bilingual counsellor based at a community health centre; and a person with nursing experience who led an ethno-specific health and welfare agency. They were bio-medical trained, operated with the autonomy of private consultants, and/or had been accorded a bicultural designation within an agency.

This exercise in position mapping captured bicultural professionals operating in three distinct *fields*, each with their own logic and terms of exchange. Fields do not refer to types of services or industries, but to the social spaces where constellations of factors come together and confer power. These are the fields where capital accrues to individuals based on their status as a mental health professional, as a professional with culture-oriented mental health competence, or as a community member who has senior or elder status or has been conferred permission to lead, speak or advise about issues relating to the wellbeing of a group. Fields in this sense are social spaces of relation, where different *types* of capital – economic, social, cultural or symbolic capital – are exchanged. Agents occupying these spaces are afforded different *amounts* of capital that they may gain, lose and exchange over time (Bourdieu, 1998).

What matters a great deal in one field may matter less in another. One may occupy a higher status position in mental health settings, for example as a team leader, or clinical specialist, or senior management role. One can also develop a reputation at work as having language or cultural knowledge and skills. These may or may not go hand in hand. However, socio-economic status plays a part in attributing prestige, value and visibility to bicultural professional work, from the viewpoint of professional peers, organisations as well as community members. This is evidenced by the positionality of the three individuals described above. Across the group, garnering the respect of professional peers as a culture-oriented professional within a multidisciplinary team seemed to be especially challenging. There are indications that without the power conferred by high social status as a mental health professional, overtly positioning oneself in work settings as someone who shares common cultural or experiential ground with PeMH/EI who are recently arrived, undermines the status of the person as a professional.

Bicultural professionals' status at work and status in the community are also distinct features. Having a higher socio-economic status or being highly regarded culture-oriented professional at work is no guarantee of being regarded as helpful by communities. In this Study, numerous participants had formed relationships with groups where they are regarded as both mental health experts and as friends of a community.

Getting recognition

Participants saw themselves as having skills, knowledge, insights or influence that they could use or exchange for the benefit of PeMH/EI. They described the regard or disregard they believe professional colleagues – teammates, supervisors, and other professional colleagues – and service users had for them. Some were also known among informal ethnic or faith communities and networks for their mental health expertise, generosity and advocacy on behalf of individuals and groups. There were also instances where the biases of others (work colleagues and service users) left them feeling undervalued, undermined, or exposed to racism.

Professional peers especially appreciated and respected the transactional or instrumental aspects of their work – when they provided background information, explained information in other languages, and reached hard to reach populations. While they believe they were regarded as having other strengths, several participants felt that their contributions were often overlooked or only cursorily acknowledged. They also experienced micro-aggressions from some professional peers. Several interviewees described cautiously offering advice in team discussions. Some opted to work solo and beyond the direct gaze of peers.

Community members valued their mental health and cultural expertise as well as their commitment to long-term involvement. Outside more formal health structures individuals were regarded within ethno- cultural communities as trustworthy, and as role models for the young. On occasion, they were also seen as outsiders, or faced situations when they needed to earn their right to speak or be listened to by people who held more sway in communities (for example, #15).

They described working to establish credibility with service users from minority and majority ethnicity backgrounds alike. Some used dialogue about their cultural difference from "white" clients to enliven professional-client power dynamics. For example, a participant who acquired English following migration as a young adult, asked a client who was a former teacher to help him find the "right words" to complete the client's

psychosocial support plan. Another connected with older "white" clients over conversations about their common experience of childhoods spent in close-knit families and neighbourhoods. There were also distressing recollections of times when participants were exposed to the hostility of majority background service users.

Here is an example of a reflective memo on Participant 7's account of an interaction with other professionals. It demonstrates some processes associated with being a useful professional and having interests that align with a particular community:

> The participant is well known and regarded in the [ethnocultural] community. She had known a family for many years and had been providing a young person with psychosocial support and informal counselling. In doing so she had gained the respect of a general and private psychiatrist (perhaps their practices around seeking expert advice when required disposed them to seeking cultural advice as well?). However, the young person's key mental health clinician stopped including her in care planning meetings and wasn't taking her advice on board (perhaps service provider culture encourages key clinicians to try to be all things, to all people?). The participant felt that the key clinician resented her involvement. The participant felt that her status as a professional was being undermined. She was convinced that her understanding of the situation was more informed. To her, this was an objective claim – she had unique insider cultural knowledge and the upper hand due to her proximity to the client and family. It felt like a battle for the heart and soul of the client. She took the moral high ground – he was being denied his right to engage a health advocate! She dug in and found a work around. She appealed to the higher authority in the system (the medical practitioners), and then reluctantly, professionals at the mental health service became more cooperative. (Memo)

Recognition of bicultural work, by service users, professional peers, local communities and wider society of bicultural professionals matters to the professionals themselves – it is human to expect and seek acceptance and validation. However, it also matters to the culture-oriented practice, because work settings and communities construct their own criteria for evaluating services, knowledge, and status. These evaluations shape how and when bicultural professionals make their practice visible to others. It may even determine whether they continue to practice at all. These tactical choices leave traces in the ways professionals embody their practice.

Experiencing disregard

Participants experienced a lack of regard or recognition in a range of ways. I present these here as if they are distinct from racism and other forms of discrimination; they could equally be presented on a continuum.

When agencies don't seem to care enough

One of the ways bicultural professionals experience disregard is in observing that the organisations in which they work are not trying to improve how they respond to diverse communities. Even though bicultural professionals perform roles that are in line with service provider stated intentions to tackle health inequity and social exclusion, participants described working in institutions where other interests were prioritised. For example, Participant (#11) witnessed policy shifts away from dedicated cultural liaison roles in a community sector that were not based on program outcomes or community preferences but argued for on the principle of "integration". In settings where dedicated culture-oriented roles had never been established, participants observed mainstream service provider agencies, and the majority of people who work in them, simply falling into step by "adhering to the rules of the system that provides them positions of privilege" (Schubert, 2008, p. 184). For example, in relation to work with communities, Participant 1 commented: "I think organisations are not generally not that great at supporting people [workers] to make those relationships [with the community]", and in relation to the workforce itself:

> The thing that has stood out for me for a long time is how we run our services. We talk a lot about diversity for our clients, but I feel like not a lot comes back about the diversity of our actual workforce. And how unforgiving and unaccepting we are of the diversity in our workforce sometimes. You know, you kind of see... it almost feels like strategies for getting a homogenous workforce, to meet a particular style or whatever.

Diverse experiences are not acknowledged or valued

Some participants also believed that their professional peers did not think about the realities of clients' current and past lives. Some participants recalled colleagues questioning the relation between past traumas, including exposure to political violence, and developing mental health issues. When a professional in a mainstream service provider questioned why members of an ethnocultural community were getting "special treatment" Participant 7 interpreted this as minimising and trivialising profound

experiences. She also recalled occasions when clients felt compelled to provide detailed accounts of their war trauma, in order to be taken seriously, even though this caused them great distress. Witnessing other professionals disregard client experiences in these ways was also harmful to participants because their own experiences and those of family members were also reflected in these stories.

Turning the spotlight on "differences"

Responding to cultural issues as part of their everyday work could leave bicultural professionals feeling exposed. Participant 1 recalled the tensions that developed in an inpatient care team when colleagues held opposing views as to whether to accommodate clients' preferences, for example for contact with particular staff with whom they identified culturally or to be visited by large extended families. The professional who often found herself preferred by clients and was more attuned to the needs of families and carers, described a growing awareness that team members "were forming two camps": some supported a flexible approach while others were sticklers for rules and established process. The participant wanted to lead the way on these kinds of practices, yet she recalls feeling all eyes were on her. In these dialogues, she felt positioned within the care team as culturally different from her colleagues and responsible for the unrest.

Negotiating visibility

Participants developed ways to influence the situations they faced doing cultural work in institutional settings. Sometimes they negotiated more visibility by explaining or persisting. At other times, sensing a lack of interest or hostility, they opted for stealth or to work somewhere else.

Speaking up

Some participants would take opportunities, usually in team discussions or informal conversations to remind colleagues to consider the cultural context in which they were providing care. For example, Participant 17 would try to point out his strengths to others and how he could help. A team leader in a community managed mental health service, wanted his team to explore alternative perspectives to the mainstream understandings of mental health. He would try to "have a big voice", but mostly found that senior staff, colleagues and supervisees were reluctant to change their ways or take on different perspectives.

Digging in

There were many examples of participants quietly persisting, in team settings, in the interest of improving internal processes or better client outcomes. They were cultivating recognition among professional peers by demonstrating immediate successes, reducing inconveniences, and helping the agency to develop more status and influence. For example, Participant 1's work with large extended family member groups made life easier for the whole team who were unsure how to accommodate them in inpatient settings. Participants took care to inform colleagues how they could help (#7, 8). Participant 13 eventually convinced the large health provider where she was based that a specialised project designed to meet the needs of a specific language community could attract long term funding.

Staying out of view

There were also occasions, participants explained, when it was more expedient to pursue their culture-oriented practice out of the view of others. For example, Participant 14 had just taken up a new role and was attending a clinical team meeting when a colleague explained that they intended to discuss a client's recovery plan with their spiritual advisor present; they were hoping that this would lead to stronger engagement in therapy and treatment. When the consulting psychiatrist declared the plan "inappropriate", the participant made a mental note, then and there that any connections that she facilitated between clients and community and faith representatives would remain covert. She put any hopes she had harboured of influencing how this team and other teams responded to migrant and refugee communities on hold. She took deliberate steps to ensure her own culture-oriented practices were not visible to peers. There were also other instances where participants explained that they never spoke at work of their own wellbeing and spirituality (#11, 19) and would self-censor when discussing cultural themes with colleagues (#1).

Finding another place

Sometimes the lack of regard for cultural issues and for culture-oriented practices that participants encountered at work stirred them to either find alternative employment or avenues outside formal services. One participant decided many years ago to stop working in mainstream services and to head up a community managed ethnocultural agency (#7). Two individuals had recently established new ethnocultural community-based organisations geared to provide psychosocial support services while also holding jobs in mainstream agencies (#11, 16). A further two individuals were doing some voluntary

work with young people (#6, 9). Hence a quarter of the nested sample had opted to devote at least some of their time to doing culture-oriented work for minimal or no remuneration in settings that were more aligned with their perspectives on culture and how to support communities

Experiencing exclusion and racism

Participants also described being excluded or directly experiencing the racist views of "majority" background peers and service users. Several participants described instances of knowing that others saw them primarily through the lens of ethnicity. Focus on their cultural identity often went hand-in-hand with assumptions that they were less qualified or had less mental health expertise than other colleagues. They felt disrespected as a result. There were also instances where participants felt devalued or threatened by interactions with people who expressed racist views.

Participant 3 felt disrespected by "white" colleagues at mainstream mental health agencies who were in senior roles, recalling the responses of some with medical qualifications. She wondered if this was due to pre-existing hierarchies among health professionals (that is, of social workers v. medical practitioners), or her cultural background and the way she expressed herself in English. She also recalled experiencing the hostility of "white" colleagues who were in subordinate roles to her or who were less qualified. She felt sure that these expressions of resentment and envy were informed by racism.

Another participant (#12) complained of unfair treatment from "white" managers where he worked in an agency that provided specialised programs for refugees. He attributed this to their preoccupation with career and status, lack of genuine ethical commitment to refugee populations, and emotional disconnect from their experiences.

Participant 8 worked in a mainstream health provider and explained that it is "difficult to fit in sometimes". She has had her qualifications questioned by new staff, practitioner students, and service users. She frequently finds herself reminding colleagues, and majority-background service users, that she holds multiple qualifications and has relevant professional experience.

In the latter part of the interview, this participant explained that the main reason she wanted to participate in the Study was to let others know about the racism that she has experienced at work. In her words, so that:

> people be aware of this, and how we can be supportive of them... I am outspoken, I

> become [stress on this word] outspoken, I don't know [how]. I wasn't like that when I started my working life, but I am now. So, I wonder how this could be useful,... with new workers from different background, [to let them know that] this is going to happen, and it's OK, you need to take care of yourself at the same time.

She had already described encountering the occasional dismissive attitudes of colleagues and students on placement. Then she said, "If I may share an experience with you" and spoke in detail about the contact that she had with a "white" client, which, she explained had happened just a few weeks prior and it was not the first of such incidents.

> I opened the door and the second she saw me she was like, you know, she looked up and down, and I said [to myself] mm this is one of them. I just felt that. And then it was, hi, how are you, sorry to keep you waiting, come in, you know, all the rest of it. And when she came in the room, listen, that's what she said, I don't want one of those stupid people. Do you have Aussie counsellors? (Participant 8)

The participant described how she handled the situation; from my perspective with skill and grace. She recalled seeing herself respond "as a therapist" and then "as a human being". Knowing that colleagues would overhear the clients' comments compounded her distress. When the client left, the participant was physically ill. She was debriefed and felt supported by her colleagues. In the interview, she reflected:

> You know things like that, as a professional, I don't think anyone else is dealing with it, like I do. They don't have to think about you know how they will attend a meeting and actually sit there, not because you are cultural … can I be rude a little bit? I went to fucking university and I went there and I studied and I did my essays and I … you know so things like that, you know the frustration associated with that... I learned to be somewhere where I could sit comfortable in my skin. I sit comfortable in my space regardless of what it is. Ninety-nine per cent of the people are beautiful, they sit in my office and talk, but then there is this thing that is always there, it's always there, it doesn't go away. (Participant 8)

Participants across the group explained how they respond to subtle and overt racism targeted at them and experienced by clients. There was a tendency among participants who had encountered racism at work to speak of needing to find their own way to deal with it; this sense was quite strong, even among those who felt well supported by management structures. Some had attempted to teach racists to not be racist. Some spoke of drawing on their personal strengths and therapy skills to cope and stay calm.

Participant 8 reflected that professionals had the right to expect collective supportive responses from the organisations where they work.

There were also numerous accounts of participants coaching newly arrived clients on how to cope with the structural biases and disadvantages they experienced in everyday life, although most did frame it in these terms. Some suggested that own migration stories are living examples that individuals can, with time and effort, overcome hardship. They used stories to acknowledge the realities and communicate; you "will make a new life, you will be accepted, like I have been" (#15).

Discussion

At any one time and over the course of their careers, individuals in this Study perform their role as bicultural professionals with varying degrees of alignment with agency and community objectives and capacity to influence others in each of these fields.

Participants saw themselves as having skills, knowledge, insights and influence that they could use for the benefit of PeMH/EI. They described being valued by professional colleagues and informal ethnic or faith communities. However, participants also experienced a lack of regard and recognition by professional peers. They experienced this when others neglected to care about the issues facing migrant and refugee communities or minimised the challenges they face. They adopted strategies in response: explaining the cultural issues, persisting with their own course of action, working covertly, and finding more welcoming environments in which to practice.

Distinct forms of capital are at play in how bicultural professionals work in mental health settings. In the absence of specific tertiary qualifications and senior positions that acknowledge bicultural or bilingual mental health practice, the status and remuneration of bicultural professionals follows the lines established by the dominant position of medicine in the mental health care system (Germov, 2009b). Professionals who are more aligned to clinical mental health knowledge and practice have more status in the field of mental health service delivery. The professionals described having more access to supervision at work, more discretion in negotiating ethical issues and more time for professional development and networking. More than half of the positions held by participants in this Study were located in non-mental health designated services and programs (see Chapter 4). As noted earlier in Chapter 5, many of those working in these settings had no or little supervision or support regarding their work with PeMH/EI. During interviews, some participants (#4, 7, 13) explained that, they valued the collegiality of team members,

professionals based in other agencies or the support of trusted friends outside of work.

Participants in this Study were praised for their cultural advice, yet also believed that mainstream service providers were not committed to giving the issues facing migrant and refugee communities their sustained attention. Several participants had experienced social exclusion and racism at work, and had felt personally exposed at work when others distinguished them as different. Some wondered out loud if the disregard they had experienced at work were instances of racism or other forms of ignorance or bias. Those who identified with recently arrived visible minorities believed they were likely to continue to experience distressing and disturbing encounters where they are excluded or denigrated. Practising as a bicultural professional therefore, required them to make additional everyday effort, and apply additional personal resolve, over and above the demands of the work itself and the demands that other mental health professionals experience. Hage (2017) describes this as the act of keeping "yourself together" given the inequality inherent in the shattering forces to which racialised individuals are subjected.

There is a substantial body of evidence about the detrimental effects that racism has on mental health, wellbeing and physical health (Paradies et al., 2015). Other qualitative studies have explored professionals' experiences of racism at work. For example, when Alexis and colleagues (2007, p. 2225) investigated the experience of overseas trained professionals working in public health settings in the UK, they found individuals had internalised these perceptions of being devalued, and blamed "themselves to a certain extent for what they had experienced". They felt powerless to change their circumstances because, in the words of a participant, "there is nothing I can do about the colour of my skin" (p. 2225).

This Study identified the dynamic of *getting recognition* in the working lives of bicultural professionals in mental health settings. Hage (2017) also notes that in multicultural societies, such as Australia, racism and other forms of discrimination involve making: "people visible when they want to be and need to be invisible, and... invisible precisely at the point where they need to be visible and when their experience matters'.

The ways in which professionals and organisations acknowledge diversity, demonstrate that they care about the lived experiences of migrant and refugees, and show their regard or disregard for bicultural professionals affects how these individuals express who they are at work and therefore how they practice.

Conclusion

The social position of bicultural professionals in formal service settings and in more informal community settings is relevant to understanding the opportunities they have to do culture-oriented work and how they embody these practices.

The dynamic of visibility and invisibility explored in critical race theory can also help to explain the marginal status of bicultural practice in mental health settings. The tactical responses that they make – from internal adjustments to cope to efforts to manage how others see them – need to be acknowledged, so too the negative consequences of bias and discrimination on individuals' health and wellbeing.

The findings in this chapter underline that while it is important to ensure bicultural professionals have access to progressive and supportive education and supervision, there is also an urgent need to address the underdeveloped state of the service delivery environment as a whole in relation to diversity, inclusion and anti-racism.

Chapter 9 An ethical disposition

Introduction

This chapter continues to develop and theoretically integrate categories as part of the fifth phase of the Study design. "An ethical disposition" is a category that features in the substantive theory developed to explain bicultural practice.

This chapter explores points of identification between services users and bicultural professionals and discusses professionals' motivations, tendencies and dispositions, and characterises this as being *free to respond*. These are considered with reference to examples from bicultural health and mental health literature and in light of insights from moral social theorist and philosopher Emmanuel Levinas.

Connecting with service users and community members

The complex ethical and emotional demands that arise when doing this work were evident even in participants' brief responses to open survey questions. They include references to how they experienced the work, such as *feeling capable and called*, and *encountering others* and motivating values such as *wanting to make a difference* and *affirming human dignity*.

The embodied practices of bicultural professionals arise in part from the dispositions of the professionals themselves. As part of describing themselves and their work, individuals discussed experiences and personal values that were especially important to them. This chapter explores how these are integrated into their practice.

Identification

There is no simple way to characterise how bicultural professionals drew on their own identity as part of their work or connected culturally, linguistically or with the faith traditions with service users or community member who also had a recent personal or family migrant history.

The main grounds on which interviewees perceived similarity with some service users were: identifying with others in Australia who also have ancestral, personal, or family links to a particular ethnic group or region that has "minority" status; and familiarity with the experiences of people who are recently arrived or have migration or refugee stories. They also commented on having personal or immediate family experience of preferring to speak a LOTE and difficulty communicating in English. Some observed that that their own

cultural background, personal, family or other close encounters with migration, settlement and communication barriers were sources of insight and empathy.

In addition to sharing their own experiences of being disrespected or denigrated in everyday life and at work, and of racism (micro-aggressions and explicit statements) in everyday life and at work, they were concerned for people who experience racism or other forms of discrimination in the context of service encounters. They have witnessed the prejudicial treatment of service users based on their ethnicity and listened to service users' complaints about these experiences. Participants spoke of instances where individuals told them that it meant a great deal to them that the professional listening to them was "Muslim", or "brown", or "black" or "not white".

There were other identities that mattered to these professionals and the people who encounter them at work – being young, being female, someone who has personal experience of mental illness, or cares for family members who are differently abled. Affinities also included close-up experience with domestic violence, having insecure residency status, living in public housing, struggling to find work and access education, seeing a limited horizon of life opportunities, feeling cut adrift from family and communities of support. These points of connection held places of meaning in professionals' past and present life stories; they were sources of empathy for and solidarity with service users and communities. As Participant 3 put it "I have very similar experiences. That's why I understand them, I think".

Hence the points of identification with others were multiple and shifted over time. They were based on age, gender, ethnicity, language or faith; migration and refugee stories; indigenous identity; being subjected to racism or other forms of discrimination; and many other life experiences.

Some commented that co-workers had presumed that they occupied the same cultural and faith worlds as their clients by virtue of a perceived similarity. For example:

> Sometimes you do get asked about matters in relation to the [...] community. It's nice but also, I don't think I'm able to give all the information other's want me to. I'm only a small part of one section of the community. (#11)

Community members seeking help sometimes made similar assumptions, or were especially focused on pinpointing the professional' cultural heritage. For example, one

participant[6] first stared working with newly arrived multi-ethnic communities with links to a particular region, she experienced people turning up to sessions "to check me out" and others accusing her of "hiding my clan". She was told: "You are working with [ethnocultural group] and you are not [ethnocultural group]" and was told "you get on our back", that is, you are getting special benefits and the gaining personal advantages that flow from paid work "because of us". These are examples of people attaching inalienable obligations to perceived group affiliations.

Most interviewees were involved with ethnocultural or religious groups in their personal lives outside work. Six interviewees shared in some depth the sense of continuity they feel between important aspects of their particular ethnic cultural identity, the work that they do and their relationships with communities. One spoke of "instant connection" with some families (#14). This feature was particularly strong among those who belonged to faith communities and sometimes individuals from these communities sought their advice on MH/EI.

Two participants[7] were highly committed to working with groups even though they themselves had a different heritage and did not speak their languages. One stated "I have kinship with the [community]", another that "I'm seen by community... as not selfish, who is always there to help". These professionals used their Asian or African ancestry to establish deep relationships with specific ethnocultural communities over an extended period of time. They developed strong connections with known community leaders and other health professionals who culturally and linguistically identify with these communities.

Motivations

Chapter 4 described the two main career trajectories of bicultural mental health professionals. Among these individuals were those who would have preferred to have found work in in fields other than health and human services, but the opportunities were not available to them. Some came to believe that they were better suited to a health or welfare career, and some accepted work based on what they believed was realistic. This is important, because although all participants held convictions about why this work was important, I am also aware that a constellation of circumstances limit career opportunities

[6] Participant identifier withheld to protect anonymity.

[7] Participant identifiers withheld to protect anonymity.

for newly arrived migrants and refugees. Roles in health and social support can seem more viable than fields where they have experience, qualifications or would prefer to work.

The following is a sample of how participants described the personal circumstances that led them to health, psychology or welfare qualifications and into positions where they undertook culture-oriented work supporting PeMH/EI. For example, Participant 10 recalled a moment when he was drawn to learn about psychology, a memory that holds meaning for how he works with young people:

> Part of the reason why I'm, I suppose, here is because I was considered dumb and I was considered [a collective regional ethnicity]. I was the dumbest person in my family... I thought... Mmm, what can I achieve? That's why I picked up the book. It was random... Perhaps if I can understand something that is intelligent I might be considered more intelligent. It was a sense of ignorance... Mentoring comes from life as long as you are open.

Experiences and circumstances prior to coming to Australia shaped Participant 3's sense of herself as "defender of human rights" and her current choice to work with young people of recent migrant or refugee background:

> I am [ethnocultural group] ... I'm like anybody else, equality is important for me, especially in [country]... practices against women, against children, against gays or lesbians because the government... there are lots of bad things happened and happening... Also, why I chose this field? 'Cos I am a migrant here.

She was not alone in citing a commitment to rights and inclusion as rationales for this work (#7, 11).

Participant 10 described making choices consistent with "doing my own thing within the context of... communities", Participant 7 about wanting "improve situations" for families and to be a part of seeing "this community progress", and Participant 17 to encourage communities to be more open to have conversations about mental health.

Other participants described shifts over the course of their careers toward wanting to use their personal experiences, cultural knowledge or language skills at work or deepen their understanding of social and cultural approaches to mental health. This included undertaking cultural competency and responsiveness education and joining professional networks (#1, 2, 13) and leading innovative programs (#13). Some described nascent motivations; on reflection revealing the patterns in their choices. For example, Participant

6 attributed her decision to work with supporting refugees to her progressive politics, but also wondered what part childhood memories of seeing mass movement of refugees and her family's post WWII migration were playing in her story. Participant 1 comment that:

> I always worked with the areas that were the underdog... It's only in later years that I've thought, Gee I've always been attracted to the underdog... wherever I end up working, it is that inequality and that history of racism and disadvantage.

Several participants explained that taking on work that had a social and cultural mental health focus had addressed a growing personal desire to strengthen their connection to their own particular cultural heritage (for example #6) or scaffolded exploration of existential themes of identity and belonging (for example, #1, 13).

Freedom and duty: ethical demands

Two interrelated themes emerged across the Study that related to how they identity with service users and their motivations for doing culture-oriented work. Participants commonly used the language of *freedom* to discuss orienting values that mattered to them personally and to service users. They also spoke from a strong sense of *responsibility* toward others. These twin themes express a way of being in the world as it relates to being with others.

Preoccupations with freedom, limits and boundaries emerged across the group during interviews. Speaking about culture-oriented practice in the light of other organisational guidelines, Participant 19 explained that there is "a lot of freedom in a way" about how to define "professional boundaries". Discussing early years on the job and responding to community member calls in her own time, Participant 4 laughed: "Yeah, early on... I worked three days and the other two days I did, like freelance! There were multiple references to exploring cultural identity, using human rights principles, seeking opportunities to practice with authenticity, seeking self-development and working with people in ways that promoted human flourishing. Discussions about responsibility in relation to others were also extremely common. These included feeling drawn to advocacy, feeling called upon to take responsibility for others, meeting obligations and being grateful for the support that collectives offer. While people varied in how they discussed these themes and how much they emphasised each dimension, all interviewees spontaneously raised themes of "human agency" and "obligation" as part of the story of how they came to be doing culture work or how their practice developed over time. Participants had integrated these apparently distinct energies.

The following examples illustrate how this dual sensibility featured in participants' reflections, for example, where they were both *seeing a horizon of opportunities* for themselves and others and *wanting to make a difference* in the lives of others.

Working to support migrant and refugee communities explore what mental health means to them, Participant 2 explained:

> All these things, my lived experience, have brought me to position where *I can do what I do now*. I used to do things differently... now I am older, and I feel stronger in myself and it is from this sense that I feel confident in how *I do my work and make a connection with others*.

Having arrived in Australia as a young adult Participant 15 learnt English, supported himself in various kinds of work, and did tertiary studies. He has been in the same situation as many of his clients, and pulled me up when he thought I was asking him whether he felt that he was repaying a debt of some kind by doing the work he does now:

> I have no feeling whatsoever that I was an asylum seeker therefore I should help asylum seekers... I always say this, that if *I am helping someone... then you are actually decoding the cycle of their life... in the long run*, this will go like that, but in the short run, the job I'm doing, *I just think I can do the job*, therefore I am doing it.

Ways of acting from this ethical disposition

Participant stories expressed their "sensibilities about the ways the world works" (Shim, 2010, p. 4). These enduring dispositions were evident in how professionals embody their practice. They arise from individual histories and help to shape how bicultural professionals go about their work. This *freedom and obligation* dynamic is a "generative principle" (Maton, 2008, p. 56). The following sections demonstrate some of the ways participants expressed this in practice.

Being emotionally and cognitively attuned

Participant 8 found her role as a bilingual counsellor extremely enjoyable and intellectually stimulating: "it is a bit challenging but then it is fun to do". When he works with clients with whom there is mutual cultural recognition, Participant 10 explained that there is: "a sense of freedom about conversation and that's what … the difference is, really, a sense of having an identity with someone else". One described the work as requiring a great deal of emotional intelligence, specific knowledge, a calm temperament and an

ability to support people experiencing high levels of uncertainty (#15). Another keeps a faith-based teaching in mind when working clients: "everyone is born free from their mothers and they need to explore the world" (#4).

They described an intuitive "art" of practice, the deft and authentic use of knowledge, insights and insider status. Many mental health practitioners would also relate to instances of feeling especially 'in tune' with some clients or stimulated by their work. However, it was striking (and a delight) in interviews to witness the joyful reveries participants entered as they reached for words to convey an essence of these encounters.

Standing alongside clients

A number of individuals spoke of being more prepared than colleagues to get more involved with clients to defend their dignity or voice. For example, Participant 1 recalled: "I've stepped into the fray and prevented a code from being called because I've been able to actually communicate a little bit more directly". Participant 14 pointed out that her belief that clients should be able to access interpreters or a bilingual practitioner comes directly from her own experience: "As a young child… I remember the feeling of not speaking the language, so I just feel very passionate about people being able to communicate in their language".

Clues that bicultural professionals put a high value on personal freedom are also there in the words interviewees used to describe the experiences that they hope interventions will generate. Participant 11 administers community grants programs and "defends the rights of community groups to "put the money into what they want to". Participant 4 is constantly returning to freedom themes when working with refugee women and their children: "I always say, just let them be, let them explore, let them do, what is the worst thing that is going to happen you know?" Participant 10 focuses on "giving [clients] a sense of self understanding as well as understanding what the world" as part of trauma-focused counselling. Based on the kinds of conversations that he preferred when he was a newly arrived refugee and needing practical support Participant 15 said he rarely joins clients in complaints about government services and opts instead say: "OK that happened, now what do you want to do now?"

Going above and beyond

Participants described some of the ways in which they, and bicultural colleagues, work outside formal service structures to support community member requests for assistance: "Sometimes I can work even after hours because I just want to help. It is that drive, I don't

want this person to go through what I went through" (#16). Describing the approach of bicultural colleagues: "they... did a lot of work with communities outside of work, but they didn't seem to mind, I think they accepted this, that it was expected of them, they wanted to do it" (#2). A participant accompanied a client to an outpatient clinic, and then found herself needing to decline frequent requests for more and more informal contact (#6). Another participant was very critical of counselling colleagues who had contact with clients outside of standard consultation settings: "some are giving them financial aid and money, things that are just, na. They just way cross professional and ethical boundaries" (#6).

Integrating ethical demands into practice

Participants described strategies that help them manage the ethical dilemmas that this kind of work raises for them personally and professionally. The examples below represent just a sample of ways to respond to the many issues that could arise. They described arriving at these intuitively or through experience, over time and on-the-job. Although supervision and informal workplace support were mentioned, they emphasised self-reflection, and acting on incidental feedback from peers and clinical supervisors.

Reflecting on action

Several participants described going through a stage in which they questioned their own motivations and wondered if this kind of work was right for them. One participant (#14) recounted taking up culture work tasks while working in an adult mental health service setting because professional colleagues asked for her help. She felt that by performing this role she was quietly "fighting the [service] system" but recognised she fell into the role: "probably a little bit by default". She contrasted this with her current approach: "I've selected to do the work… [it's] more driven by me".

Regulating requests

They used micro-strategies to manage direct requests from the community:

> People would say if I know you're off on Friday and Tuesday can you help me with this? Can you ring up blah blah blah? And I did this when I was new, but you can't continue this way, because you get burnt out and that's time for your family and stuff (#4).

This participant managed receiving multiple direct phone calls from the community

outside work for several years by triaging them, scheduling times to meet in working hours, texting the numbers of services that could respond, and also contacting these agencies on clients' behalf. Participant responses suggested that the demands on professionals who speak community languages are especially high.

Caring for self

Several participants discussed coming to realise the need for greater self-care in the context of high levels of community demand and exposure: "I'm now not able to take on any more referrals. And I'm struggling with that a bit, struggling with kind of, not being able to offer more, that's a bit of a personal plight" (#14). Participant 18 stressed the importance of supervision, because working with refugees has felt: "very, very, very, challenging because you just hear about traumatic history and stories and that's all".

Diversity of the service users

Participants weighed up the relative advantage for them of working exclusively with individuals and groups of a particular heritage or language community over contact with diverse community members. Several participants reflected on the benefits for them of working settings where the bicultural professional had contact with a varied client group (#, 3, 4, 5, 8, 10, 13, 17, 18, 19). Some also wanted more opportunities to work with specific communities than their current position allowed (#5, 10). Working at agencies that were closely associated with particular ethnocultural communities had benefits for participants and service users; both were likely to feel more at home in these settings. However, a participant remarked that she felt some inner tension when working in one of these settings between being loyalty to the community and maintaining her professional autonomy (#8).

Discussion

The embodied practices of bicultural professionals arise in part from the dispositions of the professionals themselves. Points of identification with PeMH/EI of similar background were multiple and shifted over time. Motivations included wanting to make a difference in the lives of others, but this too has social and cultural context.

Participants commonly used the language of *freedom* to discuss orienting values that mattered to them personally and service users. They also spoke from a strong sense of *responsibility* toward others. They expressed this by: tuning in to the core concerns of these individuals and groups; taking opportunities to generate empowerment; and being

prepared to work outside formal service structures.

There were some common elements among the intuitive ways professionals respond to particular challenges that arise from their ways of being a professional.

This Study has shown that professionals and service users find points of connection that are cultural and experiential. Stories about how participants came to be doing culture included wanting to work with people who were especially disadvantaged or marginalised, wanting these individuals and communities to adapt and thrive, and looking for workplaces that suited the professionals' own ethical dispositions. This is consistent with Williams and colleagues (2014), based in the United States, who found health professionals from racialised or ethnic minority groups who have also experienced socio-economic hardship are more drawn to work with minority groups and in economically disadvantages areas.

Participants varied in how committed they were to the notion that bicultural professionals are best or better placed to provide care compared with service as usual. The general view was that someone who has experienced a life challenge first-hand has the advantage in building empathy. Only some raised the possibility that their own experiences are not necessarily helpful in understanding a PeMH/EI (#18) or the importance of realising the limitations of their own experience (#6, 9). This was not explored in depth during the interviews, but has been the focus of sustained discussion in multicultural counselling literature (Hall, 2001).

Qualitative research has explored the links between identity, experiences and personal attributes (McKinney 2007; Verdinelli & Biever, 2009; Liu, 2013; Karageorge et al., 2018; Tan & Denson, 2019). Professionals believe that their deep knowledge of the circumstances facing individuals and groups is a comfort to service users (Liu, 2013). Personal challenges do arise in working with refugees, when professionals have had similar traumatic life trajectories (McKinney, 2007).

Emmanuel Levinas' philosophical writings explore the tension inherent in being oneself in the presence of other people; that is, relationships between "freedom" and "responsibility", in ways that resonate with the perspectives of participants in this Study.

Freedom and responsibility can be seen as opposing ontological forces – as freedom or responsibility or freedom from responsibility (Levinas, 1989a), but the most part, participants did not see freedom and responsibility in opposition. When bicultural professionals reflected on acting from outlooks and motivations aligned with marginalised

communities they spoke of feeling authentic, free agents existing in relation to others, and willing to address the ethical obligations that flow from this understanding (Levinas, 1989b).

Summarising Levinas, Hutchenson (2004, p. 18) writes that modern life emphasises the notion of the "rational, autonomous (self-ruling) and free agent capable of deciding whether be responsible and choosing which responsibilities to recognize". However, not all aspects of the human condition can be rendered "intelligible" in this way and do not disappear simply because they have been ignored. Levinas argues that being in responsibility to others is the "most 'primordial' state of interhuman relations" and that an intangible sense of the Other persists beyond the "basic state of human beings" (p. 19).

Levinas calls this the unbridgeable distance that exists between oneself and another person. To experience this gap is to understand the "significance of responsibility'' (Hutchenson, 2004, p. 19).

> Something is expected of us by other people from the first moments of our consciousness and at every moment along the pathways in life we think we choose. What we call "freedom" is actually a response to the responsibilities that the world of social relationships into which we are born, elucidates. We discover our individual freedoms in response to the exigencies of human existence, prominent among which are relations with others (p. 23).

Levinas argues that having responsibilities towards others provides opportunities to act, and that "we can discover our freedom for ourselves only if responsibilities demand it of us" (p. 18). He is describing a "model for practical action grounded in notions of being responsible *to, for*, and *as* others" (McDonough, 2007, p. 39).

These insights have implications for conceptualising the motivations of bicultural professionals. This is not because these ethical principles apply more to them than any other social group or other professionals working with PeMH/EI or that they are unique in adopting this ethical stance. In text and in conversation they described "wanting to make a difference" and feeling uniquely "called" to assist, empower or pursue the justice claims of PeMH/EI of similar cultural background or who have a recent personal or family history of migration. They described showed their sense of responsibility to others by seeking out positions in agencies that allowed them sufficient freedom to meet obligations (as they conceived them) to others. Within the constraints inherent to holding professional positions in formal services, they had carved out roles that enabled them to act from these

motivations (Lingus, 2001, xxi).

In a related qualitative study, Henderson and Kendall (2011) explored the experience of nine health "navigators", paraprofessionals and lay volunteers, recruited by non-government organisations in Queensland. They were regarded as "natural leaders selected by community members" and each acted as "a conduit between the community and health service providers". One of the main findings that Henderson and Kendall describe is participants' "commitment to an altruistic attitude of servility allowing limitless community access to their services" (p. 347). The authors note that this reveals a "dilemma". They argue:

> simply educating the navigators about how to place boundaries around their work actually placed them under greater pressure because doing so meant that they could not meet the expectation of their communities, and themselves. *Ironically, the close connection they maintained with their community was the main source of this expectation, but was also their greatest success factor* [emphasis added]. Thus, if we wish to draw on lay helpers to address inequity and access barriers for CALD communities, we need to understand that the success of the role comes with serious personal implications for which they must be adequately compensated. It is important to address this dilemma, because the role offers such significant potential for addressing access barriers and bringing about health reform for CALD communities (p. 353).

Compared with the above, the responsibilities and positions of participants in this Study held a more varied range of positions. However, there is overlap – as I have described, many participants in this Study were also mediators and community guides. And while this Study identified the same dilemma described above, I offer a slightly different characterisation of it and raise other implications.

This Study also found that participants adopted an ethical stance and were highly motivated about meeting obligations to communities or addressing injustices commonly experienced by groups. The findings suggest that it was in realising the freedom to act on their sense of responsibility, that participants felt most authentically themselves as professionals. If meeting obligations empowers rather than diminishes sense of agency this workforce, could mental health service provision accommodate this ethic and become more humanised as a result. Calls to compensate for those doing bicultural work raises another dilemma, because as explored in Chapter 8 making individuals associated with minority groups more visible is rarely a safe experience for those associated with

marginalised identities or practices. These issues could be addressed by policy settings that support bicultural professionals to strengthen and deepen their practice, create opportunities to employ them in significant numbers across the service system (Williams et al., 2004), meanwhile reforming the culture of service providers and systems around participatory approaches, and reflecting on the operations of power (Thompson & Pascal, 2012).

Conclusion

Across the group, individuals valued personal autonomy and a sense of responsibility to care for others. They sought opportunities to practice professionally in ways that felt personally authentic and made a difference to others. This emerged as a compelling explanation as to why some individuals are drawn to wanting to provide culturally mental health support to people and communities who are of similar background and or have recent migration stories. There are similar examples in relevant literature. Consonant notions of freedom and responsibility are explored in the moral philosophy of Emmanuel Levinas.

Policy leaders could consider how, given the humanistic values that inform bicultural mental health practice, greater investment in workforce diversity offers an opportunity to transform the culture of mental health service delivery for all.

Chapter 10 Interacting

Introduction

This chapter discusses bicultural professionals' tacit expertise in forming respectful relationships with service users and members of community groups. It continues to explore the interview data in depth.

The chapter begins by discussing trust before describing how showing how bicultural professionals use conversation, make connections and share stories. Some echoes of their practices can be found in mental health recovery and transcultural mental health literature.

This chapter concludes the exploration and theoretical integration of the key categories that were used to build the substantive theory

Trust as a verb

Participants emphasised the importance of trust. As discussed in Chapter 1, the capacity of bicultural professionals to gain the trust of minority background users of mainstream health and counselling services has been identified in literature as key to their effectiveness.

Several participants spontaneously offered comments about the importance of being seen as trustworthy (#17: 6; 15)

> I would number trust the first thing regardless of your experience, regardless of your education, yes regardless of your role in your community, regardless of your sense that you feel for asylum seekers or all the people going through some mental issue or coming from a traumatised background, you feel, well, you are like all like a family, I think you cannot open up someone... if they don't trust you (#15).

Participants wanted to be regarded as 'trustworthy' and in tune with the concerns of individuals, families and groups. They gained the respect and recognition of individuals and communities in a number of ways. Firstly, by demonstrating their competence and know-how (#1, 15), for example Participant 1 became "a friendly face" in community settings who could open doors to improved contact with youth mental health services. Secondly, they got involved and got to know what mattered to groups by showing their face (#11; 14: 16) and gaining the respect of community and faith leaders (#14). Thirdly,

participants stressed the importance of being genuine and sincere in all their dealings with individuals and groups. Two participants recalled needing to show that they weren't motivated by self-interest or any desire to 'exploit' local communities (#4, 16). Finally, they showed that they could be relied upon to make realistic agreements and doing what they agreed to do. Participant 12 repeatedly stressed the importance of clarifying expectations, being punctual and predictable, and following up all agreements when working with clients of refugee background. Further, participants (#16, 4) explained that allies who made long-term commitments to communities were highly esteemed. For example, speaking of a senior medical practitioner, Participant 4 explained:

> She comes twice every year to our groups and she talks about wellbeing and health… How are you travelling? How are you in this area? How are you in that? And she does it, like in a very simple way, and she is very approachable and easy going, and the women actually love her and keep asking, 'When is [the doctor's first name] coming back?

Their reflections suggest that participants not only regarded trust as something that needs to be built, it is also creates spaces where interactions can occur (Coates, 2019). Some interviewees were keen to explain the limits of their capacity to create these kinds of spaces. They saw themselves as having minimal or very modest levels of influence within institutions and in communities (#2, 15). Some of the dynamics within institutions have been discussed in Chapter 8. Among those who had close ties with communities, they considered how their roles within institutions aligned with the communities' interests and values and avoided speaking on their behalf. One participant considered how she was being seen within newly arrived communities, which are in themselves diverse, and where family and clan allegiances are important to understand and observe. She responded by creating a culturally neutral public persona that would still be meaningful to the community (#4).

This Study found that bicultural professionals were practised in drawing boundary lines that acknowledge formal and tacit rules, creating safe service encounters and using their own experiences in ways that help people secure their own sense of wellbeing. I argue that that the experience and insights of bicultural professionals should be explored as part of the current search for more innovative and humane approaches to mental health service delivery. A participant (#10) made this precise claim:

> With any [mental health approach] you use, if it's not inclusive of your general ideology, it won't be as effective... I think there's an awful lot of things in the

> multicultural environment that can be useful to the wider sphere, an awful lot.

Trust also relies on having "the confidence that we are interacting with people who are committed to the same definitions of reality to which we adhere" (Keane, 2015, p. 92). Trust then is seen as the foundation upon which all other forms of meaningful interactions occur. Bicultural professionals described creating these spaces in their face-to-face interactions with individuals, families and groups in service encounters and in other informal community settings.

Interacting with service users and communities

During interviews, some participants confided that they often felt that they were operating at the limits of their capacity for empathy (#3). Some described feeling personally responsible for what they regarded as failures of empathy (#9). Some mentioned that working with clients of similar background was emotionally demanding and at times frustrating (#6; 14). There were examples where participants recalled particular subjective experiences that arose for them. They described struggling to self-distance; they felt pulled in, unsettled or overwhelmed. These individuals were younger and less professionally experienced relative to the whole sample, or offering reflection on the experiences of their younger selves. For example, Participant 9 explained that she often thinks about her own life circumstances and the more limited life opportunities available to some clients:

> It is a challenge for me, because I think, well it is unfair that this person is going through this... [breathes in] when women do present those stories to me, there's always a big part of me that's very angry with what they are going through, but obviously I don't project that when I'm with a client, when they leave it's a different story.

Participant 14 reflected on how the emotional demands of the work have changed over time: "I often found it very confronting… depending on where I was at, at the time, my own family issues, and the family's own issues". She explained: "I think there was a bit of a parallel process. In terms of struggling with my own identity and whether I really wanted to work with [ethnicity] communities, when I'm struggling within my own community personally myself".

Participants described interacting in three main ways with PeMH/EI with whom they shared similar backgrounds or experiences. They used the predictable back-and-forth rhythms of *conversations*. All interviewees mentioned this approach and it was commonly

described as relating human-to-human and a way of acknowledging universal human dignity. Secondly, they described intuitively reading *social signs* and using language, culture, religion and common experiences. Finally, they deepened encounters by *sharing experiences and stories*.

One participant (#10) touched on each of these ways of interacting in a single interview. He described:

- making a human-to-human connection with clients is foundational to all ways of relating,
- seeing each other as family, or connecting through gender, culture and other identity positions opens up possibility that cultural and spiritual realms may offer explanations for distress and offer solace,
- this mutuality can be the base for deeper explorations, and connection over similar past experiences, familiar life circumstances.

However, not all participants mentioned interacting in all of these ways. Perhaps their utility varies with context. Perhaps participants spoke more about the practices that seemed important to them or relevant in the context of interview.

Establishing cooperative, friendly interactions based on conversation in the context of providing mental healthcare in a formal setting might seem foundational to other ways of interacting. However, many interviewees described initial encounters with service users and community members that were had more 'face-to-face' qualities than conversational ones. It seems unlikely that they are in a hierarchical relationship to each other.

Participants' accounts suggested that these were intuitive practices, or just below the level of consciousness. Some have intentionally honed these skills over time through personal reflection and discussion with others. They also discussed how they manage the issues that arise for them in using these practices.

Having conversations

Participants described using conversation to preserve dignity and communicate sincerity: Several spoke of the importance of being willing to relate "human-to-human" (#1: 6; 10; 11).

Formal service procedures sometimes get in the way of this: "it comes across, people feel it. If you're not sincere, if they're just a number" (#7). One participant who is required by his agency to use a recovery care model that entails following prescribed steps and

completing paperwork, urges his staff to: "put the service model aside, and have a normal conversation and find out what, how to get the person to respond, because we need conversations" (#17).

Participants also used conversations to show that they are *genuine, ordinary and imperfect* (#4; 7; 16; 17): "you just really need to be transparent … [because] these [refugee-background clients] think very little of themselves. Many of them have very low self-esteem" (#6).

Showing sincerity also involves *creating a safe and comfortable atmosphere*. Participants do this by thinking about the space in which conversations occur and how people are feeling about having contact with services (#7; 9; 17; 19). Speaking about working from a mainstream service provider: "some[times] I choose not [to be] in the office for the first time, or not in the home, because I am the stranger" (#17). A participant based at an ethnocultural agency explained: "we are very personable here. When they come in we're warm, you know, we're engaging open and take the time to listen, it's just the way we are" (#7).

Participants (#11; 16) also spoke of listening attentively and *giving each person due regard* as part of any exchange: "people do want what's important to them recognised (#11). This includes openness to learning new information from communities about them (#11). Several participants stressed that, having connected with families or groups, the responsibility then falls to individuals to create opportunities to *keep the conversations going*. Participant 1 explained this as: "cups-of-tea-drinking, I always call it. It is about maintaining that relationship". Communicating in a shared LOTE *enriches information exchange*, makes having conversations easier, for example, to taking in new information about mental health and recovery (#5; 14; 15).

Building rapport

Some of the opportunities for engagement and rapport building for participants arose due to their cultural, linguistic or faith similarity with service users or because they sense or learn that they have had similar past experiences. They discussed instances when services users and others instinctively trusted (or didn't) based on perceptions of shared cultural identity or lived experiences such as migration. The following outlines some of the ways in which professionals and service users develop close alliances.

Face-work

This includes instances where service users and professionals respond to each other intuitively. Service users seemed to immediately identify with the professional because they appeared to share a similar cultural background, possibly also combined with gender identification or faith identification, or simply seemed to know what their life is like (#4; 9; 15).

> People don't ask me [about my background]. Well people know that I'm from [region] background, that I speak English with an accent and they know that I was not born here. That I came when I was adult... they know. (# 15)

There were many examples of professionals building rapport on these moments of connection. For example, in an acute inpatient setting (#1) when clients choose a particular form of greeting or language to communicate an idea: "he was showing respect to me in using [the professional's language] rather than [client's language] ... maybe just knowing … that we're similar, similar but different. In counselling relationship, another participant (#9) explained: "[clients] who have culturally recognised with me, it's just a greater sense of connectedness in what they want to share and talk about. I find that with them they are more likely to call [me] themselves and say, hey this happened or this is happening, can I have some help?". When supporting young people in schools, Participant 6 found: "they like to work with me because they know I'm not quite Australian but I'm Australian enough... I think they quite like walking in and seeing someone who is... not quite white".

Similarly, some professionals (# 5; 9; 12; 14; 16; 17) described *just knowing* what people were concerned about and knowing how to respond without much forethought. For example: "it did feel like I had an instant connection, with some families, not all families of [ethnicity] background. I had an instant connection. Um, that kind of broke through a lot of the barriers you might normally have with families".

Participant 12 explained that it was easy for him to gain the trust of refugee clients, and this was especially so for those who were also from his country of origin. He described a first encounter with one client: visiting the man's house, having taken care to ensure that he was well dressed. On arrival, he used a formal greeting, did not attempt to directly speak to the man's wife and noticed that the man seemed relieved by this. He proceeded to communicate with the man in his preferred language, drawing out more personal information as the interview progressed, pulling back when he noticed that the man was

becoming more distressed.

As the above example highlights, participants spoke about knowing that their understanding cultural norms and ability to speak community languages puts clients at ease and that this enables them to introduce new information, encourage them to get support from other professionals or other services, or move on to deeper engagement in a in shared project of recovery.

There were instances where professionals were especially mindful of the service users' recent experience as an asylum seeker or humanitarian arrival and took care to modulate the emotional intensity of their encounters with these clients. In the context of providing case management, participants (#3; 15) contrasted the ways they interact with these clients with the approaches they have observed in mainstream colleagues. For example:

> I don't dramatize. When I speak with my clients I try to use a kind of official language, not like a very … [facial expression of pity], very sticky, you know what I mean? … We are here, we have to be realistic and we have to continue from here. Here. (# 3)

> This makes a lot of clients unhappy, when someone says, 'I understand what you have gone through'... I don't use this, although I have been myself through that, because I, when someone used with me, I hated that. [Several] years ago when someone used that with me, I hated that. I said, no you don't, but I won't say it to your face, I'll just think in my mind. [Lowers volume for next comment] You don't know, you don't know anything about me. [Returning to usual voice level] And I hated that, and I know a lot of clients who come here, they hate this, the same thing… It's important to be real. (# 15)

Signaling social relationships – using a LOTE

Participants were also aware of a kind of intimacy that is created, when two individuals speak a minority language. These speech acts carve out a space of refuge within a mainstream language-speaking world. Speaking a *mother tongue* not only provides professionals and clients with an ease of conversation, it intensifies the intimacy of the relationship.

Languages convey meaning and also exceed meaning making. The latter has been variously described as the language elements that are prior to meaning, symbolic, poetic or akin to music – language has patterns and rhythms that connect us with others and with

our own memories, prior embodied states, affects and desires. This has been the subject of much exploration in semiotics and linguistics, and in particular by feminist theorists (such as Julia Kristeva) and the psychodynamic explorations by psychiatrist Salman Akhtar on migration and acculturation experiences (Galdi, 2004). The emotional jolt for the stranger or exile who chances upon or uses mother tongue language fragments – such as greetings, phrases and words – may be profound because they are encounters that simultaneously immerse one in pre-language child-like states and remind one the security inherent to these experiences have been ruptured as well.

Social relationships can be signalled consciously or unconsciously as part of service encounters by how the professional's turn of phrase: "well language is a big thing... in shifting things, so you can easily use expressions like, proverbs, idioms... humour, you know, all that… use slang... show that I'm from the same kind of culture" (#18). Another participant (#1) explained:

> "I revert back to my [country] accent [laughs]. It probably is a bit stronger after sitting with someone, and I can't even think what words we might use differently, it might just be the structure of our sentences might be more casual".

Communicating in a shared language enable direct communication at a deeper emotional level (#8; 9). Another professional recalled:

> I think there was one session that the case manager was sick, and it was me and the client. And the client started speaking in our first language and then I asked him, oh do you prefer that, we've never spoken, he said, well of course, there's no way I can talk about my emotions and things better than this. And that was when he started talking about his experiences and his symptoms. That kind of changed the management plan. (#18)

There were instances when participants knew that clients appreciated counselling in their preferred language with a professional who did not identify with the same cultural community (#8).

Signaling social relationships – using the structure of kinship

Professionals and service users use words, phrases and gestures to signal to each other that they are in a social relationship. There were also descriptions of using kinship terms as part of greetings expressed in English, such as "Hey bro" [# 67], saying "Hey, girlfriend" in community languages [# 7] when the professional and client were of similar age, and

elderly clients calling a younger health professional, "daughter'" also in a community languages [# 115]. These might seem to just be commonly accepted ways to affectionately and informally acknowledge or address someone without using the person's actual name, in much the same way such as "mate", or "dear" might be used among some Australian-born generations. Nonetheless, the form that these expressions take is of note because kinship terms and references to "family" in the interviews went beyond their use in greetings and pervaded all of the interviews.

For example, one participant characterised the connection among people, of varying backgrounds with recent migrant experiences, as a "silent sisterhood and brotherhood" (#11).

Another (#7) described the relationships that staff working at an ethno-community agency have with members of the community; that it serves as being "like a family to them" and used analogies such as "being like a sister", or "being seen like an aunty" to capture the qualities of actual professional-client interactions. The same participant went on to describe working with older individuals who "see me as their child, so engagement [is] helped at times with them".

Participants working in mainstream psychosocial support mental health services also described instances where this family-like dynamic was also present. For example, a team leader in a community managed mental health service explained: "after they know me for some time, say, you're part of my family, or friend or whatever" [#17]. Another participant said: "when I practice in that way, they more likely accept me, and treat me, sort of like a family, they know I am not, they know that, but they treat me that way [#19].

Another participant (#10) who works as a trauma-informed counsellor explained:

> We talk about bros and cousin ... you can more easily draw connections with how they relate to other people in terms of the way they are speaking about them as opposed to perhaps the way someone from a different culture wouldn't... The connection of where you come from, where you belong, the sense of grounding that is family and place, it's something that you can relate to and use in counselling that enables that connection to be quicker and easier to manage.

A participant [8]who works with families uses words and greetings that signal kin while simultaneously acknowledging the cultural (and geopolitical) differences:

> I have a like a generic thing... we say when you meet someone from your own country, you say, a girl from my own town! And like I just say, what's happening hometown girl?... And they just have that immediate [demonstrates a sigh of relief]. Because you know, I'm wearing the veil and like [she may be thinking] OK, she's Muslim, I'm Christian. So hopefully breaking the ice in that way.

One participant (#1) also explained how contact with objects that had spiritual significance for them both evoked a kin-like relation between her and a young client:

> she knew I knew the value of it... and being able to allow her to sit and next to me... and touch my [jewellery] she would sit and say, aunty, I just need some power... Some people might see that as crossing boundaries, but actually it was a calming and soothing thing for her to be able to hold [the object] and I never felt threatened by her, because I knew what her purpose was.

Gestures of hospitality, such as sharing tea, may also be ways of enacting hospitality in a kin-like structure (#18).

Several participants mentioned *boundaries, crossing lines*, and *blurred lines* when discussing how kin or family-like modes of interacting signal social relationships. Their reflections distinguished between relating in a friendly, family-like way and becoming an actual friend to a client or being adopted into their family structure. They had considered professional codes of ethics, their own intentions and assessed those of the clients and families involved, and were aware that it was easy to intuitively slip into relating in family-like way when they came across clients and families of similar background to themselves. This way of relating is on continua, from welcome to best avoided, responsive to unprofessional, and from helpful to dangerous.

Most saw this kind of boundary work as useful and that it should be "managed" to avoid harms to the professional themselves and clients. There was a general sense that while this way of relating is as a core business for bicultural professionals, this is not well understood by professional peers who are not bicultural.

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[8] Participant identifier withheld to protect anonymity.

There were accounts of case workers doing things for clients that a close friend or family member might do, and could be considered outside their professional role, such as accompanying people to appointments (#2; 7). I reflected that it was fairly easy to draw the line when a service focused on offering practical assistance, as this could be resolved at a team level by agreements and protocols. But what do professionals applying counselling, psychosocial or recovery-oriented approaches do? I explored the notion of boundaries in the second set of interviews, and as part of enquiring about their practice in the third set. Here are some examples of how boundary questions arise in these contexts:

When a young man on an inpatient ward kissed a professional on the cheek, and greeted her in her language, she noticed how other members of the multidisciplinary team reacted: "I could see that people could see me as having blurred boundaries, but... it was actually a respectful way of saying hello" (#1).

A senior mental health clinician reflected:

> I had people... kind of like regarding me like their younger daughter or their older sister, from the same background, and feeling so comfortable in the room talking and that. And agreeing to do things that their case worker had been trying with them for two years and they wouldn't (#18).

She went on to explain:

> One of them literally called me, my daughter... he was maybe even a couple of years younger than my own father, he was definitely regarding me [pause] you know respecting me as his [health professional], but also regarding me, really [pause] like he literally called me... my dear daughter can I ask you for an appointment... something like that... it was not weird or uncommon or anything to me... And the other way 'round, I had a young one... that I felt I had to push, in terms of psychosocial rehabilitation, get him out there to get a job or do a course, and he was kind of like avoiding... And it did happen a couple of times, that I said, look OK, just let me just annoy you like a big sister, just go out there, and do this... You wouldn't do it with someone who is not tuned into [pause]. Yeah, I can't imagine a Caucasian young client, I can't imagine calling them, my little brother, let me tell you this and that. They would probably be offended or something, or just think, oh my God that's a bit weird (#18)

She explained that these ways of relating would be very familiar to people who are of similar background to her. Working in her country of origin, see found: "it was always like

that... in rural settings and I was always called, by the elderly... ah, my daughter... hi, my dear daughter" (#18).

As part of exploring how professionals use kinship structures and terms in the interview, this participant discussed how using kinship terms not only signals involvement between professional and client, it respects the social norms of interpersonal contact that matter to clients and co-exist with those that operate during health service encounters. When a professional uses kinship terms they are bringing powerful metaphors into the present: of being cared for and accepting care, and referencing the obligations that fall to each party because they are in relation to each other. At the same time, adopting a specific kin-like frame can actually make it easier for the parties to be in a professional-client relationship, because both can perform their respective roles while observing elder and gender roles and thereby honour any restrictions that normatively apply when a female practitioner interacts with an older male client. Hence there are ways in which using kinship structures in service settings actually enable clients to locate the encounter in their social world as a professional-client encounter. This frees them to address their concerns because they can take all the other normative aspects of their interactions with that professional for granted. Another participant offered similar reflection (#5).

The participant also noted that because the logic of some family and social structures is similar across some geo-political regions:

> I have had examples of connectedness, the familial thing, I wanted to say that, it's not just my culture, it's from the same region, [name of region], but not even the same language, I couldn't understand their language, I needed an interpreter, but that feeling, that regard, everything was exactly the same. (#18)

Sharing experiences and stories

Participants integrated their life experience and stories into their work with service users and community members. Bicultural professionals discussed making their authentic, genuine experiences available to others, using "post facto recounting… secondary elaboration…" and turning their experiences "into meaningful narrative[s]" (Jay, 2005, p. 7). They also encouraged clients to do the same and this opened opportunities where "both parties contributed to the agenda" of what was to come next (Galletly et al. 2020, p. 6).

During the interviews, one participant[9] introduced the many strands of her story: her professional interest in diversity and access and equity in health, growing up in a multicultural neighbourhood, her personal connection to a cultural community strengthened through marriage, managing an ethnoculturally specific mental health program. She spoke of a growing commitment to this work, influenced by her own experience as a young adult, by this time a qualified health professional, immigrating to Australia and learning to make life in a new country, and grappling with all that entails. And yet, in the closing minutes of our discussion, after I reflected that we had spoken about the connections between her past experiences and her work, she said:

> Yes, you bring up a point, that I do have a lived experience of an immigrant background, and I bring that experience into my work, it enhances my work. I'd never really thought of myself as a person with that particular lived experience.

That is, while her migration story was important to her and her career trajectory showed an enthusiasm for systemic advocacy, prior to participating in this study, she had not paid much attention to how she had integrated these personal and professional elements of her own story and practice.

I wondered to what extent those who are more recent migrants, strategically "forget" or "minimise" these experiences at work in order to function in a service system that is not inclined to acknowledge the cultural diversity and migration stories of the professionals who constitute the mental health workforce. Perhaps this kind of response was more prevalent among those who, similar to this participant, have a relatively high socioeconomic status and possess qualifications and seniority that place them well within the mainstream mental health field. Her comments suggested that professionals such as were not inclined to explore the interplay between life opportunities, professional roles and responsibilities and mental health practice.

Some participants had drawn together the threads between lived experience, diversity and mental health practice. For example:

> Connecting as a carer, as a migrant, having my own journey, having to use a second language, I can relate to all those things… I want to speak from narratives, from my experience... I now I see them as a source of strength, from which I can do this work. (#2)

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[9] Participant identifier withheld to protect anonymity.

Some saw this kind of integration as essential: "with any counselling methods you use, if it's not inclusive of your general ideology, it won't be as effective" (#10).

Through interviews, I explored related questions including: What are the implications for bicultural professionals when they speak from personal experience? Should they self-disclose and to what depth? One participant – who had regular supervision arrangements in place – had developed her own guidelines on sharing information about herself. She put it this way:

> It's your personal story, it's about your inner world, which you know plays out there, it's in the room with the client, how could it not be? Sometimes you're talking to a client, it's as if they are talking about a mini aspect of your story I think. Um about disclosing. I'm not a big… I would try to be as professional as possible and not disclose any personal, unless it is highly relevant. Otherwise, no. (#18)

Similarly, other participants described consciously limiting the amount of detailed personal information that they disclose.

On limiting the detail of what she discloses about herself to clients of similar background, another participant commented:

> In a conversation... they ask me many questions. I could on the spot answer whatever the question is, but then just to come back and reflect... did I have to answer that? So, I have [said] that I'm not comfortable in answering that (#5).

Another mentioned becoming more conscious about using self-disclosure: "I also need to think about how to use my lived experience, when sharing it is too much, to hold back sometimes" (#2). And sensing it's important to limit self-disclosure, Participant 12 decided it was best to not share too much, even though team leaders offered no advice on the matter.

Another spoke about weighing up the costs and benefits for clients:

> I think about it... If I say this, what is going to happen?... What will be the point of it, if I share this memory?... I think about my memories from their point of views, and then I start to say something. I'm very careful about this (#3).

Another participant described intentionally disclosing aspects of his own story, and making this as a part of adopting a recovery-oriented practice approach:

> So, when I work with people, um with my clients I mean, they are from all different background but my principle to work with clients, is like sharing my experience... I believe in you know, human interaction. They are human being, they are a stranger. I am a stranger to them. We are coming to each other. We talk to each other (#19).

Professionals spoke about their personal or family recent history of migration or relevant other experiences in the belief that client will find these familiar stories validating, reassuring or motivating (#2; 3; 6; 12; 15; 18; 19). Participant 12 explained that he would disclose things about himself if he thought it would encourage others or give them hope.

Some participants have made storytelling an integral part of their work:

> when they start speaking, when they share their life experience, I start to give examples from my own life... I have similar memories... they feel comfortable and then they start to say more 'cos they trust me, they think ah, she is a trustable person, she knows, she understands, she understands me. (#3)

Discussion

The considerations that participants gave to how they interact with services users were among the strongest themes that emerged from the interviews. Being seen as trustworthy and generating trust in service encounters were of primary concern.

Participants described using a range of relational practices: using conversational structures, face-work and kin-signalling during exchanges, and making use of their own experiences and stories.

Using a shared "mother tongue" had particular meaning and implications. Interactions require different kinds of perspective taking, from acting directly from one's own psychological dispositions and social location, to acting in ways that establish and use empathy, through to bringing in external cultural perspectives and norms. Maintaining a degree of self-distance when working with service users of similar background may be especially challenging for less experienced professionals.

Participants had nuanced views on communicating trustworthiness, showing empathy in interactions and developing collaborative relationships. The main relational practices identified in this Study – conversation, social signalling and sharing experiences – have echoes in the work of others. For example, the transactional, relational, interactional

moves that psychiatrist make in interviewing patients with thought disorder described by Galletly and colleagues (2020). Similarly, Kirmayer (2008) argues that the micro-practices of culturally responsive service encounters involve seeking dialogue, mutual recognition, and collaboration.

Service user relationships with professionals have been studied in psychotherapy and recovery-oriented practice literature with the aim of identifying the *common factors* in successful interventions with PeMH/EI or what is fundamentally responsible for transformative change (Topor, Borg, Di Girolamo, & Davidson, 2011; Nahum, Alfonso, Sonmez, 2019). This literature seeks to understand the commonalities that cut across different theories and techniques that are attributable to the professional-client relationship.

Investigations by Miller and colleagues show that a psychotherapist's ability to establish a working alliance is highly predictive of therapeutic success (Miller, Hubble & Chow, 2017). Effective therapists have "constructive interpersonal interaction[s]" because they are able to "interact warmly, empathically and collaboratively" when faced with a broad range of clients and presenting complaints. (Miller et al., 2017, p. 34-5). Practitioners not only need knowledge and skills, they need to know *when* to do, *what* they know *how* to do. Effective practitioners combine content knowledge with procedural knowledge, in ways that fit the conditions at hand. Miller and colleagues conclude that empathy is "one of the most consistent predictors of psychotherapy outcome". Clinicians who score highly in relational skills, who do not create interpersonal distance, are rated more highly by clients for their alliance, from the outset of contact (p. 35).

Topor and colleagues (2006) explored therapeutic relationships with a view to understanding how professionals from a range of disciplines apply recovery-oriented mental health approaches. They asked service users to recount what if felt like when professionals tuned into and understood their reality. Service users "talked about the importance of clinicians or other professionals going above and beyond what is expected of them". Topor and colleagues reflected:

> To stand by someone, to remain by his or her side, and to become involved over and above familial or professional duty is what appears to makes [sic] the difference between help and hindrance. As we have seen in these narratives, an intervention does not acquire meaning simply through the official position, or lack of official position, of the person performing it. It is the context that determines the meaning of the action, but it is the action that makes the difference (Topor et al.,

2006, p. 36).

The same study discusses the family-friend like relationships that can exist between service users and professionals, noting that:

> Contrary to the fears of many professionals, the people who were interviewed quite easily distinguished help from professionals from that of friends or other loved ones. Mia referred to her relationship to her contact person and his family as a family relationship. At the same time, *she was well aware that they were not her real family*. When Kari described her relationship to a professional who had helped her, she used a term that often occurs in interviews with people who have recovered: "as-if" friends ("like friends") ... there are professionals who "do something different," and this something different... "Like-friends" relationships seem to occur in a variety of settings in different countries and in different cultures. The rules that are broken are among those that are considered prerequisites for the traditional institution's survival... this new kind of professionalism seems to be beneficial and not at all uncommon, it is seldom accorded the same value as a more formal sense of professionalism. Rather, *the tendency is to suppress knowledge of it and to characterize it in official contexts as unprofessional* [emphasis added] and evidence of "over-involvement" or "failure to maintain distance." In this sense, the "like-friend" relationship constitutes breaking the rules and professionals who do so take a risk. Not only have they broken the rules of the institution where they work, but they have also called into question institutionalized knowledge about madness (Topor et al., 2006, p. 34-35).

The similarity between these sentiments and those expressed by participants in this Study is striking. So too are the observations about the covert yet ubiquitous nature of these forms of "rule breaking". The notion of professionals seeking out spaces of possibility within institutional structures is another echo.

Turning to transcultural mental health and multicultural counselling literature, there is considerable discussion regarding the client-professional relationship considerations when there are cultural similarities and also when there are cultural differences. Research indicates that professionals who practice cultural humility – are willing to self-reflect and are curious, open-minded and respectful about the experiences and social positions of others – achieve better working alliances with service users (Watkins, Hook, Owen, DeBlaere, Davis, & Van Tongeren, 2019). Carrera and colleagues (2020, p. 3) emphasise the importance of professionals "decentering"; developing an ability to "distance oneself

from oneself and from one's own cultural point of view". There are also discussions about the challenges and limits of "clinical empathy" (Kirmayer, 2008, p. 458) given that in reality all service encounters are "partial, conditional, transient, and fragile" (p. 470). Kirmayer (p. 458) describes empathy as a communicative process where another's feelings are seen, we share that we have seen their pain, and get to the other's response in turn, and from this learn if we have or failed to understand. Where these practices succeed, he argues, is in the extent to which professionals read the feeling of disconnect that service users communicate, and respond in a way that moves them "closer together" (p. 465).

Participants in this Study, practice empathy with PeMH/EI in different ways: sometimes by encouraging acceptance and modelling integration and bringing a horizon of possibilities into view, reducing uncertainty for those who have known trauma, and providing opportunities for people to connect with bigger life themes (because they sensed identity confusion and a lack of a place to stand).

Conclusion

The ways in which bicultural professionals described interacting with PeMH/EI of similar background to them by means of dialogue, social signalling, and storytelling resonated with discussions in mental health literature about common factors in psychotherapy and recovery-oriented practices, and key considerations in transcultural and multicultural mental health.

Participants were aware of some of these complexities; considerations regarding trust and empathy, ways to establish a degree of self-distance in client-professional relationships, the need to develop self-awareness and reflect on one's own assumptions. Most, however, described intuitive approaches to interacting with service users that were gradually refined as they gained experience, without reference to theoretical discussions and not by reflecting in the company of peers. Chapter 5 has noted that opportunities across the group for relevant supervision and support were limited. There is scope for offering bicultural professionals more opportunities to reflect on the principles and practices that underpin how they interact including trust and empathy.

Chapter 11 Practice pathways

Introduction

This is the first of two chapters that explore the substantive theory.

This chapter introduces the notion of practice pathways. It uses three case examples to describe bicultural professionals practising the three main principles, discussed in Chapter 7.

These accounts explore bicultural professionals' motivations and predispositions, consider the contexts in which they work and consider how they embody culture-oriented practices.

Practice paths

Chapter 4 used the notion of fields and worlds to indicate the physical, conceptual, and social spaces that participants occupied when working with PeMH/EI of similar cultural background or migration experiences to them. I have also described the ways in which participants traversed spaces or world views, physically moving between service and community settings, negotiating different forms of knowledge or beliefs, sometimes explaining the meaning of one group's perspective to the another.

Many writers and researchers have used spatial images to capture these kinds of activities. For example, bicultural professionals are sometimes referred to as bridging, or being the go-between (for example NCCC, 2004; Liu et al., 2017). Having a sense of belonging was important to many of the participants; it was how they characterised wellbeing for themselves and for clients and communities with whom they identified. Sometimes they related to the experiences of other newcomers who felt adrift, or were longing for home. Others who recalled growing up with the stories of migrant parents could relate to young people who experienced "being in-between" different worlds of home, friends, school and so on (Butcher & Thomas, 2003, p. 31).

I had all these spatial metaphors in mind– of reaching across, feeling at home, feeling lost, being ejected or excluded from, being amidst – when adopting the notion of *pathways,* a way to characterise and explore some of the deeply experiential aspects of bicultural mental health practice.

I identified three pathway patterns across the Study. These paths reveal mental and social

dynamics and structures and the ways participants have perceived and internalised them (May, 2005). They show professionals negotiating social spaces at work and beyond. These travels begin with personal motivations, and are mediated by workplace structures, evident in the everyday roles and responsibilities they assume. As they go about their work, doing tasks, and performing culture-oriented roles they also are revealing themselves as unique persons, interacting within webs of human relationships (Arendt, 1998). These practices manifest as relationships, intensities, ideas and feelings along the way. Even so, the Study found that ways of being a bicultural professional took a limited number of forms, or paths. Together these three paths comprise the range of ways bicultural professionals practised when assisting PeMH/EI.

The following accounts explore three principles through the work of particular participants. Each pathway embodies one of the main practice principles discussed in Chapter 7. These case examples were prepared by making comparisons, thinking metaphorically, and paying attention to affect and emotional demands. The cases are juxtaposed and compared to generate theoretical insights (Lehmann, 2001) and as a prelude to developing a coherent explanation that applies across a diverse group of bicultural professionals.

Three case examples

These participants were selected as the basis for case examples because each exemplified one of the main principles, and because they varied with respect to industry setting mental health frameworks and links with other agencies and groups. Across the group, they performed a range of tasks. There were differences in their formal status at work, their reputation for having cultural expertise at work and whether they had influence in ethnocultural communities. An outline of each participant's features, based on analysis of quantitative and qualitative data is provided in Table 21.

Table 21 Three Cases from the Nested Sample: Practice Pathways Including Information about Work Context and Roles

	Case Examples		
	Kit	Fin	Jule
Practice pathways			
Establishing boundaries	x		
Creating safe spaces		x	
Guiding returns			x
Contextual features			
Hold positions in these types of organisations			
Migrant and refugee (multicultural)	x		
Migrant and refugee (ethnocultural)		x	
Mental health service (clinical)		x	x
Have links with these agencies and groups			
Police/ courts	x	x	
Social support	x	x	
Tertiary education	x	x	
Schools	x	x	
Community mental health teams		x	x
Faith community		x	x
Ethno-community group		x	x
Professional development network			x
*Use these mental health practice frameworks**			
Counselling	x		
Social support	x	x	
Mental health and AOD		x	x
Perform these types of culture-oriented work roles			
Mental health/ wellbeing expert	x	x	x
Guide	x	x	x
Mediator		x	x
Advocate		x	x
Change-maker			x
Positioned as having relatively medium to high capital, in terms of			
Social capital for doing culture-oriented work	x	x	
Social capital for mental health support or advice in a community		x	x
Socioeconomic status		x	x

Note. * Users of community development frameworks not represented

Practice pathway: Establishing boundaries

"We have to be realistic" (Kit)

Background

Kit had been a writer in his country of origin and after settling in Australia undertook tertiary study and gained a social work qualification. He regards his heritage as an indigenous culture, one of the world's First Nations. He belongs to a diaspora without a homeland and rendered stateless by generations of inter-border wars and armed conflict.

Kit works in a team that offers young people support and counselling. He especially wanted to work with young people from a range of migrant and refugee backgrounds. He expressed a sense of solidarity with people who have had recent migration or refugee stories, especially those who have known political violence. For him, there is an ethical connection between being a social worker and doing culture-oriented work with young people.

Boundaries

He described his commitment to working with multicultural youth, especially those who have had similar experiences to him. It was something he felt compelled to do, and exactly the kind of work that he wanted to do. He developed everyday approaches to working with clients that worked for him. He emphasised the importance of having conversations, finding ways to manage the emotional demands on him and communicating warmth and hope.

He offered some critical reflections on empathy:

> I'm very empathic, empathetic, this is a big problem for me actually, this is. Actually, when I was going to uni, they were all the time, they were thinking about being empathic of sympathetic, or whatever, I think this is not a good idea, not a good theory... Because I was very emotional before, when I was listening to the stories and memories of people, I was taking it serious, I was very empathically, but now I feel more strong, more professional.

On establishing boundaries that worked well for him and service users, he reflected:

> I know the boundaries, and I'm careful about it, actually. We are close and far apart. [Gestures with one hand touching his upper chest and the other arm outstretched in front, this hand open and palm facing away from him] ... We are communing from a similar situation... but we are here, we have to be realistic and we have to continue from here.

Reflecting on the need to manage alliances with clients who identified strongly with him, he knew that "when they see me as a person who has brown colour skin [points to his own arm] or a person who has broken English, they feel comfortable". He recalled a client who on one occasion wanted to give him a gift and on another wanted to have contact with him outside of the work context. His explanation emphasised knowing the limits of his capacity as a professional:

> I had a [ethnicity] client and then we were very close, because we had many common things, language, culture, or interests, or something like that, or political problems, similar points of view… She was thinking that I accept everything... I explain it to her and she just said, I didn't know, I thought that because we are [ethnicity] that you are going to help me. I say yeah, I'm happy to help you, but you have to make an appointment, you can't just walk in whenever you want. Something like that.

He works at maintaining a healthy degree of separation between himself and his clients while being both realistic and ambitious about the possibilities for growth and change.

Implications

Several participants favoured the kind of practice path described by Kit (for example, #3; 5; 6; 12, 13; 15) and were based in community-based settings that founded on a multicultural or social justice ethos. They made interpersonal boundaries visible by discussing otherwise implicit rules. They usually opted to not use a shared mother tongue in session, and avoided social contact with clients outside designated times and places. They were aiming to practise at an "optimal distance" (Akhtar 2004; Galdi, 2004). These participants believed this led to more positive client outcomes. It also helped them, as professionals to manage their own empathic responses (Galdi, 2004).

Participants who practised this pathway took a pragmatic approach and were realistic about the pace at which communities integrate. They spoke about supporting people to see a horizon of opportunities and encouraged individuals, families and communities to use formal health and social services, even though they are imperfect. They wanted communities to understand that they are part of the wider community for whom these services exist and for services to acknowledge that they needed to be responsive to diverse local communities.

In their interactions with clients, Kit and others were open about their own experiences of migration and the challenges that they had faced making a life in a new country. They were less likely to focus on having a shared cultural identity or heritage or to explore alternative ways of understanding to mental health issues or health and wellbeing. These participants had taken up and applied elements that this Study characterises as the principle of *using diversity*.

The participants who practiced this path had interpreted the ethical challenges of bicultural work in a particular way. Like Kit, they were highly motivated to make a

difference in the lives of others. They described that it felt like an *indeclinable responsibility* (Hutchenson, 2004). This is reminiscent of the way Levinas describes how coming face-to-face with other people calls us to recognise our responsibilities to them. This practice pathway is informed by this awareness and a response to it. This is expressed in the way professionals took responsibility for their own actions in the presence of service users, ensuring that their own perspective did not overwhelm encounters and left spaces for service users to step in, accept the reality of their current circumstances and experience their own agency.

Practice pathway: Creating safe spaces

"I'm always there for them" (Fin)

Background

Fin migrated to Australia from a region in Southeast Asia with health practitioner qualifications. She held senior positions in aged care and then, after personally experiencing mental health issues, gained additional tertiary qualifications and worked as a mental health practitioner. She has worked as a case manager and counsellor as part of multidisciplinary teams in mental health and AOD services. She later established an ethnocultural community organisation that supports individuals and families, who identify with heritages that originate in Southeast Asia, and now live in outer metropolitan Melbourne. She explained:

> Most of our people don't trust mainstream services but I actually connect them, [I explain] that we are in Australia, we have to work with them... So, I always [tell] the clients that I see, that it's good to work well with the agencies or other communities. (#16)

Safety

Five years ago, while working in mainstream mental health service, she began bringing relevant people together with the aim of creating a not-for-profit organisation that could do community outreach. Since then, the agency has been working hard to establish links with local health services, schools, vocational training centres, police and the courts. Staffed almost entirely by volunteers, the agency offers youth and family support, and mental health, education and legal advice.

Fin's aim was to create a place –a physical location and a milieu – that facilitates

conversations about mental health and wellbeing and imparts practical and emotional support. She believes that recently arrived individuals, families and local communities are feeling isolated, struggling to address emotional and mental health issues, have limited or insecure incomes and are distressed by negative and racialized portrayals in mainstream media.

She explained that she strongly identifies with people of similar Asian heritage living in Australia including those who have experienced mental health and emotional issues. She created the agency in order to "lift mental illness taboos and help other people" and is open about the challenges that she has faced, knowing that these will resonate with other newcomers: "[If] I was in a village, if someone is suffering from some sort of illness, we talk about it." Hence, she has fashioned a village-like agency that responds to the challenges facing young people and families by offering wrap-around support.

Fin explained that by operating outside mainstream mental health service structures, the agency is able to be more responsive to individuals, families and groups. Even so, she predominantly uses Western medical and psychological paradigms to explain mental health issues and her interventions have led individuals to accept effective treatment options.

She commonly uses actual kinship terms such as mother, son, auntie, or sister in service encounters, and a degree of self-disclosure, to deepen interpersonal engagement with community members. Her relationships with individuals, families and groups are often based on strong and long-lasting bonds structured along mutually understood kinship lines.

Fin also integrates her religious values of service and compassion into her approach. She feels a responsibility to be there for others and to alleviate their suffering. She has addressed the risk of becoming exhausted and overwhelmed, by growing the agency and recruiting more people to the cause. Hence the focus on harnessing a wide range of formal and informal networks of support, largely drawn from her own and other faith groups, and using the inherent relational strengths of local communities.

Implications

Several participants described leading or joining similar community-based ethnocultural initiatives with communities of varying scale (#7; 9; 11; 16), while others drew on the trust building ethos of this practice pathway while working in formal services that deliver counselling or other support services (#4; 8; 14). In both instances, they were re-

imagining and enacting service encounters that prioritise personal and cultural safety.

Across the Study participants, faith communities, and religious motivations featured among professionals who took this path. These professionals encouraged connections with formal service providers and were also well connected with informal sectors – such as ethnocultural agencies, with sporting and faith communities – and with particular individuals in formal sectors.

They saw recent arrival in Australia as a period of profound uncertainty, where one's sense of self can feel out of sync with the reality of others. This leaves people feeling untethered and places extreme emotional demands on isolated individuals and small family groups. These professionals build rapport through face-work and signalling social relationships based on broad conceptions of a shared cultural identity. Some also used mother tongues to communicate or evoked kinship when interacting with clients.

Some practitioners used the language of providing collective care, as Fin did, and others spoke of supporting communities to become more empowered. All discussions related to this practice principle included comments that professionals risk becoming overwhelmed by the responsibilities that they had taken on and about the exhaustion of fielding relentless requests and being seen as all-things to the community.

They discussed ways to regulate demands, for example, scheduling their availability, cultivating support crews or creating a relatively neutral persona that they could turn on or off when operating in spaces that left them open to contact with multiple community members. Some other Study participants explained that they had attempted working with a similar degree of proximity to communities and found themselves emotionally under-prepared. They subsequently avoided working with people of certain ethnocultural heritage, or took steps to avoid particular informal community settings. Several participants explained that these feelings changed over time, as they matured and had different life experiences; while they once felt this path was personally too demanding, they now felt better prepared to follow it.

The participants who embodied this principle rallied personal and collective energies and resources, and used these to create spaces of healing and support. They worked in ways that expressed the principle of *creating sanctuary*. Shared heritage, identity, and sometimes religion and language were used to define the edges of the safe spaces they created. They focused on acknowledging the uncertainty that newly arrived communities face and doing what they could to relieve their distress. These practices were about

creating a form of strategic communality, a staging post where individuals, families and groups could relax, derive comfort, be with others and feel included.

Like Fin, the ethical demand accepted by participants who took this path involved attending to the suffering of others as if it was their own. Empathy compelled them to take steps to provide care or seeking justice on the behalf of others (Hutchenson 2004).

Practice pathway: Guiding returns

"Connecting back to my own" (Jule)

Background

Jule has worked a mental health social worker, with indigenous communities and in youth mental health. Culturally, she identifies with the heritage of people from Sub-Saharan African. She has worked in acute inpatient mental health for young people as well as providing online counselling. Her long-standing interest in culturally responsive approaches to mental health care has seen her play leadership roles within services and in interagency networks.

Returns

In her experience, the mental health needs of culturally diverse migrant and refugee communities are accorded low priority across mental health services. In her view, being culturally responsive is integral to not separate from providing person-centred mental health care.

She spoke a great deal about fairness: "we want everyone to be treated equally in a service" and sees the potential for people to connect across cultures and tap into a sense of their shared humanity.

Practising in a culture-oriented way has also been an opportunity to connect with her heritage. She explained that initially, connecting with these communities at work was: "actually quite emotional for me, to be connecting back to my own". She saw these encounters as welcome opportunities to improve outcomes for clients and develop her own professional practice, yet these encounters were also tinged with feelings of loss and nostalgia.

She described the importance of helping people, who are experiencing mental distress, connect with their cultural heritage. She also focused on strengthen their family

connections. She explained that "belonging, identity and self-worth... are key things for mental health". She would like more focus on community empowerment, more acknowledgement by mental health services of "what the communities are doing for themselves" and more support for communities when mental health issues arise

Implications

Similar to Kit, Jule's practice is motivated by ideologies of equality and fairness, but for Jule the focus is less on finding ways for people to accept their circumstances and move forward and more on assisting people to connect with their own experience and heritage. Also, like Fin, Jule also engaged families as allies in mental health recovery. But unlike Fin she didn't attempt to emulate kinship structures. Her approach was to tap into beliefs and practices that mattered to individuals, families and communities, and encourage people to use cultural heritage as a force for empowerment and healing.

Several participants spoke of helping people to connect to culture and faith traditions, through sacred objects, rituals, prayers, and community events or by simply open up conversations about cultural heritage (#1; 2; 4; 10; 19). They did so with the intention of not just eliciting social support but to encourage individuals and groups to find solace in something bigger than themselves and sometimes to collectively mark celebrations or grief. They helped people to connect with cultural or faith leaders who were sympathetic to mental health concerns and family matters (#8; 14). Some engaged in prayer and rituals with clients (#4) or referred to sacred texts (#4; 14; 18). They integrated cultural or faith practices into the structure of meetings and group programs (#1; 16). Participants also explained that they had made similar connections with others and had their own rituals, and felt the benefits for their own wellbeing.

Participants using this practice path were interested in assisting people to discover the meaning of their experiences and circumstances, making links between personal explanations and family, cultural and social structures. Sometimes, when they had direct experience of the person's culture, they offered guidance in the role of an elder. Sometimes they suggested other cultural or spiritual guides, or encouraged people to undertake their own explorations. They saw this pathway as compatible with working in formal service settings, and across mental health frameworks because culture could be a source of personal insight and growth or a technique for regulating feelings and thoughts, as well as form of community solidarity and practical support. The practice of these professionals was consistent with the principle of *using culture*.

One of the challenges that arise for professionals, who practice in this way, was their own displacement or exile sometimes made them feel like inauthentic guides. Another common experience was that engaging with cultural meaning in service settings could evoke feelings of loss and longing in them. Several participants recounted a similar experience – that they too recalled feeling lost and at times angry in their youth. When they were presented with an opportunity to lead a community engagement project focused on mental health they were excited. They immediately felt homesick, and were reminded of their own family obligations, regretfully unmet due to time and distance apart.

Professionals who take this pathway know that everyone is born into a web of human relations and lives with the personal reality that life circumstances can and do affect these bonds. This is what underlies practices that focus on restoration and return. It is premised on the belief that re-connection to cultural identity and heritage is a source of existential strength and path to healing. Levinas called this a responsibility that precedes the ontology of each individual; that is, connection to others underpins all other ethical claims and obligations that we believe that we have (Hutchenson, 2004). This is our basic and inescapable responsibility to others. This is another way of stating that culture and ancestors precede and exceed the life of each human being.

Professionals who adopt this pathway are curious. They are focused on helping people to see possibilities and engage in bigger narratives. This is especially important because exile, displacement, migration and colonisation can disrupt a person's sense of self, leaving them feeling unfit for purpose in the terms defined by the wider world in which they find themselves (Hardy, 2008).

Discussion

Each case example has been used to exemplify a single practice pathway and explore patterns across the groups. This focus on practices was a meaningful way to differentiate the sample.

There was a subgroup of participants (#4; 8; 14; 16) who combined practices associated with providing both sanctuary and guidance. Two of these individuals (#8; 14) were bilingual counsellors who had strong connections to particular cultural and faith communities. The other two (#4; 16) were well known in communities, were points of linkage and brokerage between services and sectors, and were also in the business of providing direct mental health support. Seeing elements of their practice in two pathways may speak to the comprehensive way they approached their work.

These pathways might help to explain connections and miscommunication from the point of view of what service users perceive service providers. For example, when Participant 18, working in a multicultural setting, found a client refused to see her because they had a cultural and language background in common. The client was looking for counselling support but not in an imagined space of commonality or sanctuary; she wanted to receive help at an optimal distance for her.

They also help to conceptualise the adjustments professionals made based on experience and maturity. For example, when Participant 3 noticed that she was uncritically trying to recreate safe family-like interpersonal structures with clients, she modified her approach and focused on setting clearer interpersonal boundaries. In other examples, Participants 1 and 13 each described how they recalibrated their focus on diversity and inclusion and found ways to connect with cultural communities that were especially close to their hearts.

These examples suggest that there are meaningful patterns between the kinds of social practices bicultural professionals tend to adopt and other elements. These are represented visually in Table 21.

They include the characteristics of the different types of agencies that assist PeMH/EI of migrant or refugee background, the types of common connections made with other service settings and groups, and the approaches to providing mental health care that they these settings tend to support.

The pathways show the relations between professionals' personal experience and context and how they perform their roles at work and interact with service users. These elements in professionals' stories are "mutually constitutive" (Naraindas, Quack, & Sax, 2014). For example, when Jule felt moved to work with a marginalised community because she saw echoes of her own personal story, interacting with these individuals and groups from these communities raised further feelings and thoughts about what it means to belong. This co-constitutive dynamic plays out at other levels as well; for example, beliefs about health and illness, modes of treatment and where appropriate help can be found (Naraindus et al., 2014, p. 1).

The personal dispositions, beliefs and values of professionals set the direction of each path, which in turn was structured by the possibilities open to them for employment and in performing their work position and role.

These pathways express different responses to the ethical tension – toward seeking

freedom and duty – the personal disposition that was common across the bicultural professionals who participated in this Study. The pathways can be conceptualised as professionals seeking a place in service settings and their networks that fits, or fits well enough with the way they make meaning of this ethical dilemma. This fit is manifest in some of the culture-oriented principles that abound in cultural responsiveness discourses.

Chapter 7 identified these principles as *seeing diversity, creating sanctuary*, and *using culture.* The pathways show that mutually constituting forces have socialised bicultural professionals into believing an integrated society, finding a place to belong and being connected to cultural narratives matter for health and wellbeing and recovery in the context of mental health issues or past trauma. The paths are a representation of how these predispositions and principles come together in everyday practice of bicultural professionals: where establishing boundaries relates to a broader principle of *seeing diversity,* offering spaces for *creating sanctuary*, and guiding returns to *using culture.* The paths show professionals striving to be authentic, meet their ethical obligations, and aiming to provide mental health care with pragmatic kindness, kin-like empathy, and with the curiosity and respect due a fellow traveller.

These practices are also co-constituted in the sense that professionals are socialised into these practices by health and human services institutions. Bourdieu argues (1996, p. 1) "that there exists a correspondence" between "mental structures'' and "social structures". This Study has identified relations between the subjective ways people experience and embody being a bicultural professional and the ways that in which the objective world of mental health service delivery is organised. For the most part in Victoria and Australia, the work of bicultural professionals goes unacknowledged. Some of the ways in which mental health discourses minimised, marginalised and regulated the work of bicultural were identified in the analysis of discourses about them (see Chapter 2). The status and regard they are given in local service settings turns on how and when they are made visible or invisible (Chapter 8). The practice pathways show bicultural professionals positioning and repositioning themselves in service settings and networks and finding the "space of possibles" in which to practice (Bourdieu, 2007, p. 4).

There seem to be local settings to which these paths are more suited, and this may explain why people were drawn to particular disciplines and work settings. The pragmatic approach of multicultural agencies to helping people address psychosocial issues and linking them to mainstream services calls for aptitude in managing interpersonal boundaries. To work in an ethnocultural community organisation or lead community initiatives from within a formal service one needs to be comfortable with being recognised

outside work settings and negotiating informal relationships. Applying psychotherapeutic transcultural approaches in counselling or mental health services calls for competencies in exploring identity and culture in order to "search for meaning and for a solution to ... symptoms and their various forms of distress" (Carrera et al., 2020, p. 3).

On reflection, these practices are connected with ideas that have currency in mental health service delivery: person-centred recovery's emphasis on a culture of hope and strengths (AG, 2013a), the opportunities arising from mutual help and self-help (Grow, 2020); and a renewed focus on interpreting the meaning of mental illness symptomatology (Johnstone & Boyle, 2018). However, the notion of each pathway has its genesis in conversations with participants and my mediations on these conversations. For example, one participant mimed the gesture that he commonly uses with clients to draws an interpersonal boundary line. Another described his way of relating to clients as "holding up a mirror" Both individuals[10] themselves had direct life experience of exile and both emphasised the need to maintain interpersonal distance and help clients to remain oriented toward the future. Actual and symbolic gestures of embrace and folding people in, which characterise the second pathway, were witnessed directly by me when interviewees, introduced me to family members or invited their colleagues and allies to join the interview session. For a brief moment, I had been welcomed into the social worlds of support they were creating for communities. I felt the poignancy of the last pathway before I could articulate it, because these actions were told as part of stories of displacement and longing. This sense of loss was related to bigger themes of colonisation, and systematic denial of connection to heritage. I saw the depth of feeling professionals had for the healing potential of heritage in the way they spoke about these struggles and the solace that prayer and other communal rituals offered.

Conclusion

Practice pathways offer a way to understand how people embody bicultural practice in encounters with PeMH/EI. They capture personal dispositions, how people connect to broader ideologies, and find a space to work within a formal service system that can feel alien to their interests.

The practices described in these pathways are consistent with broader culture-oriented principles that matter to bicultural professionals. The practices and cultures of bicultural

[10] Participant identifiers withheld to protect anonymity.

professionals who assist PeMH/EI in a formal setting are concerned with power, visibility, affect, freedom, responsibility, relationality, identity, boundaries, sanctuary, and longing. These themes could be the basis for renewing discussions about the cultural responsiveness of mental health services.

Chapter 12 The substantive theory

Introduction

This chapter completes phase six of the Study design by outlining the findings in relation to the Study objectives. The descriptive and exploratory findings are followed by presentation of a substantive theory of the culture-oriented mental health practice of bicultural professionals. Its relation to other theories is also discussed.

Report of the findings based on Study objectives

The guiding question of this Study, as outlined in Chapter 1 was: What is the experience of professionals, based in Victoria, who identify as bicultural or bilingual and assist PeMH/EI with whom they share similar a cultural, linguistic, or faith background? In particular, the Study asked:

1. What characterises these individuals and their work?
2. How do they combine their personal background with expertise associated with their professional qualifications, training or discipline?
3. What theories explain their practice and how others perceive them?

The following summary of findings mostly presents the inductive elements of the Study that emerged from the open and iterative enquiry approach (Creamer, 2018b). It also draws on deductive elements about work and principles, and some demographic features, where the constructs and relationships between items were tested, bearing the small sample size in mind. The descriptive and exploratory findings are summarised before presenting the substantive theory.

Describing bicultural professionals in mental health settings

These findings were mostly derived from quantitative data. Quantifying descriptive text generated the information about supervision opportunities.

Professionals were diverse in their countries of birth, ancestries and languages spoken and most were born overseas. They all held post-secondary qualifications, nearly all in health, psychology or welfare field.

Most held jobs that involved direct contact with individuals or families experiencing mental health issues and most were not located in designated mental health services. It was relatively unusual for their job titles to indicate that they were using their cultural or

language expertise. More hours worked in a job was associated with greater focus on performing culture-oriented work.

Individuals working in mental health organisations were more likely to get supervision or informal support than those based in non-mental health organisations. There were no accounts of practitioners receiving supervision from individuals who are also experienced in performing bilingual or bicultural work. There were also no accounts of individuals participating in peer supervision groups that explicitly focus on the issues that arise when performing this kind of culture-oriented work.

More than 80% reported doing each of the following: directly helping PeMH/EI, advocating on their behalf, or assisting service providers and practitioners be more culturally sensitive. Nearly all were involved in facilitating interactions between people experiencing mental health issues and other health professionals. There was an association between bicultural professionals working within agencies to promote the interests of particular groups and directly engaging with community-based groups and agencies. There was a significant association between speaking a LOTE at work and assisting service providers to work with PeMH/EI by mediating mistrust between a service provider and ethnocultural groups. For most, working directly with individuals, and families, involved providing information about mental health and wellbeing or recovery.

There was support across the group for the cultural responsiveness principles commonly described in literature and policy and regarded as good practice for professionals and organisations. Compared with professionals who did not speak a LOTE at all, or spoke a LOTE but not at work, those who spoke a LOTE at work were likely to agree more strongly that their work supported ethnocultural or faith communities with which they identified. Similarly, in comparison with other groups, those who spoke a LOTE at work more strongly agreed that by doing their work they were helping to create services that valued pluralism.

Experiential themes and patterns that emerged about their practice

These findings were derived from patterns identified in quantitative data and from experiential themes, tacit assumptions, and implicit meanings of actions derived from analysis of text and conversations.

During the course of their careers, it was common for professionals to move between multicultural, ethnocultural or migrant support agencies and mainstream health or human

service organisations. Those working in multicultural, ethnocultural or migrant or refugee support agencies were especially well networked with other service providers and community groups.

Bicultural professionals gain status and recognition at work in different ways. Their socio-economic status – was determined by their professional background qualifications and seniority. They could gain the recognition of colleagues for their cultural or language expertise. They may also have standing in the community as someone who understands mental health and is helpful to others.

Bicultural professionals were aware of the extent to which agencies were responsive to migrant and refugee communities. They felt diminished when agencies were not committed to becoming more responsive, when the diverse realities of clients were not acknowledged, and when they were made to feel different from their professional peers. Participants responded to these situations by claiming more visibility for themselves and the issues, opting to work more covertly or by leaving jobs. There were reports of racism at work, sometimes from colleagues and sometimes from service users with racist attitudes.

Based on an analysis of the activities done by these professionals and their purpose, five culture-oriented roles were identified across the group: being a mental health or wellbeing expert, a health advocate, a mediator of relationships and communication, a change-maker within organisations and a guide to communities. Three cultural responsiveness principles were especially important across the group. These involved acknowledging cultural diversity at the level of the population and individual identities, offering marginalised communities spaces of sanctuary, and utilising cultural perspectives to support the mental health and wellbeing of individual or groups.

Bicultural professionals were highly motivated to make a difference in the lives of migrant and refugee communities. Acting with a sense of personal autonomy and authenticity mattered to them, as did acting on responsibilities toward others. This could involve taking responsible for oneself in the presence of others, taking responsibility for the suffering of others, or offering support because they are driven by a strong sense of justice that applies to all.

Being seen as trustworthy and generating trust in service encounters were of primary concern. Bicultural professionals emphasised the importance of conversational dialogue, signalling sociality, and storytelling in their interactions with service users. They largely did this intuitively, possibly refining their approach over time as they gained experience,

usually without reference to theories, and not by reflecting in the company of peers. These ways of interacting arose by connecting with others based on culturally appropriate understandings of proximity and modes of communication.

When interacting with service users, speaking a shared language could enrich encounters. Professionals were aware that speaking a mother tongue has immediate effects on the sense identification and intimacy from both professional and service user standpoints. It also alters everyday work roles, in particular how one performs the role of a mediator, or intercultural communicator.

Bicultural professionals strive to practice in person-centred ways when assisting people of migrant or refugee background. Like all individuals, the ways in which they act at work reveals who they uniquely are (Arendt, 1998) and the experiences that they have had. The ways that they speak and act also locates them in their particular social worlds of work and community life (Maclean, Harvey & Chia, 2012). Their perspectives are shaped by first-hand experience.

Bicultural professionals seek to understand each person in their cultural context and acknowledge the ways cultural differences are used to disempower and marginalise. They use the sense of having also "been there" to engage PeMH/EI of migrant and refugee background and to communicate acceptance, safety and belief in their self-efficacy. That is, these professionals use their familiarity with migration, and their understanding of how structural societal forces can silence people and limit life opportunities. They combine this with their mental health or wellbeing expertise. This has led them to develop innovative and transformative practices. Working in this way requires personal maturity and a reflective countenance. It is enhanced when local service settings also support the wellbeing of the professional.

A substantive theory that explains bicultural professionals' practice

A meta-inference of these findings is that bicultural professionals do goal-directed work and also act tacitly from their own experiences and ideas. They respond to others in particular contexts – when facing clients and communities, negotiating recognition at work, and responding to "othering" discourses about them. When bicultural professionals get opportunities to consciously explore their own ways of doing and knowing, they create empowering counter-narratives that have implications for developing their own practice and change at local and systemic levels.

The main elements of the generated theory and their relation to each other are discussed

below and presented in Figure 12.

The substantive theory developed here has three elements. The dynamic interaction between these elements – the professionals' ethical stance, the local healthcare and human service work settings in which they work, and the recognition and regard of others– result in practices. Their culture-oriented practices are principled, interactional, embodied and performative. They are accompanied by reflective and reflexive actions as well.

Bicultural professionals combine the following elements to generate culture-oriented practices.

> 1.1 Bicultural professionals share a durable ethical sensibility. This is a personal sense that their own *freedom* is connected to their ability to act on the *responsibilities* they have toward others. Being *free to respond* is the generative subjective principle (interpreted in multiple ways) of bicultural professional practice.
>
> 1.2 Bicultural professionals combine their competencies as a professional with their qualities as a person. They apply mental health frameworks and have cultural, knowledge, skills and experience (these are kinds of technical know-how). They also use themselves, their life experiences, maturity, capacity to form trusting relationships, and adeptly use language and culture (these are tacit, indeterminate ways of knowing and being). This describes a way of being a *professional as a person* in formal healthcare settings. The settings themselves determine whether these qualities are fit-for-purpose in that setting.
>
> 1.3 Bicultural professionals make their own assessments of whether their workplaces are prioritising diversity and inclusion and whether their culture-oriented practices are valued and appreciated. They experience this as a sense of recognition, a positive form of visibility. When diversity and inclusion are low priorities, bicultural professionals may stop their practice, but more often they use tactics to either negotiate more value and visibility or find ways to practice covertly. Visibility can harm the dignity of the professional, if it is based on accentuating differences from others or has racist intent.

The dynamic interaction between these elements result in practices. This is consistent with Bourdieu's approach to theorising about any social practice: that is, practices result from relations between one's durable way of being (habitus), one's position in a local field or social world (capital), and within the "current state of play" in that local world (field)

(Maton, 2008, p. 51). Social practices are the outcome neither of free choice nor rational calculation (Grenfell, 2008). They are strategic responses that express the logic of their circumstances (Shim, 2010).

The culture-oriented practices of bicultural professionals have four properties:

2.1 They are underpinned by principles of acknowledging diversity, creating places of sanctuary and using culture.

These principles are multidimensional and linked to contemporary understandings of cultural responsiveness (including cultural safety), critical social discourses (for example, intersectionality) and progressive trends in mental health (for example, the expertise derived from lived experience). These three cultural responsiveness principles were especially important across the group. These principles apply in different social domains:

- the immediate and particular effects on health and wellbeing of individuals, families and communities whom they come into contact,
- the behavior and actions of professional peers and organisations when using education and capacity building approaches; and
- influencing the culture of formal service sectors and the wider society by participating in occasions of truth telling and advocacy.

2.2 Culture-oriented practices involve professionals *interacting* with individuals, families and groups in ways that affirm human dignity, show proximity and sociality, and become opportunities to share experiences and stories. The ways in which bicultural professionals interact with service users are consistent with being person-centred and culture-oriented. It is underlined by a determination to be trustworthy.

2.3 Culture-oriented practices are expressed in pathways that reveal the ways professionals perceive and internalise the mental and social dynamics that are at play. They express *ways of being* pragmatic, empathic, and curious. These pathways establish boundaries, create safe spaces, and guide people as they explore identity and belonging.

2.4 Culture-oriented practices are expressed in the everyday roles that these professionals perform at work, with local networks and in communities. They act as mental health or wellbeing experts, health advocates, mediators, change-makers

in organisations or community guides. Sometimes their cultural work explicitly focuses on practical objectives that coincide with those of colleagues, teams and services and communities' need for information, advice or language interpretation. Their work is also oriented by social justice and equity goals. These roles are ways of serving these practical and ethical objectives.

Bicultural professionals take opportunities to reflect on their practice and bring more conscious and critical awareness to their own practice. There are four points of actual or potential opportunity for bicultural professionals to be reflective or reflexive (Thompson & Pascal, 2012).

3.1 Bicultural professional *reflect in-action*. They ways they negotiate power at work, interact with clients, and pursue practice pathways requires them to be extremely agile and flexible in how they respond. This is also how individuals modify and develop their practice over time (Thompson & Pascal, 2012).

3.2 Where they are available, professional supervision and networks, and informal supports, provide opportunities to *reflect-on-action* with colleagues, supporters or supervisors (Thompson & Pascal, 2012).

3.3 Bicultural professionals occupy a space of possibilities; they operate in dynamic relation to their local situations. Their (sometimes) "outsider" status offers a vantage point from which to reappraise and develop fresh understandings, including about how services address the cultural safety of clients and staff and bicultural practice itself (Maclean, Harvey & Chia, 2019).

3.4 Discourses that focus on the deficits – of cultural groups and professionals – shift our gaze from how organisations and systems can cause harm and reproduce inequalities. Research, consultation, and policy discussions are opportunities for bicultural professionals to engage in *critical dialogues* that can influence discourses about cultural responsiveness and bicultural professionals in mental healthcare. This could include critiquing assumptions about bicultural professionals and culturally responsive approaches.

Positioning the substantive theory in extant literature

Bicultural professionals are drawing on their personal and family stories of migration, settlement and other experiences in the context of offering mental health care and support. The substantive theory described above explains the elements that generate their culture-oriented practice, its properties and how reflection and reflexivity can drive personal and professional growth as well as organisational and systemic change.

The descriptive and explorative findings and also the substantive theory have implications for understanding other health or human service roles where professionals' personal and family experiences and history are particularly important. Examples from Australian health literature include: Genat (2006) and collaborators' exploration with Aboriginal healthcare workers in rural and remote communities; Brown and Reeders' (2016) documentation and evaluation of peer-led responses to HIV that utilise staff and volunteers who identify as gay men; and Byrne (2019) and colleagues' investigation of "lived experience" mental health practitioners working in tertiary mental health care services. Similar, to bicultural professionals, participants in these studies perform roles that combine technical expertise, local knowledge and lived experience in mutually transforming ways.

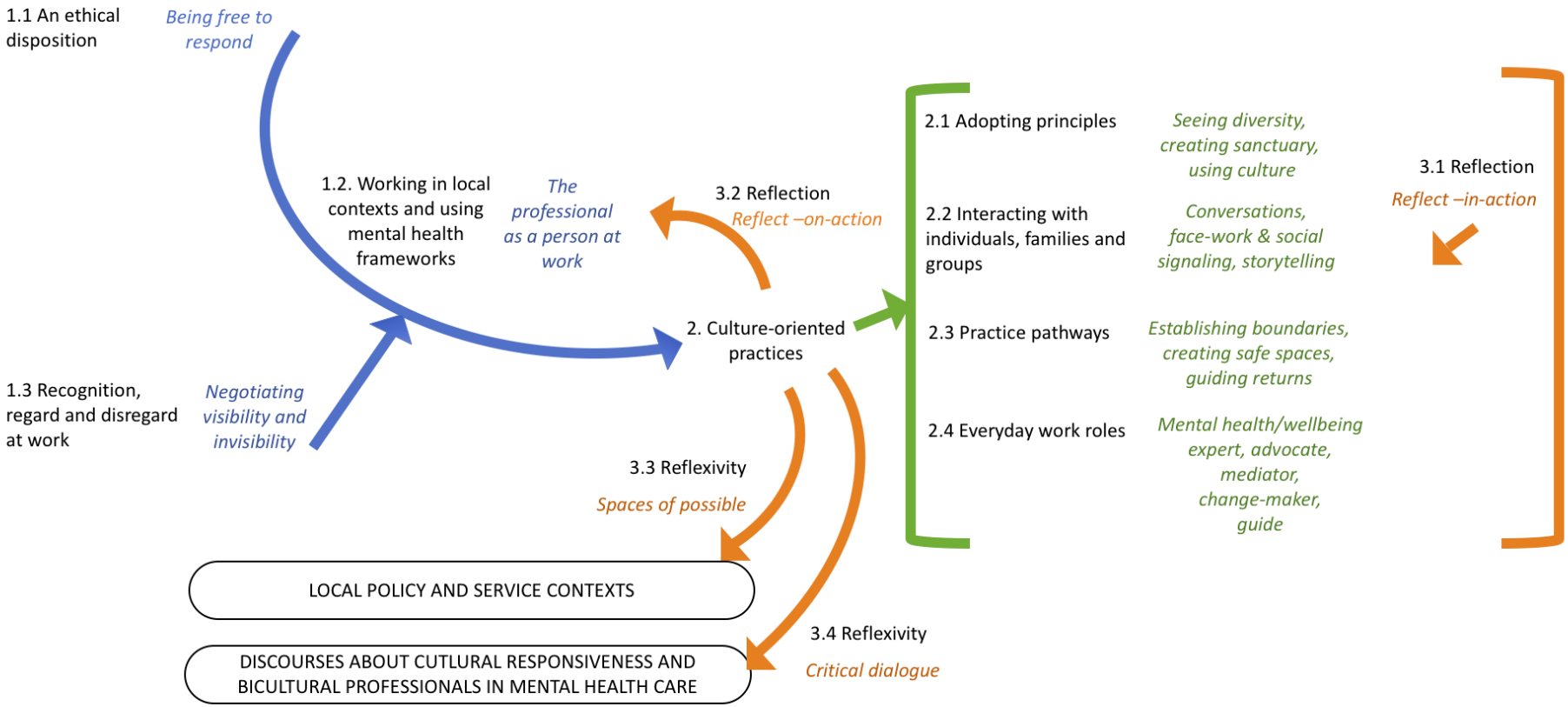
There are also connections to the work of writers in therapy, community empowerment and social activism fields. Vikki Reynolds (2010, p. 18) uses the term "centering ethics" to describe the position of the mental health worker or professional who is motivated to "respond to clients' varying needs from within contexts of power" and address the issues that arise from individuals who work in contexts which "violate" humane beliefs and their personal dignity. These practices are also ways of being oneself in the presence of others and engaging in real work alongside those with whom one "shares ethical responsibilities" (p. 14). Reynold's framework uses a nuanced vocabulary underpinned by social theory and activism: principles are called "guiding intentions", interacting with others is described as "co-creating relationships of enough safety" (p. 19) and working is organised around performing the role of a witness or acting in solidarity (p. 14)

Many contemporary writers on therapeutic practices stress the importance of reflective practice for all individuals involved in "helping" work. The work of Thomas and Pascal (2012) was used to inform the categories in the substantive theory developed in this Study. Heron (2005, p. 341) notes that that reflection "on the privileges associated with social location is considered the cornerstone" of adopting an "anti-oppressive" professional practice in mental health or counselling. Critiquing "dominant power

relations" is part and parcel of developing a self-reflexive practice. Reynolds (2010) argues that people need opportunities to engage in collective spaces of reflection. She, like many others in this field, stand on the shoulders of Paulo Freire (1970) who, writing on the essential links between action and reflection, observed that "doing" without "thinking" can be the source of great harm.

These discussions suggest areas for further exploration with bicultural professionals themselves. Other perspectives will deepen the meaning of the substantive theory and show how bicultural work links to other theories and practices that use lived experience from an ethical stance. The substantive theory has relevance to organisations and policy makers as well: combining pragmatism with an ethical stance could lead to "co-creating relationships of enough safety" (Reynolds, 2010, p. 104) at all levels of service settings, and developing compassionate policy that really is "good policy" for marginalised communities (Lea, 2020).

Figure 12 A Substantive Grounded Theory: The Culture-Oriented Mental Health Practice of Bicultural Professionals



Chapter 13 Conclusion

Introduction

This chapter concludes the Thesis by discussing the strengths and limitations of the research and offering some recommendations for how to apply the findings. Potential areas for future research are also discussed.

Implications for practice and service delivery

The overall findings suggest bicultural professionals have been making substantial contributions to the mental health and wellbeing of migrant and refugee communities. Consistent with the Study objectives, I have developed a description of this local workforce. I have also explored the experiential themes that they identified, along with assumptions and patterns that emerged from this mixed methods enquiry. I have also developed a theory that explains their practice in the local Victorian context. Each of these raises several implications for mental health service providers and policy leaders.

Given what we know about the people and the work

Beginning with implications that arise from seeing "what is". Any entities engaging or wishing to engage with this workforce can do so knowing that they are qualified, skilled and knowledgeable individuals. The literature search found no descriptions or practice guidelines about bicultural professionals and mental health. The Study found that as a group they lack access to resources that could support their professional development and empowerment. This group has limited opportunities for professional development and supervision that directly relates to their practice. There are very few opportunities in Victoria for these professionals to connect with each other.

Based on what the Study discovered about what professionals do, there are two observations that have implications that could be addressed with minimal additional investment, just by organisational leaders taking steps to communicate more with these professionals. Firstly, this group is on board with the cultural responsiveness principles that have been promoted in Victoria for over a decade. Secondly, they have been undertaking service development and community engagement initiatives. In particular, bicultural professionals who speak a LOTE at work regard their culture-oriented practice as a way to support the ethnocultural and faith communities with which they identify. However, bicultural professionals believe that they are an untapped resource. Steps could

be taken in local agencies to explore individuals' preferences in these areas and redefine jobs and roles accordingly in order to leverage and illuminate their work.

There are also two specific areas arising from the characterisation of "what is" that could be addressed by further investment. Nearly all of these professionals are involved in facilitating conversations between service users and other professionals. In other settings in Australia (Queensland Health, 2020; Transcultural Mental Health Centre, 2020) these practices are formalised as cultural consultation services. Various models also exist internationally (Carrera et al., 2020). There is scope to develop this aspect of their practice through reflective discussion and supervision. Cultural consultation models, programs or services that involve bicultural professionals could be developed. Secondly, with nearly all bicultural professionals in the Study reporting that are having conversations with individuals and groups about mental health issues and recovery, there is scope to co-design dialogic mental health literacy resources and approaches that could enrich this work (Ingleby, 2012; Tribe, 2019).

Learning that arises from understanding experiences, discourses and institutional structures

The implications that flow from the experiential themes that participants identified, as well as assumptions and patterns that emerged from this mixed methods enquiry are described.

The Study learnt that these professionals move between sectors and many have extensive networks across agencies and with informal community groups. As a group, they had considerable first-hand experience of working across sectors, forming networks, educating their professional peers, and creating community initiatives. Recruitment processes could more explicitly value the existing networks these staff have developed and thus "bring with them" into organisations.

Their direct experience of migration and settlement, everyday discrimination and working in hierarchical teams and systems gave them an acute understanding of the operations of power. Their accounts of how they are regarded at work are a poignant indication of the need to pay attention to dynamics of visibility, belonging, empowerment and racism in work settings. Organisational leaders who build awareness of this not only enhance the experience of these staff in the workplace, they enhance the experience of all staff and the experience of people from diverse backgrounds who use services.

The Study identified work roles based on the range of work these professionals currently undertake. This could be the basis for developing competencies. It is also a way to explore

the continuity between the work undertaken by bicultural professionals and the responsibilities that rest with the whole workforce with respect cultural responsiveness.

There is much that the wider service system can learn from these professionals and about how to practice in culturally-oriented ways. This includes strategies for interacting with individuals, families and communities and how they embody practices. They also demonstrate how their approach arises due to shared experience and identification with service users. This suggests that the particularity of their motivations and positionality should also be respected. Further acknowledging and respecting these differences is an important baseline from which to develop a more culturally diverse mental health workforce. There are additional considerations for bilingual professionals, because their use of language raises other dynamics in professional-individual encounters and in the additional roles they may assume in service settings.

Implications arising from the theory

The substantive theory presents professionals' personal histories and power and local healthcare and human service work settings and their priorities in a dynamic inter-relationship. Based on the perspective of bicultural professionals in service settings, the theory is compatible with calls in international literature, and to a more limited extent in Australia, to put cultural safety at the centre of professional, service and systemic responses to migrant and refugee mental health. This entails noticing the way power is embedded in service systems and how the assumptions that mental health professionals, institutions and systems "wittingly and unwittingly hold can have negative consequences" for racialised communities (VTMH, 2020). The substantive theory is compatible with arguments for considering the cultural safety of all encounters – between colleagues and collaborators, in teams, and in management or supervisory relationships – as well as at the interface of service and service users.

The theory also shows how the presence and practice of bicultural professionals changes the internal culture of services. They can raise awareness of the operations of bias and discrimination in racialised communities. They can also normalise pluralistic ways of being, doing and knowing. Greater cultural diversity presents learning opportunities for the mental health system as a whole. The properties of the culture-oriented practices included in the theory could be unpacked through reflection and conversation that have implications beyond the practice of bicultural professionals.

The sentiment across the group was hopeful about that systemic transformation was possible. However, government policies and guidelines are not only silent about

bicultural professionals, they have ignored the ways these professionals have kept alive a neglected policy area.

Consistent with themes that emerged from the review of literature, the Study also found that Victoria's cultural responsiveness mental health service policy and practice, including in the area of workforce diversity, is underdeveloped. Furthermore, while policies, frameworks and initiatives exist, the Victoria State Government (2009) framework for cultural responsiveness is over a decade old, and does not reflect contemporary trends in mental health, such as consumer participation (Le Roux, Clarke & Petrakis, 2018), intersectionality (Crenshaw, 1995), and decolonising practices (O'Mahony & Donnelly, 2010; Kirmayer et al., 2012, 2020; Dudgeon & Walker, 2015).

Participants have been strong advocates of the equity ethos that underpins cultural responsiveness approaches and apply principles in practice. They have shown that the current policy direction premised on universal rights to "high quality health care regardless of their cultural', ethnic, linguistic and religious background or beliefs" (Department of Health, 2009, p. 10) is compatible with using targeted strategies. Other institutes are exploring this perspective. For example, the targeted universalism frameworks (National Collaborating Centre for Determinates of Health, 2014; powell et al., 2019) place the "productive use of difference" at the heart of working "toward a more fair and inclusive society" (powell et al., 2019, p. 43). In the light of these developments, the theory has implications for continuing to explore how formal service delivery can be not only more equitable, but more just.

Potential areas for future study

This Study suggests several areas for future study. The resonance of the substantive theory could be explored with bicultural professionals of varying personal and professional background working in various jobs and service types. Elements of the theory could be explored in more depth. For example, the activity, strategy and role aspects could be used as a basis for further defining competencies and roles. Understanding of the practice paths could be deepened and this would be a step toward professionals becoming more deliberate in their practice and reflective on underlying assumptions. Similarly understanding of the modes of interacting identified in the study could be deepened. As noted in Chapter 3 Methodology, when discussing Study design, as relevant local groups and networks develop, future grounded theory studies could involve bicultural mental health professionals as both research participants and co-contributors.

Another area relates to opportunities for professional development and meaningful supervision. These issues have been identified across relevant literature and were also explored in this Study. For example, Owen and English (2005) wrote an extended reflection on supervising bicultural paraprofessionals, from the point of view of supervisees. Brar-Josan and Yohani's (2014) report outlines a professional development strategy for bicultural staff based on a collaborative model. Many participants in this Study had no access to regular supervision. There is scope for more qualitative exploration of what culturally safe and effective support, supervision and learning entails, how it can be resourced, and the organisation-level and systems features that might enable or hinder these initiatives.

One of the key eligibility criteria for participation was perceived similarity between the professionals' language, culture or faith background and PeMH/EI whom they assist. Focusing on these points of identification excluded professionals who have a strong interest in mental health service delivery and cultural diversity or who have become allies of newcomer migrant and refugee communities. The culture-oriented practice of these professionals could also be the focus of future studies. The Study also did not explore the role lay people play in migrant and refugee communities in providing mental health support and navigating service systems. Future studies could explore how their practices compare with those of the professionals who participated in this Study.

Another option for enquiry would begin from Butler's (2019) premise that "seekers of political freedom, underpinned by antiracism, feminism and more, who want to live in a more equitable and liveable world" are "multivariate". Firstly, a mental health workforce that is culturally safe and responsive sees diversity and its intersections of gender, sexuality, ability, age and so on. It would also understand that people who have identities associated with reduced social power can experience multiple and unique forms of discrimination that cannot be conceptualised separately (Hankivsky, 2014). Therefore, exploring the practice of bicultural professionals for whom multiple identity positions matter suggests another rich area to explore. Secondly, based on the key role personal freedom and sense of obligation toward others had in generating the bicultural practices explored in this Study, the interaction between personal dispositions and social structures in mental health settings could be explored with other lived experience workforces. As Butler's claim suggests, we could ask what the practices of bicultural professional share with liberatory approaches to delivering mental health care and other movements for social change.

Research strengths and limitations

This Study offers an in-depth and situated exploration of bicultural and bilingual professionals. No ethical issues arose in the course of the Study. Several participants voiced that they welcomed more discussion in service and policy forums about the role of bicultural professionals in mental health service delivery.

The quality and trustworthiness of the research arises from adhering to constructivist grounded theory methods as described by Charmaz (2014) and Birks and Mills (2015) as well as the situational and discourse analytical approaches described by Clarke and colleagues (2015) and Cheek (2004). The compatibility of grounded theory and mixed methods has been noted by leading writers on grounded theory methodology, including its classical, axial and constructivist iterations; however, there are only a limited number of examples in the health field to learn from that use mixed and grounded theory methods as combined methodology.

Adopting a mixed method research design in combination with a cGT methodology proved a useful way to address this complex and multilayered aspect of mental health service delivery. The discussion regarding culture-oriented work is an example of what "mixing" combined with an iterative reflective approach can deliver. The quantitative findings revealed that the specific activities identified were meaningful. Exploring the data and analyses further identified how participants grouped these in practice and experienced these as roles. They captured the activities, the purpose (ends) and the roles these professionals adopt to achieve them (the means) and had echoes in other literature.

Guiding texts, such as Creamer's (2018b) were not available when I commenced this research journey. For example, her description of *dialectical pluralism*, a paradigm that places diversity "at the heart of human and physical reality" and values "diverse ways of knowing" (p. 45) is a welcome insight into some of the philosophical assumptions that informed this Study's design.

Adopting a situational perspective and applying iterative approaches to the analysis of two data sets both enriched the process and added to the complexity and challenge of the analysis and interpretation of the findings. No pre-existing survey instruments were available that suited the study's objectives; the survey developed and used here has not been validated. It is however a starting point for future workforce studies or could be the basis of creating validated instruments regarding identifying culture-oriented activities and alignment with contemporary approaches. The length of engagement with each participant

in interviews was adequate to meet the Study aims. Memoing, visual mapping, and constant comparative methods were especially important in moving the analysis of each sample forward, integrating interpretation across the Study and developing the substantive grounded theory.

The thesis focused on bicultural professionals' views and perspectives, based on their written responses and comments and what they shared with me in conversation. I did not directly observe or measure their activities, routines, interactions with others, and all the other elements that constitute life at work. I did not gather information from other viewpoints, for example clients or service users, team members and organisational leaders, and any of the networks and communities that mattered to these professionals. Using ethnographic approaches and exploring multiple perspectives would enrich future studies.

A larger survey sample would have enabled the statistical analysis to guide selection of interview candidates (Lieberman, 2005). The smaller sample also limits the generalisability of interpretations based on the statistical analyses. The demographic similarity of the nested to the whole was serendipitous and added to the ease of interpreting the findings overall. Future studies should not only strive for larger overall sample size, and carefully consider characteristics of the whole and nested samples, but also explore ways to recruit a representative sample of the workforce by considering personal histories, professional background as well as service settings. Given the lack of visibility these professionals have within the service system, and the lack of publicly available demographic information about health and human service workforces, recruitment to future studies would be enhanced by the cooperation of the large service provider organisations, professional networks and state government departments.

The Study sample was especially heterogeneous as intended – professionals who provide mental health support of any kind and in any formal setting. This is both a source of strength and a limitation. It adds to the meaningfulness of the findings about these professionals' practice. The Study participants were diverse in cultural backgrounds, disciplines and settings, and yet the pathways cut across this diversity to reveal the deeper logic, that relates to ways of being in the world, and informs how these individuals assist others. Without this diversity, I may not have identified all three pathways, or I may have over-attended to "factors" such as the characteristics of a person or workplace. This may have made the ontological dimensions more difficult to see. It was actually during the extended face-to-face interviews that I experienced these emergent ways of being, and gained a sense that this would become the central concern of the Study. I realised this when I heard an experienced senior mental health nurse with a long history of providing acute

inpatient care and a counsellor of men who perpetrate domestic violence strike the same emotional tone, and communicate the same poignancy of knowing both the loss and want of ancestral connection. I was thinking of them and others when I identified the third practice pathway. Their stories let me imagine encounters where they activated this deep knowledge of belonging with clients. An ethnographic approach may have yielded more depth, about the particular backgrounds, experiences and talents of the individuals who participated in the Study. This includes their facility with languages and the use of culturally derived healing rituals.

Conclusion

This study has described bicultural professionals in mental health settings, practising in ways underpinned by being oneself in the presence of others and informed by core principles about what it means to deliver person-centred and culture-oriented mental health care. They are negotiating power in their relationships with others at work and pursuing equity and social justice goals. Their sensibilities and abilities when connecting linguistically and culturally with others are expressed in the practice pathways they pursue and in the culture-oriented roles they perform. They combine these roles with providing mental health or wellbeing expertise.

The findings of this study show culture and social context are at the heart of mental health service delivery. Mental health challenges are connected with struggles for a fairer society, issues of poverty, discrimination and injustice as well as personal and traumas. Mental health policy and practice would be enhanced by learning how bicultural professionals are helping individuals, families, communities and colleagues to address these challenges.

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Appendices

Appendix A Ethics

First application

Letter of approval

LA TROBE UNIVERSITY

COLLEGE OF SCIENCE, HEALTH & ENGINEERING

MEMORANDUM

To: **Associate Professor Virginia Lewis**

From: **Secretariat, Human Ethics Sub Committee**

Subject: **S15/15 Review of Human Ethics Sub-committee Application.**

Title: **The perspective of workers in Victoria who assist members of immigrant and refugee communities experiencing mental health or emotional issues.**

Date: **27/03/2015**

Thank you for your recent correspondence in relation to the research project referred to above. The project has been assessed as complying with the *National Statement on Ethical Conduct in Human Research*. I am pleased to advise that your project has been granted ethics approval and you may commence the study now.

The project has been approved from the date of this letter until 31/12/2017.

Please note that your application has been reviewed by a sub-committee of the University Human Ethics Committee (UHEC) to facilitate a decision before the next Committee meeting. This decision will require ratification by the UHEC and it reserves the right to alter conditions of approval or withdraw approval at that time. You will be notified if the approval status of your project changes. The UHEC is a fully constituted Ethics Committee in accordance with the National Statement under Section 5.1.29.

The following standard conditions apply to your project:

- **Limit of Approval.** Approval is limited strictly to the research proposal as submitted in your application while taking into account any additional conditions advised by the Human Ethics Sub-committee (HESC) .

- **Variation to Project.** Any subsequent variations or modifications you wish to make to your project must be formally notified to the HESC for approval in advance of these modifications being introduced into the project. This can be done using the appropriate form: *Ethics - Application for Modification to Project* which is available on the Research Services website at http://www.latrobe.edu.au/researchers/starting-your-research/human-ethics. If the HESC considers that the proposed changes are significant, you may be required to submit a new application form for approval of the revised project.

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Participant information statement

You are advised to save or print a copy of this statement and retain a copy for your own records. This statement is also available as a pdf to download or print from a link within the Qualtrics online survey.

Project:

THE PERSPECTIVE OF WORKERS IN VICTORIA WHO ASSIST MEMBERS OF IMMIGRANT AND REFUGEE COMMUNITIES EXPERIENCING MENTAL HEALTH OR EMOTIONAL ISSUES

Investigator: Susan McDonough, Candidate for research higher degree, PhD
School of Nursing and Midwifery
College of Science, Health & Engineering
La Trobe University
Bundoora, Vic, 3086
e: 97000188@students.latrobe.edu.au

Supervisor: Associate Professor Virginia Lewis, College of Science, Health & Engineering (SHE), School of Nursing and Midwifery, Australian Institute of Primary Care and Ageing.

Co-supervisor: Dr Celia McMichael, College of Arts, Social Sciences and Commerce, School of Humanities and Social Sciences.

What is the aim this study?

The study aims to learn more about the background and practices of individuals who assist people from immigrant or refugee backgrounds who are experiencing mental health and emotional issues. Overall, the aim is to understand the scope of their work with service users, organisations and communities. In particular the ways in which these individuals (whom we call "culture workers") help people to use health and social services and other supports and how they assist service users and health professionals to understand each other's viewpoints.

Who should take part?

In order to participate you must:

- be aged 18 years or older
- be based in Victoria
- regard yourself as bilingual or bicultural
- work (in a paid or unpaid role) to assist people of immigrant or refugee background who are experiencing mental health or emotional issues
- be of similar culture or faith to the people you assist or communicate with them in a language other than English
- be currently doing this work or have done this work in the past 24 months.

If you are not sure whether or not this describes you, please contact the investigator to discuss or start the survey. The first few questions will help confirm if you meet the criteria.

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What will you be asked to do?

Should you agree to participate, you will be invited to complete an online survey that will ask you to answer questions about your background, qualifications and experience, your work role and the support and training you receive. The survey will take approximately 30 minutes to complete.

You may choose to complete a paper copy of the survey if you prefer. It is not possible for participants to use the online survey link to generate their own printed copy of the survey. Please contact the investigator named above if you would like a hard copy version of the online survey sent to you by post.

You will be able to complete and submit the survey without providing your name. Your submission of the survey implies consent to participate in the study. Participants who are interested in being interviewed as part of the second phase of this study will be invited to provide their contact details when they submit their responses to the survey. Only the investigators will have access to this information.

Are there any risks for participants?

We are not aware of any risks arising from participation in this online survey.

How will the data collected be handled?

Survey data will be collected using an online survey tool (Qualtrics). Data will be stored online in a password-protected location during and after the period of collection. After the survey response time is finished, data will be downloaded from the Qualtrics site and stored in a password-protected area of the La Trobe University server. Only the Investigators will have access to the raw data: data collected will not be divulged to others.

Survey data will be analysed using a statistical software program. Comments and answers to open-ended questions will be analysed to identify themes.

Data collected in the course of this project will not be kept for use in future projects. The data will be kept securely for five years from the date of collection, or any publication based on it, before being destroyed.

If you choose to provide your contact details at the end of the study and are contacted for an interview, all contact detail information will be removed from your participant data file once the interview has been completed. If you choose to provide your contact details at the end of the study and are not selected for an interview, all contact detail information will be removed from your participant data file.

Results of the study may appear in publications, be included in a thesis or presented at conferences. Findings will be reported so as to not identify particular individuals.

A summary of key findings will be available within three months of the survey's closing date. It will be available, via the original hyperlink to the online survey, until the end of 2015. You may also request that a copy of the summary be sent to you by contacting Ms Susan McDonough at the email or postal address above.

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What are the benefits of this project for participants and society in general?

Participation in the study may directly benefit you by providing you with an opportunity to reflect, in a new way, on your work.

This study has the potential to increase mental health sector understanding about how "culture workers" improve the cultural responsiveness of services and assist families and communities to respond to mental health issues.

New knowledge generated by this study will contribute to sector understanding about ways to implement relevant standards and practice guidelines related to culture workers.

Are there any disadvantages for me if I do not participate?

Responses to the survey will be un-identifiable. Participation in this study is voluntary. There are no disadvantages, penalties or adverse consequences if you choose not to participate or if you complete some or all of the survey and choose not to submit it. That is, making either of these decisions will not affect any future contact you have with the researcher, any organisations associated with the researcher, the University or any health or community-based organisations.

What if I have questions?

Questions regarding this project may be directed to Ms Susan McDonough or Associate Professor Virginia Lewis, School of Nursing and Midwifery, on t: 03 9479 3924.

What if I have a complaint?

If you have any complaints or concerns about your participation in the study that the researcher has not been able to answer to your satisfaction, you may contact the Senior Human Ethics Officer, Ethics and Integrity, Research Office, La Trobe University, Victoria, 3086 (t: 03 9479 1443 e: humanethics@latrobe.edu.au)

Please quote the application reference number: SHE Human Ethics Sub-Committee (CHESC) Reference No. S15/15.

What if I decide to withdraw from the study?

You are free to cease participation in the study at any time. Given the anonymous nature of the survey, please be aware that once you have submitted your answers to the survey, the data cannot be withdrawn.

You are also free to show your interest in being contacted for interview by providing your contact details when you submit the survey and then change your mind and no longer wish to be interviewed. If this happens, please get in touch, as soon as possible, with Susan McDonough by email at: 97000188@students.latrobe.edu.au

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Second application

Letter of approval

LA TROBE UNIVERSITY

COLLEGE OF SCIENCE, HEALTH & ENGINEERING

MEMORANDUM

To:	**Dr Virginia Lewis**
Student:	**Susan McDonough**
From:	**Secretariat, SHE College Human Ethics Sub-Committee (SHE CHESC)**
Reference:	**S15/15 - Ethics application for modification to project - Approved**
Title:	**The perspective of workers in Victoria who assist members of immigrant and refugee communities experiencing mental health or emotional issues.**
Date:	**24 June 2015**

Thank you for submitting your modification request for ethics approval to the SHE College Human Ethics Sub-Committee (SHE CHESC) for the project referred to above. The CHESC has reviewed and approved the following modification/s which may commence now:

Implementation of the second phase of the project.

Please note that your request has been reviewed by a sub-committee of the UHEC to facilitate a decision before the next Committee meeting. This decision will require ratification by the UHEC and it reserves the right to alter conditions of approval or withdraw approval at that time. However, you may commence prior to ratification and you will be notified if the approval status of your project changes.

The following standard conditions apply to your project:

- **Limit of Approval.** Approval is limited strictly to the research proposal as submitted in your application while taking into account any additional conditions advised by the SHE CHESC.
- **Variation to Project.** Any subsequent variations or modifications you wish to make to your project must be formally notified to the SHE CHESC for approval in advance of these modifications being introduced into the project. This can be done using the appropriate form: *Ethics - Application for Modification to Project* which is available on the Research Services website at http://www.latrobe.edu.au/researchers/starting-your-research/human-ethics. If the SHE CHESC considers that the proposed changes are significant, you may be required to submit a new application form for approval of the revised project.
- **Adverse Events.** If any unforeseen or adverse events occur, including adverse effects on participants, during the course of the project which may affect the ethical acceptability of the project, the Chief Investigator must immediately notify the chesc.she@latrobe.edu.au. Any complaints about the project received by the researchers must also be referred immediately to the SHE CHESC Secretary.
- **Withdrawal of Project.** If you decide to discontinue your research before its planned completion, you must advise the SHE CHESC and clarify the circumstances.
- **Monitoring.** All projects are subject to monitoring at any time by the SHE CHESC.

- **Annual Progress Reports.** If your project continues for more than 12 months, you are required to submit an *Ethics - Progress/Final Report Form* annually, **on or just prior to 12 February**. The form is available on the Research Services website (see above address). Failure to submit a Progress Report will mean approval for this project will lapse.
- **Auditing**. An audit of the project may be conducted by members of the SHE CHESC.
- **Final Report.** A Final Report (see above address) is required within six months of the completion of the project.

If you have any queries on the information above or require further clarification please contact me at chesc.she@latrobe.edu.au.

Ms Kate Ferris
Human Ethics Officer
Secretariat – SHE College Human Ethics Sub-Committee
Ethics and Integrity / Research Office
La Trobe University Bundoora, Victoria 3086
E: cCHESC.she@latrobe.edu.au
P: (03) 9479 – 3370
http://www.latrobe.edu.au/researchers/ethics/human-ethics

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Participant information statement (Interviews)

You are advised to save or print a copy of this statement and retain a copy for your own records.

Project:

THE PERSPECTIVE OF WORKERS IN VICTORIA WHO ASSIST MEMBERS OF IMMIGRANT AND REFUGEE COMMUNITIES EXPERIENCING MENTAL HEALTH OR EMOTIONAL ISSUES

Investigator: Susan McDonough, Candidate for research higher degree, PhD
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Supervisor: Associate Professor Virginia Lewis, College of Science, Health & Engineering (SHE), School of Nursing and Midwifery, Australian Institute of Primary Care and Ageing.

Co-supervisor: Dr Celia McMichael, College of Arts, Social Sciences and Commerce, School of Humanities and Social Sciences.

What is the aim this study?

The study aims to learn more about the background and practices of individuals who assist people from immigrant or refugee backgrounds who are experiencing mental health and emotional issues. Overall, the aim is to understand the scope of their work with service users, organisations and communities. In particular the ways in which these individuals (whom we call "culture workers") help people to use health and social services and other supports and how they assist service users and health professionals to understand each other's viewpoints.

Who should take part?

In order to participate you must:

- be aged 18 years or older
- be based in Victoria
- regard yourself as bilingual or bicultural
- work (in a paid or unpaid role) to assist people of immigrant or refugee background who are experiencing mental health or emotional issues
- be of similar culture or faith to the people you assist or communicate with them in a language other than English
- be currently doing this work or have done this work in the past 24 months.

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What will you be asked to do?

We are getting in touch because you completed an online survey, provided your contact details and told us that you were interested in being interviewed during the second phase of this study.

We will ask you to meet the researcher for a face-to-face interview lasting 1-2 hours, at a location convenient to you. With your permission, the interview will be audio-recorded.

It may be helpful for us to get in touch with you again after the first interview: for example to arrange another interview session, discuss information with you in more depth or invite you to comment on study findings.

At any time during the project period, you are free to let the researcher know whether or not you want to continue providing information. During your period of involvement in the project you are free to let us know what kind of contact with the researcher you prefer (i.e. face-to-face meetings, telephone or email). Only the investigators will have access to the information gathered during this study.

The researchers anticipate that all contact with participants will be complete by mid 2016.

Are there any risks for participants?

We are not aware of any risks arising from participation in this study.

How will the data collected be handled?

The researcher will make notes of interviews. Your consent will be sought to make audio-recordings of interview sessions. Notes will also be made or telephone conversations.

Interview transcripts, researchers' notes, emails and other documents exchanged between the researchers and participants will be regarded as data for this study and collated by using N-vivo, a qualitative research computer programme.

Data will be stored in a password-protected location during and after the period of collection. Once data collection is complete, data will be stored in a password-protected area of the La Trobe University server. Only the Investigators will have access to the raw data. Data collected will not be divulged to others. All contact detail information will be removed from your participant data file.

Data collected in the course of this project will not be kept for use in future projects. The data will be kept securely for five years from the date of collection, or any publication based on it, before being destroyed.

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Results of the study may appear in publications, be included in a thesis or presented at conferences. Findings will be reported so as to not identify particular individuals.

You may request a copy of your interview session transcripts. You may also request a copy of the key findings summary that will be available by early 2017. To do so, contact Ms Susan McDonough at the email or postal address above.

What are the benefits of this project for participants and society in general?

Participation in the study may directly benefit you by providing you with an opportunity to reflect on your work in a new way.

This study has the potential to increase mental health sector understanding about how "culture workers" improve the cultural responsiveness of services and assist families and communities to respond to mental health issues.

New knowledge generated by this study will contribute to sector understanding about ways to implement relevant standards and practice guidelines related to culture workers.

Are there any disadvantages for me if I do not participate?

Reports of data arising from this study will not identify participants.

Participation in this study is voluntary. There are no disadvantages, penalties or adverse consequences if you choose not to participate.

Choosing not to participate or to withdraw from the study will not affect any future contact you have with the researcher, any organisations associated with the researcher, the University or any health or community-based organisations.

What if I have questions?

Questions regarding this project may be directed to Ms Susan McDonough or Associate Professor Virginia Lewis, School of Nursing and Midwifery, on t: 03 9479 3924.

What if I have a complaint?

If you have any complaints or concerns about your participation in the study that the researcher has not been able to answer to your satisfaction, you may contact the Senior Human Ethics Officer, Ethics and Integrity, Research Office, La Trobe University, Victoria, 3086 (t: 03 9479 1443 e: humanethics@latrobe.edu.au)

Please quote the application reference number:
SHE Human Ethics Sub-Committee (CHESC)
Reference No. S15/15.

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What if I decide to withdraw from the study?

Even though you have already expressed your interest in being contacted for interview by providing your contact details when you submitted the survey, you are free to change your mind and no longer wish to be interviewed.

You have the right to withdraw from active participation in this study at any time. This includes during and after the period in which interviews are conducted. If you no longer wish to be involved, please get in touch, as soon as possible, with Susan McDonough by email at: 97000188@students.latrobe.edu.au

You may request that data arising from your involvement in this study are not used in this research project provided that this right is exercised within four weeks of completion of your participation in the project. You are asked to complete the "Withdrawal of Consent Form" or to notify the researcher by email or telephone that you wish to withdraw your consent for your data to be used in this research project.

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Consent form

THE PERSPECTIVE OF WORKERS IN VICTORIA WHO ASSIST MEMBERS OF IMMIGRANT AND REFUGEE COMMUNITIES EXPERIENCING MENTAL HEALTH OR EMOTIONAL ISSUES

Investigator: Susan McDonough, Candidate for research higher degree, PhD
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email: 97000188@students.latrobe.edu.au

Supervisor: Associate Professor Virginia Lewis, College of Science, Health & Engineering (SHE), School of Nursing and Midwifery, Australian Institute of Primary Care and Ageing.

Co-supervisor: Dr Celia McMichael, College of Arts, Social Sciences and Commerce, School of Humanities and Social Sciences.

CSHE application reference number S15/15.

"I (the participant) have read (or, where appropriate, have had read to me) and understood the Participant Information Statement (Interviews) and Consent form, and any questions I have asked have been answered to my satisfaction.

I understand that even though I agree to be involved in this project, I can withdraw from the study at any time, and can withdraw my data up to four weeks following the completion of my participation in the research.

Further, in withdrawing from the study, I can request that no information from my involvement be used.

I agree that research data provided by me or with my permission during the project may be included in a thesis, presented at conferences and published in journals on the condition that neither my name nor any other identifying information is used.

I agree to my responses being published by La Trobe University in any format."

"I agree to audio recordings of interviews being taken."

☐ Yes
☐ No

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Name of Participant (block letters):

Signature:

Date: / /

Name of Investigator: MS SUSAN MCDONOUGH

Signature:

Date: / /

Name of Student Supervisor: ASSOCIATE PROFESSOR VIRGINIA LEWIS

Date: / /

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Appendix B Survey

Copy of Survey instrument

COLLEGE OF SCIENCE, HEALTH &
ENGINEERING

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LA TROBE UNIVERSITY

Victoria 3086 Australia

INTRODUCTION

Q 1

This survey is part of a study that aims to explore how people use their cultural knowledge and language skills to help individuals experiencing mental health issues who are of immigrant or refugee background. Our study is seeking the perspective of workers who are of similar cultural, linguistic or faith background to the people they assist.

This includes people who are employed by agencies or organisations to perform this type of role. It also includes people who are asked by agencies or organisations to help when needs arise.

Your participation in the study will remain anonymous and your responses will be un-identifiable.

Q 2.

To decide if you meet the criteria for participation in this study, please indicate (yes/ no) if:

- you are aged 18 years of over
- you work in Victoria
- you think of yourself as bilingual or bicultural
- you work (in a paid or unpaid role) to assist people experiencing mental health or emotional issues who are of immigrant or refugee background
- some of these people of similar culture or faith or speak the same language as you
- you are currently doing this kind of work or have you done so in the past 24 months?

(Answered 'yes' to **all** of these questions – go to Q 3.)

(Answered 'no' to one or more of these questions – go to Q 4. 'Exit the survey – criteria not met')

Q 3.

Yes, you qualify, thank you for your interest in taking part in this study.

This survey will take about 30 minutes to complete. It may take more or less time depending on how many jobs you decide to tell us about.

For more information about this study, please read the **participation information statement** (hyperlink)**.**

We advise that you keep a copy of the participation information statement for your own records. The statement is available as a pdf to print or download by clicking here. (hyperlink)
(Select ONE of the following)
☐I have read the participation information statement and I am willing to take part in the study (begin the survey, go to Q 5.)
☐I do not wish to participate (exit the survey - go to Q 4. below)

Q 4.

Thank you for considering taking part in this study. You have either chosen not to participate or do not meet all the criteria for participation.
OR
(Message if did not meet criteria)
Thank you for considering taking part in this study.
Your answer to the previous question indicates that you do not meet all the inclusion criteria for participation in this study.
If you are not sure if you meet the criteria, and would like to discuss, please email Susan McDonough e: 97000188@students.latrobe.edu.au

To close this page, click the EXIT THIS SURVEY button or just close your browser.
Yours sincerely,
Susan McDonough.

THE SURVEY

SOME IMPORTANT INFORMATION

Q 5.

There are many different ways to help people experiencing mental health and emotionally issues with whom you share a cultural, faith or language connection. Perhaps you are…

- Directly helping individuals and families as a community worker or clinician
- Advocating for, standing up for or speaking on behalf of individuals and families
- Improving understating between service users and other professionals
- Working on changing the ways services respond your ethnocultural community
- Helping your ethnocultural community find ways to cope with mental health issues

Here are some examples to keep in mind as you answer the survey questions.

Saada speaks several Horn of Africa languages. A number of families from African backgrounds attend the childcare centre where she works and some have been significantly affected by traumatic experiences. When she answers the survey questions, she **does** include dong ply therapy with these families under the guidance of a psychologist. She **does** include running staff discussions about issues affecting these families, such as settlement and intergenerational issues. She **does** include her other voluntary work, at a multicultural African association, where she runs a social media site for young people about wellbeing She **does not** include the time she spends helping families who are not experiencing mental health of emotional issues to fill out Centrelink forms or talk to housing officers.

Kham works in an inpatient mental health unit. He is of Southeast Asian background, belongs to a Buddhist community, speaks Lao and Thai languages and migrated to Australia with his family when he was of primary school age. When he answers the survey questions he **does** include meeting clients of South East Asian background and their families, early on in a hospital admission, offering them information and reassurance and helping them speak up if they have any concerns. He **does** include helping the hospital quality improvement manager to prepare service referral information that will be available at local temples. He **does not** include helping people of immigrant or refugee background who are of a difference cultural, faith or linguistic background to them who are admitted to the unit even though he empathises with some of their experiences, such as growing up in an immigrant family.

YOUR WORK

Q 6.

Please name the jobs that you have done within the past 24 months where you help people experiencing mental health or emotional issues who are of similar background to you.

We would like you to think about paid work and unpaid jogs that you do. Paid work includes having a casual, part-time or full-time job or being self-employed.
Unpaid work includes regularly or occasionally working on a volunteer basis for an organisation.

Please add the occupational of title of each job.
You can tell us about just one job or as many as four jobs if you like.

Job one *(text box)*
Job two *(text box)*
Job three *(text box)*
Job four *(text box)*

Q 7.

For each job, please

- Select whether it is a paid or unpaid role
- Select the type of industry or the business of the employer where you work or worked
- Add the name of the suburb, tow, or city where this organization or agency is located

Paid or unpaid?
☐Paid
☐Unpaid

Type of industry or the business of the employer where you work or worked
(Dropdown menu)

☐asylum seeker support service	☐justice system program or service e.g. a court or correctional service	☐residential support service for older persons
☐child health centre	☐local government diversity program	☐residential support service for people with other needs
☐community health centre	☐maternal child health service	☐settlement service for refugees
☐education provider e.g. a school or university	☐mental health service that provides clinical care	☐social support agency e.g. provider of housing assistance or financial counselling
☐emergency service, that is, fire, police or ambulance	☐mental health service that provides community support	☐specialist counselling service for survivors of torture and trauma
☐English language program provider for new arrivals	☐migrant resource centre	☐translating and interpreting service
☐ethnic or multicultural organisation	☐psychological counselling service	☐women's health centre
☐family or relationship counselling service	☐refugee health service	☐youth service
☐Health and Community Care (HACC) provided by local government or other agency	☐residential support service for people with mental health issues	☐other, please specify (open text)

Name of suburb, town or city name and postcode where job is located
The list will scroll when you click in the box and type the first letter of name or postcode.

(dropdown menu)

Q 8.
For each job please,

- Select how many hours you work or worked in this role in a typical week
- Select the length of time you spent working in this role
- Select how much of the role relates to helping people experiencing mental health of emotional issues who are of similar background to you

How many hours do you or did you work in this job in a typical week?
☐8 hours of less
☐9-16 hours
☐17-24 hours
☐25-32 hours
☐33-40 hours

How many months or years have you worked in this job?
☐5 months or less
☐6 to 11 months
☐1 year
☐2-3 years
☐4-5 years
☐6 years or more

How much of the job is focused on helping people experiencing mental health or emotional issues who are of similar background to you?
☐None (0%)
☐Very small (up to 20%)
☐Some (20-39%)
☐About half (40-59%)
☐Large (40-79%)
☐All or almost all (80-100%)

THE TYPES OF TASKS YOU DO

Q 9.
Think about ALL the jobs you currently do or have done in the past 24 months to assist people experiencing mental health or emotional issues who are of immigrant of refugee background and of similar cultural, fait, or linguistic background to you.

Do you do or have you done any of the following tasks?
Answer 'yes' or 'no' to each statement
If you're not sure, choose 'yes' and browse the list of tasks that appear under that statement.
Use the arrow at the bottom of the page to come back to this page and change your answer to 'no' if you wish

I directly help individuals and families experiencing mental health or emotional issues?	Yes	No
I advocate on behalf of people experiencing mental health or emotional issues? That is, ensure they are able to exercise their health or civil rights?		
I facilitate interactions between people experiencing mental health or emotional issues and other health professionals?		
I assist service providers and practitioners to be culturally sensitive?		
I assist ethnic, faith and multicultural groups or organisations to respond to mental health and emotional issues?		

I assist in other ways		

Q 10.

Directly helping individuals and families experiencing mental health issues who are of similar background to you.

Select ALL the ways you help.

	Yes	No
I provide information about services and make referrals		
I provide information about mental health, emotional issues and recovery		
I am the primary person responsible for providing someone with individualised assistance e.gs. therapy; or recovery support		
I work alongside other professionals to provide someone with individualised assistance e.gs. therapy; or recovery support		
I coordinate the services provided by other professionals		
I mediate conflict within families		
I do outreach to those at risk of developing problems e.gs. families in conflict; or people who seem isolated		
I directly assist in other ways. *Please specify*		

Q 11.

Advocating on behalf of people experiencing mental health or emotional issues who are of similar background to you.

Select ALL the ways you help.

	Yes	No
I help to ensure people get a good quality service e.gs. explain hospital admission procedures; or help someone make a complaint		
I assist individuals who are especially disempowered or vulnerable e.g. support a woman from a patriarchal community/ society to make choices		
I provide reports about individuals to courts or tribunals e.g. Mental Health Review Board, migration or refugee review tribunals		
I represent the interests of an ethnocultural group e.gs. make submissions to government enquiries; or talk to the media		
I advocate in other ways. *Please specify*		

Q 12.

Facilitating interactions between people experiencing mental health or emotional issues, who are of similar background to you, and other health professionals.

Select ALL the ways you help.

	Yes	No
I promote and facilitate contact with another professional e.gs. explain how a social worker can help; or attend an initial assessment with a case manager		
I interpret information from one language to another to ensure accurate and meaningful communication between the service user and professional, i.e. act as an *interpreter*		
I explain service user and professional perspectives to each other i.e. act as a *cultural intermediary*		
I build the relationship between a service user and health professional i.e. act as a *cultural mediator* e.g. discuss misunderstandings		
I advise health professionals about cultural issues related to mental health i.e. act as a *cultural consultant* e.g. help clarify a diagnosis		
I facilitate interactions between service users and professionals in other ways. *Please specify*		

Q 13.

Assisting service providers and practitioners to be culturally sensitive when people of similar background to you use services.

Select ALL the ways you help.

	Yes	No
I listen to health professional accounts of a person's issues and provide advice, i.e. provide secondary consultation		
I advise service provider organisations about ways to be more culturally responsive to an ethnocultural group		
I implement quality improvement programmes that target service-users from an ethnocultural		
I inform service providers about the perspectives and needs of an ethnocultural group		
I support service user (consumer) representatives from an ethnocultural group		
I mediate distrust or conflict between service providers and an ethnocultural group		
I educate a service provider's workforce about cultural issues through shared case-work, mentoring, workshops or education sessions		
I participate in partnerships and networks involving other services		
I assist service providers and practitioners in other ways. *Please specify*.		

Q 14.

Helping ethnic, faith and multicultural groups or organisations respond when people of similar background to you experience mental health issues.

Select ALL the ways you help.

I build relationships with community groups and organisations	Yes	No
I inform groups and organisations about how mental health services can help e.g. organise visits to services		
I advise groups and organisations about mental health issues, e.g. lead discussions that communicate positive messages about recovery		
I implement community-oriented programmes e.gs. provide health education sessions; connect ethnocultural groups with sporting clubs; or run a programme for children and parents		
I mediate disputes within ethnic, faith or multicultural groups or organisations		
I use mainstream or social media to discuss issues		
I assist these groups and organisations in other ways. *Please specify.*		

Q 15.

Helping people experiencing mental health or emotional issues, who are of similar background to you, in other ways.

Tell us about what you do in the boxes below.

(text boxes)

HOW YOU APPROACH YOUR WORK

Please think about ALL the jobs you currently do or have done in the past 24 months to assist people experiencing mental health issues or emotional issues (PeMH/EI).

Please choose a response to each statement based on how it applies to helping people who are of immigrant or refugee background and of similar cultural, linguistic or faith background to you.

Please indicate how much you disagree or agree with each of the following statements
The choices are:
strongly disagree
moderately disagree
slightly disagree
slightly agree
moderately agree
strongly agree
don't know

	Strongly DISAGREE	Moderately DISAGREE	Slightly DISAGREE	Slightly AGREE	Moderately AGREE	Strongly AGREE	Don't know/ Unsure
Q 16. When I do this work I...							
build trust with people experiences mental health or emotional issues (PeMH/EI)							
build trust between PeMH/EI and other professionals							
help PeMH/EI talk about stigma and negative beliefs about mental health issues							
help PeMH/EI get informal support from their ethnocultural or faith community							
help PeMH/EI learn about how mental health services can help							
help PeMH/EI connect with their own cultural traditions							
help PeMH/EI connect with other cultural groups and form wider social networks							
ensure PeMH/EI do not experience racism when using services							
ensure PeMH/EI are not disadvantaged when using services							
help create services that value pluralism							
help increase the diversity of the mental health workforce							
let service users know about the recommendations of other health professionals							
tell other professionals about the needs and concerns that PeMH/EI express							
facilitate two-way exchanges between PeMH/EI and other professionals							

	Strongly DISAGREE	Moderately DISAGREE	Slightly DISAGREE	Slightly AGREE	Moderately AGREE	Strongly AGREE	Don't know/ Unsure
Q 17. My work …							
makes service providers more culturally responsive							
improves the cultural competence of the mental health workforce							
supports my ethnocultural or faith community							
increases rates of mental health service use by PeMH/EI							
	Strongly DISAGREE	Moderately DISAGREE	Slightly DISAGREE	Slightly AGREE	Moderately AGREE	Strongly AGREE	Don't know/ Unsure
Q 18. I use knowledge and practices about mental health and recovery that come from ...							
Western bio-medicine and psychology							
the ethnocultural or faith-based traditions with which I identify							
the links between social context (e.gs. inequality, political oppression) and personal issues							

YOUR EXPERIENCE, OPPORTUNITIES FOR TRAINING, SUPPORT AND SUPERVISION, ISSUES & CONCERNS

Q 19.

What kinds of LIVED EXPERIENCE have you personally had that enables you to do this work? For example: child of immigrant partners, lived for a time in a refugee camp, grew up in a county that has colonised, aware of holocaust stories in my family
(open text)

Q 20.
What types of TRAINING have you done that helps you to this work? (Note we will ask you to name your qualifications later)
(text box)

Q 21.
What types of SUPPORT OR SUPERVISION do you receive or have you received that helps you do this work?
(text box)

Q 22.
What ISSUES ARISE when you do this work?
(text box)

Q 23.
What helps to RESOLVE ISSUES when they arise?
(text box)

Q 24.
Do you have ANY OTHER COMMENTS that you would like to make?*(text box)*

YOUR BACKGROUND AND QUALIFICATIONS

The rest of the survey asks questions about your background and qualifications.

Responses to these questions will help us identify the range of people who help improve the mental health and wellbeing of immigrant and refugee communities by drawing on their own cultural knowledge, language skills and personal and family experience of migration.

Q 25.
Please indicate your gender.
☐Female
☐Male
☐Other

Q 26.
Which category below includes your age?
☐18-29
☐30-39
☐40-49
☐50-59
☐60 or older

Q 27.
Were you **born in Australia or overseas**?
☐Australia
☐Overseas

Q 28.
In which country you were born?
Browse the list below and choose the country or add the name of the country.

☐China (excludes Taiwan and special administrative regions e.g. Hong Kong)
☐Croatia
☐Former Yugoslav Republic of Macedonia
Lebanon
☐Germany
☐Greece
☐Hong Kong
☐India
☐Italy
☐Lebanon
☐Malaysia
☐Malta
☐The Netherlands
☐New Zealand
☐Philippines
☐Poland
☐Serbia/ Montenegro (former Yugoslavia)
☐South Africa
☐Sri Lanka
☐Turkey
☐UK
☐Vietnam
☐Other country (please specify) *(text box)*

Q 29.
In what year did you first arrive in Australia to live for one year or more?
(drop down box)

Q 30.
Was your mother born in Australia or overseas?
☐Australia
☐Overseas

Q 31.
Was your father born in Australia or overseas?
☐Australia
☐Overseas

Q 32.
What is your ancestry.
Please select or specify ONE or TWO terms that best describe your ancestry.

☐Australian
☐Chinese
☐Croatian
☐Dutch
☐English
☐Filipino
☐German
☐Greek
☐Indian
☐Irish
☐Italian
☐Lebanese
☐Macedonian
☐Maltese
☐New Zealander
☐Polish
☐Scottish
☐Sinhalese
☐Turkish
☐Vietnamese
☐Other *(text box)*
☐Other *(text box)*

Q 33.
Do you speak a language or languages other than English?
☐No I only speak English
☐Yes

Q 34.
Which language or languages do you speak?
Please select ALL the languages that you speak

☐Arabic
☐Cantonese
☐Filipino/Tagalog
☐Greek
☐Hindi
☐Italian
☐Mandarin
☐Punjabi
☐Turkish
☐Vietnamese
☐Other *(text box)*
☐Other *(text box)*
☐Other *(text box)*
☐Other *(text box)*
☐Other *(text box)*

Q 35.
Do you speak this language or these languages at work?

	Yes	No
(List of languages selected in Q 34.)		

Q 36.
What is your religion?
Please select ONE option that best describes your religion.

☐Anglican (Church of England)
☐Baptist
☐Coptic Orthodox
☐Greek Orthodox
☐Lutheranism
☐Other Christian religion
☐Other Eastern Orthodox
☐Presbyterian and Reformed
☐Uniting Church
☐Western (Roman) Catholic
☐Buddhism
☐Hinduism
☐Islam
☐Judaism
☐Sikhism
☐Other *(text box)*
☐No religion

Q 37.
What is the highest level of education that you have completed?

☐Post-secondary Education (*go to qualifications Qs)*
☐Senior Secondary Education Year 11, 12 or equivalent
☐Junior Secondary Education Year 7, 8, 9, 10 or equivalent
☐Primary Education
☐Other, please specify *(text box)*

Q 38.
Have you gained higher qualifications in any field?
☐Yes
☐No

Q 39.
In what fields have you gained higher qualifications?
Please select ALL the fields that apply at ANY LEVEL, certificate, diploma, bachelor degree, graduate or postgraduate
☐Health, Psychology and Human Welfare
☐Social, Cultural and Political Studies
☐Education
☐Management and Commence
☐Other

Q 40.
What qualifications have you completed in HEALTH, PSYCHOLOGY or HUMAN WELFARE?
Use the list to SELECT ALL the areas of study that apply OR if it's not listed SPECIFY under 'other' and DRAG it into the qualification box.
Here is an example [image]
Drag at LEAST ONE area of study into the qualification box, or use the arrow button at the bottom of the page to go back to the question 'In what fields have you gained higher qualifications?' and change your selection if you wish.
If you hold more than one qualification in an area of study, drag it to the HIGHEST LEVEL.

- Certificate Level – I & II, III & IV Level
- Advanced Diploma and Diploma Level
- Bachelor Degree Level
- Graduate, Graduate Diploma, Graduate Certificate
- Postgraduate Degree Level – Master Degree, Doctoral Degree

	Certificate Level – I & II, III & IV Level	Advanced Diploma and Diploma Level	Bachelor Degree Level	Graduate, Graduate Diploma, Graduate Certificate	Postgraduate Degree Level – Master Degree, Doctoral Degree
Counselling					
Medical Studies					
Nursing					
Occupational Therapy					
Pharmacy					
Psychology					
Public Health					
Social Work					
Youth Work					
Acupuncture					
Massage Therapy					
Traditional Chinese Medicine					
Other Alternative/ Complementary Therapy *(text box)*					
Other *(text box)*					

Q 41.
What qualifications have you completed in SOCIAL, CULTURAL and POLITICAL STUDIES?
(instructions repeated as Q 40.)

	Certificate Level – I & II, III & IV Level	Advanced Diploma and Diploma Level	Bachelor Degree Level	Graduate, Graduate Diploma, Graduate Certificate	Postgraduate Degree Level – Master Degree, Doctoral Degree
Anthropology					
History					
Indigenous Studies					
Language and Literature					
Philosophy and Religious Studies					
Sociology					
Other *(text box)*					

Q 42.
What qualifications have you completed in EDUCATION
(instructions repeated as Q 40.)

	Certificate Level – I & II, III & IV Level	Advanced Diploma and Diploma Level	Bachelor Degree Level	Graduate, Graduate Diploma, Graduate Certificate	Postgraduate Degree Level – Master Degree, Doctoral Degree
Teacher					
Other *(text box)*					

Q 43.
What qualifications have you completed in MANAGEMENT AND COMMERCE?
(instructions repeated as Q 40.)

	Certificate Level – I & II, III & IV Level	Advanced Diploma and Diploma Level	Bachelor Degree Level	Graduate, Graduate Diploma, Graduate Certificate	Postgraduate Degree Level – Master Degree, Doctoral Degree
Business and Management					
Other *(text box)*					

Q 44.
What qualifications in OTHER FIELDS have you completed?
(instructions repeated as Q 40.)

	Certificate Level – I & II, III & IV Level	Advanced Diploma and Diploma Level	Bachelor Degree Level	Graduate, Graduate Diploma, Graduate Certificate	Postgraduate Degree Level – Master Degree, Doctoral Degree
Natural and Physical Sciences					
Information Technology					
Engineering and Related Technologies					
Architecture and Building					
Creative Arts					
Other Field *(text box)*					

INVITATION TO BE INTERVIEWED AND END OF SURVEY

Q 45.
Thank you for completing the survey.

The next phase of the study will involve interviewing workers to discsu their experience in more depth
☐ WOULD LIKE to be contact about being interviewed
☐ DON'T WANT to be contacted about being interviewed

Q 46.
Thank you for your interest in being contacted for an interview.

It will be a few months before we are ready to interview people, so feel free to get in touch with us again if any of your details change.
If you change your mind and no longer wish to be interviewed, please let us know as soon as possible. You can get in touch with Susan McDonough directly by email at:
97000188@students.latrobe.edu.au

Please also be aware that you may not be selected to take part in an interview if we have more volunteers than we are able to include in the study; however, we will try to be in touch with everyone who provides their contact details within the next few months. If you ARE contacted for an interview, all contact detail information will be removed from your participant data file once the interview has been completed. If you ARE NOT selected for an interview, all contact detail information will be removed from your participant data file.

Please provide your preferred contact details here and continue to the last screen to submit your survey

(Note, only the investigators will have access to this information)

Name *(text box)*
Address *(text box)*
Email address *(text box)*
Verify email address (text box)
Mobile phone *(text box)*
Landline (include area code)

Literature used in survey development

Table 22 Survey Questions: Sources Used to Develop Questions about Activities

Activities: General and specific task items
1. Directly help individuals and families experiencing mental health or emotional issues
1.1 provide information about services and make referrals (Australian Government (AG), 2013a; Bennegadi, Acklin-Kalil, & Larchanché, 2010; Brar-Josan & Yohani, 2014; CEH, 2008; CMY, 2011; Liu, 2013; Musser-Granski & Carrillo, 1997; NCCC, 2004; Owen & English, 2005)
1.2 provide information about mental health, emotional issues and recovery (AG, 2013a; Bennegadi et al., 2010; Brar-Josan & Yohani, 2014; CEH, 2008; Chao, Steffen, & Heiby, 2012; CMY, 2011; Musser-Granski & Carrillo, 1997; NCCC, 2004, Owen & English, 2005)
1.3 be the primary person responsible for providing someone with individualised assistance, e.gs. therapy; recovery support (Cabral & Smith, 2011; CEH, 2008; De Jong & Van Ommeron, 2005; Farsimadan, Khan, & Draghi-Lorenz, 2011; Nagayama Hall, 2001; Ito & Maramba, 2002; Karlsson, 2005; Kirmayer et al., 2003; Kokaliari, Catanzarite & Berzoff, 2013; McLeod, 2012; Owen & English, 2005; NCCC, 2004; Ton, Koike, Hales, Johnson, & Hilty, 2005; Verdinelli & Biever, 2009; Yohani, 2013; Zane et al., 2005).
1.4 work alongside other health professionals and services to provide someone with individualised assistance e.gs. therapy; recovery support (Al-Krenawi & Graham, 2001; Bennegadi et al., 2010; Brar-Josan & Yohani, 2014; CEH, 2008; CMY, 2011; Kirmayer et al., 2003; McKinney, 2017; Miklavcic & LeBlanc, 2014; NCCC, 2004; Owen & English, 2005; Ton et al., 2005)
1.5 coordinate services provided by other professionals or programs (AG, 2013a; Liu, 2013)
1.6 mediate conflict within families (Al-Krenawi & Graham, 2001; Budman, Lipson, & Meleis, 1992; CMY, 2011; Yohani, 2013)
1.7 do outreach to those at risk of developing problems e.gs. families in conflict; people who seem isolated (Brar-Josan & Yohani, 2014; De Santis & Ugarriza, 1995; Liu, 2013, Musser-Granski & Carrillo, 1997; Owen & English, 2005)
2. Advocate on behalf of people experiencing mental health or emotional issues, that is, ensure they are able to exercise their health or civil rights
2.1 help ensure people get a good quality service e.gs. explain a hospital admission procedures; help someone make a complaint (AG, 2013a; Bennegadi et al., 2010; CMY, 2011; Dysart-Gale, 2007; Jezewski & Sotnik, 2001; Miklavcic & LeBlanc, 2014; NCCC, 2004)
2.2 assist individuals who are especially disempowered or vulnerable e.g. support a woman from a patriarchal community/ society to make choices (AG, 2013a; Al-Krenawi & Graham, 2001; Bennegadi et al., 2010; CMY, 2011; Liu, 2013; Nagayama Hall, 2001; NCCC, 2004; Owen & English, 2005; Yohani, 2013)
2.3 provide a report about an individual to a court hearing or tribunal e.g. Mental Health Review Board, migration or refugee review tribunals (VTMH, 2014*)
2.4 represent the interests of an ethnocultural group e.gs. make submissions to government enquiries; talk to the media (VTMH, 2014*)

Activities: General and specific task items (cont.)
3. Facilitate interactions between people experiencing mental health or emotional issues and other health professionals
3.1 promote and facilitate contact with another professional e.gs. explain how a social worker can help; attend an initial assessment with a case manager (Al-Krenawi & Graham, 2001; Bennegadi et al., 2010; Brar-Josan & Yohani, 2014; Carers Victoria, 2010c; CEH, 2008; CMY, 2011; McKinney, 2017; Miklavcic & LeBlanc, 2014; NCCC, 2004; Owen & English, 2005; Yohani, 2013)
3.2 interpret information from one language to another to ensure accurate and meaningful communication between the service user and professional, i.e. be an *interpreter* (Bennegadi et al., 2010; Bischoff & Dahinden, 2008; Cabral & Smith, 2011; Czwartos & Worthington, 2011; CEH, 2008; CMY, 2011; Dysart-Gale, 2007; Farsimadan et al., 2011; Karlsson, 2005; McKinney, 2017; Miklavcic & LeBlanc, 2014; NCCC, 2004; Owen & English, 2005; Ton et al., 2005; Yohani, 2013)
3.3 explain service user and professional perspectives to each other i.e. be a *cultural intermediary* (Bennegadi et al., 2010; Bischoff & Dahinden, 2008; Budman et al., 1992; Butow et al., 2012; Jezewski & Sotnik, 2001; McKinney, 2017; Miklavcic & LeBlanc 2014; NCCC, 2004; Owen & English, 2005; Ton et al., 2005)
3.4 build the relationship between service user and health professional i.e. be a *cultural mediator* e.g. discuss misunderstanding (Bennegadi et al., 2010; Brar-Josan & Yohani, 2014; Jezewski & Sotnik, 2001; Miklavcic & LeBlanc, 2014; NCCC, 2004; Owen & English, 2005; Ton et al., 2005)
3.5 advise health professionals about cultural issues related to mental health i.e. be a *cultural consultant* e.g. help clarify a diagnosis (AG, 2013a; Al-Krenawi & Graham, 2001; Bennegadi et al., 2010; Bischoff & Dahinden, 2008; Boss-Prieto, de Roten, Elghezouani, Madera, & Despland, 2010; Brar-Josan & Yohani, 2014; Budman et al., 1992; Chaudhry, Husain, Chaudhry, & Husain, 2010; De Jong & Van Ommeron, 2005; Miklavcic & LeBlanc 2014; NCCC, 2004; Owen & English, 2005; Ton et al., 2005)
4. Assist service provider organisations to use culturally sensitive principles, values and practices in their work
4.1 listen to a health professional's account of a person's issues and provide advice, i.e. provide secondary consultation (AG, 2013a; Kirmayer et al., 2003; Miklavcic & LeBlanc, 2014)
4.2 advise a service provider organisation about ways to be more culturally responsive to an ethnocultural group (CMY, 2011; Jezewski & Sotnik, 2001; Kirmayer et al., 2003; NCCC, 2004)
4.3 implement quality improvement programs that target an ethnocultural group of service-users (AG, 2013a; CMY, 2011; NCCC, 2004)
4.4 inform a service provider about the perspectives and needs of an ethnocultural group (Brar-Josan & Yohani, 2014; CMY, 2011; NCCC, 2004)
4.5 support service user (consumer) representatives from an ethnocultural group (AG, 2013a)
4.6 mediate distrust or conflict between a service provider and an ethnocultural group (CMY, 2011; NCCC, 2004)

Activities: General and specific task items (cont.)
4. Assist service provider organisations to use culturally sensitive principles, values and practices in their work (cont.)
4.7 educate a service organisation's workforce about cultural issues through shared case-work, mentoring, workshops or education sessions (AG, 2013a; Al-Krenawi & Graham, 2001; CMY, 2011; NCCC, 2004; Ton et al., 2005)
participate in partnerships and networks involving other services (AG, 2013a; NCCC, 2004)
5. Assist ethnic, faith and multicultural groups or organisations to respond to mental health and emotional issues
5.1 build relationships with community groups and organisations (AG, 2013a; Brar-Josan & Yohani, 2014; CMY, 2011; Musser-Granski & Carrillo, 1997; NCCC, 2004)
5.2 inform groups and organisations about mental health services e.g. organise visits to services (Brar-Josan & Yohani, 2014; CMY, 2011; Musser-Granski, & Carrillo 1997; NCCC, 2004)
5.3 advise groups and organisations about mental health issues and recovery, e.g. lead discussions that communicate positive messages about recovery (AG 2013a; Brar-Josan & Yohani, 2014; CMY, 2011; NCCC, 2004)
5.4 implement community-oriented programs e.gs. provide health education sessions; connect ethnocultural groups with sporting clubs; run a program for children and parents (Brar-Josan & Yohani, 2014; Corkery et al., 1997; CMY, 2011; De Santis & Ugarriza, 1995; Han, Cao, & Anton, 2015; NCCC, 2004; Yohani, 2013)
5.5 mediate disputes within ethnic, faith or multicultural groups or organisations (Bennegadi et al., 2010; De Santis & Ugarriza, 1995; Han et al., 2015)
5.6 use mainstream or social media to discuss issues (VTMH 2014*)

Notes. * informal discussion with VTMH team. Australian Government (AG); Centre for Culture Ethnicity and Health, Australia (CEH); Centre for Multicultural Youth, Australia (CMY); National Center for Cultural Competence, (NCCC) USA.

Table 23 Survey Questions: Sources Used to Develop Statements about Cultural Responsiveness

Cultural responsiveness: Approach, belief and knowledge statements
1. When I do this work I aim to build trust with PeMH/EI (Cabral & Smith, 2011; AG, 2013a; CMY, 2011; Farsimadan et al., 2011; Nagayama Hall, 2001; Karlsson, 2005; Kokaliari et al., 2013; McKinney, 2007; McLeod, 2012; Miklavcic, & LeBlanc, 2014; NCCC, 2014; Owen & English, 2005; Zane et al., 2005)
2. When I do this work I aim to build trust between PeMH/EI and other professionals (Bennegadi et al., 2010; Brar-Josan & Yohani, 2014; CMY, 2011; Miklavcic & LeBlanc, 2014; NCCC, 2004; Owen & English, 2005; Ton et al., 2005; Yohani, 2013)
3. When I do this work I aim to help PeMH/EI talk about stigma and negative beliefs about mental health issues (AG, 2013a; McKinney, 2007)
4. When I do this work I aim to help PeMH/EI get informal support from their ethnocultural or faith community (CMY, 2011; AG, 2013a; NCCC, 2014; Owen & English, 2005)
5. When I do this work I aim to help PeMH/EI learn how mental health services can help (CEH, 2008; CMY, 2011; NCCC, 2014; Yohani, 2013)
6. When I do this work I aim to help PeMH/EI connect with their own cultural traditions (Berry, 2007; CMY, 2011; NCCC, 2014; Owen & English, 2005)
7. When I do this work I aim to help PeMH/EI connect with other cultural groups and form wider social networks (Bennegadi et al., 2010; Berry, 2007; CMY, 2011; Yohani, 2013)
8. When I do this work I aim to ensure PeMH/EI do not experience racism when using services (Cabral & Smith, 2011; Hall, 2001; Miklavcic & LeBlanc 2014)
9. When I do this work I aim to ensure PeMH/EI are not disadvantaged when using services (Bennegadi et al., 2010; Bischoff, & Dahinden, 2008; Cabral & Smith, 2011; CEH, 2008; AG, 2013a; CMY, 2011; Farsimadan et al., 2011; Nagayama Hall, 2001; NCCC, 2014; Yohani, 2013)
10. When I do this work I aim to help create services that value pluralism (Bischoff & Dahinden, 2008; CMY, 2011; McLeod, 2012; NCCC, 2014)
11. When I do this work I aim to help increase the diversity of the mental health workforce (AG, 2013a; CMY, 2011; NCCC, 2014)
12. When I do this work I aim to let service users know about the recommendations of other health professionals (Miklavcic & LeBlanc, 2014; Owen & English, 2005; Ton et al., 2005)
13. When I do this work I aim to tell other professionals about the needs and concerns that PeMH/EI express (AG, 2013a; Miklavcic & LeBlanc, 2014; Owen & English, 2005; Ton et al., 2005)
14. When I do this work I aim to facilitate two-way exchanges between PeMH/EI and other professionals (Budman et al., 1992; CEH, 2008; CMY, 2011; Miklavcic & LeBlanc, 2014; NCCC, 2014; Owen & English, 2005)

Cultural responsiveness: Approach, belief and knowledge statements (cont.)
15. I believe that my work makes service providers more culturally responsive (Bennegadi et al., 2010; CEH, 2008; CMY, 2011; English & Owen, 2005; Nagayama Hall, 2001; Karlsson, 2005; McKinney, 2007; Miklavcic & LeBlanc, 2014; NCCC, 2004; Ton et al., 2005; Zane et al., 2005)
16. I believe that my work improves the cultural competence of other workers and professionals (AG, 2013a; CMY, 2011; Miklavcic & LeBlanc, 2014; NCCC, 2004; Owen & English, 2005; Ton et al., 2005)
17. I believe that my work supports my ethnocultural or faith community (Bennegadi et al., 2010; CMY, 2011; NCCC 2004)
18. I believe that my work increases rates of mental health service use by PeMH/EI Bennegadi et al., 2010; Cabral & Smith, 2011; CEH, 2008; CMY, 2011; Farsimadan et al., 2011; Flaskerud & Liu, 1991; McKinney, 2007; NCCC 2004)
19. I use knowledge and practices about mental health and/ recovery that come from my understanding of Western bio-medicine and psychology (CEH, 2008; CMY, 2011; Miklavcic & LeBlanc, 2014; NCCC 2004; Owen & English, 2005)
20. I use knowledge and practices about mental health and/ recovery that come from my understanding of the ethnocultural or faith-based traditions with which I identify Bennegadi et al., 2010; CMY, 2011; Miklavcic & LeBlanc, 2014; NCCC, 2004; Owen & English, 2005; Ton et al., 2005)
21. I use knowledge and practices about mental health and/ recovery that come from my understanding of the links between social context and personal issues (Bennegadi et al., 2010; CMY, 2011; NCCC, 2004)

Notes. Australian Government (AG); Centre for Culture Ethnicity and Health, Australia (CEH); Centre for Multicultural Youth, Australia (CMY); and National Center for Cultural Competence, (NCCC) USA.

Table 24 Outline of Survey Data Items

	Survey question	Data item		Item type, analysis, value	Transformed data item	Item type, analysis, value or theme
Personal and professional characteristics	Q 25.	1	*Gender*: 'Male'; 'Female'; or 'Other',	Nominal: Frequencies, gender.		
	Q 26.	2	*Age*: Age in years.	Continuous: M and Range, age in years.	*Age groups*: 'Less than 25 years'; '26 to 35 years'; '36 to 45 years'; '46 to 55 years'; '56 to 65 years'; and '66 to 75 years'.	Ordinal: Frequencies, 6 age groups.
	Q 27.	3	*Australian born*: 'Australia'; 'Overseas'	Nominal: Frequency, 'Australian born'; or 'Overseas born'.		
	Q 30.	4	*Mother's birth*: 'Australia'; 'Overseas'	Nominal: Frequency, 'Australian born'; or 'Overseas born'.		
	Q 31.	5	*Father's birth*: 'Australia'; 'Overseas'	Nominal: Frequency, 'Australian born'; or 'Overseas born'.		
	Q 29.	6	*Years living in Australia*: Number. Year first arrived	Continuous: Mean and Range, time in years.	*Time period living in Australia*: '1 to 10 years'; '11 to 20 years'; '21 to 30 years'; '31 to 40 years'; '41 to 50 years'; and '51 to 60 years'.	Ordinal: Frequencies, 6 time period groups.
	Q 28.	7	*Country of birth* (COB): Country names	Nominal: Frequency, COB	*Region of birth*: 'Oceania'; 'North Africa and the Middle East'; 'North-East Asia'; 'Sub-Saharan Africa'; 'Southern and Central Asia'; 'Southern & Eastern Europe'; 'South-East Asia'; 'Americas'; and 'North-West Europe'.	Nominal: Frequency, Region of birth.

	Q 32.	8	*Ancestries*: Ancestry names, narrowly defined.	Nominal: Frequencies, ancestries, narrowly defined.	*Ancestry regions*: 'European (so described)'; 'North African and the Middle Eastern'; 'North-East Asian'; 'North-West European'; 'Oceanian'; 'Sub-Saharan African'; 'South-East Asian'; 'Southern & Central Asian'; and 'Southern & Eastern Europe'.	Nominal: Frequencies, ancestry broadly defined by regions.
	Q 33. to Q 35.	9	a) *Language other than English (LOTE) spoken capability*: 'no other language spoken'; 'other language spoken but not at work'; and 'other language spoken at work'. b) *Names of (LOTE)* spoken.	Nominal: Frequencies, speakers' capabilities. Discrete: Count of languages.	*Names of language regions*: 'Eastern Asian Languages'; 'Eastern European Languages'; Northern European Languages'; 'Other Languages (African)'; 'Southern Asian Languages'; 'Southern European Languages'; 'Southeast Asian Languages'; and 'Southwest and Central Asian Languages'	Discrete: Count of language regions.
	Q 36.	10	*Religious affiliation*: Religious tradition names	Nominal: Frequencies, religious affiliations.	*Religious affiliations grouped*: 'Christian'; and 'non-Christian'.	Nominal: Frequencies, grouped affiliations.

	Q 37. to Q 44.	11	a) *Level of education* *b) Qualification levels.* c) *Qualification fields, general and specific.*	Nominal: Frequencies, general fields. Ordinal: Frequencies, levels.		
Culture work position Characteristics	Q 6.	12	*Position type*: Coded based on open text. 19 position types identified.	Nominal: Frequencies, position types	*Position type, 5 groups* 'Practitioner, not specified as counsellor, discipline specified'; 'Practitioner, not specified as counsellor, discipline unspecified'; 'Practitioner, counsellor and/or advocate role'; 'Community leader, educator and development role'; and 'Mental health sector leaders or advisor' *Position type group* 'All practitioner roles'; and 'All lead and advisory positions'.	Nominal: Frequencies, position type, 5 groups Nominal: Frequencies, position type, 2 groups

	Q 7.	13	*Industry type:* 22 industry work settings.	Nominal: Frequencies, position types.	*Industry type, 6 groups:* 'Mental health service or agency'; 'Migrant, refugee or asylum seeker support agency'; 'Health centre'; 'Counselling service'; 'Social support agency'; and 'Education provider' *Industry type, 2 groups:* 'All mental health agencies'; and 'All other'.	Nominal: Frequencies, position type, 6 groups Nominal: Frequencies, position type, 2 groups.
	Q 7.	14	*Employment status:* 'Paid'; 'Unpaid'.	Nominal: Frequencies, employment status.		
	Q 7.	15	*Geographical area types*: Coded based on post codes of suburbs 'Metropolitan'; 'Rural'; 'State-wide'; 'National'; 'Off-shore detention'	Nominal: Frequencies, geographical area.		
	Q 8.	16	*Typical hours worked per week:* Number.	Continuous: M and Range, hours in week.	*Typical hours worked, time periods*: '1 to 5 hours'; '6 to 10 hours'; '11 to 15 hours'; '16 to 20 hours'; '21 to 25 hours'; '26 to 30 hours'; '31 to 35 hours'; and '36 to 40 hours'	Ordinal: Frequencies, 8 time period groups.

	Q 8.	17	*Years of experience, time periods*: '5 months or less'; '6-11 months'; '1 year'; '2 years'; '3 years'; '4 years'; '5 years'; '6 years'; '7 years'; '8 years'; '9 years'; '10 years or more'	Ordinal: Frequencies, 12 time periods.	*Years of experience, time periods*: 'up to 2 years'; 'between 3 and 9 years'; and '10 years or more'	Ordinal: Frequencies, 3 time periods.
	Q 8.	18	*Culture work focus as proportion of the position*: 'Very small amount (less than 20%)'; 'Some (20-39%)'; 'About half (40-59%)'; 'Large amount (60-79%)'; or 'All or almost all (80-100%)'.	Ordinal: Frequencies, proportion of culture work focus.		
Features of culture work tasks	Q 9.	19	*General tasks*: general tasks.	Nominal: Frequencies, 5 general tasks.		Pearson's Correlations, relationships and strong relationships between general tasks.
	Q 10. to Q 15.	20	*Specific tasks:* specific tasks.	Nominal: Frequencies, 32 specific tasks.		Pearson's Correlations, relationships and strong relationships between specific tasks. Mapping of strong relationships.

Perspectives on culture work	Q 16. to Q 18.	21	*Statements about culture work*: approaches, impacts, relevant knowledge, levels of agreement.	Ordinal: Frequencies, 6 levels of agreement.		Pearson's Correlations: relationships and strong relationships between responses to statements. Mapping of strong relationships.
Training, supervision and support as enablers of culture work	Q 20.	22	*Training availability.*	Text comments, thematic analysis.	*Training available, 'yes'; or 'no'.*	Nominal: Frequencies, training availability.
	Q 21.	23	*Supervision and/or informal support availability.*	Text comments, thematic analysis.	*Supervision and/or informal support 'yes'; or 'no'.*	Nominal: Frequencies, supervision and/or informal support availability.
Lived experience, work issues, ways of resolving issues, and other comments	Q 19.	24	*Lived experience.*	Text comments, thematic analysis, GTM coding.		
	Q 22.	25	*Issues that arise.*	Text comments, thematic analysis, GTM coding.		
	Q 23.	26	*Ways of resolving issues.*	Text comments, thematic analysis, GTM coding.		
	Q 24.	27	Any other comments.	Text comments, thematic analysis, GTM coding.		

Appendix C Interview questions

Schedule of questions (set one)

As you know, I am looking at how people use their cultural or faith background or language skills when helping people are experiencing mental health issues or facing any kind of emotional issue who are from a similar background to them.

Opening questions

[If needed to clarify any survey responses provided by particular individual] I know some things about you and your work from your answers to the survey, could you explain some more about...

How did you come to be doing this kind of work?
[Explore links between lived experience, ethical dimensions and work role e.g. expressing self-belief, commitment, and motivations]

About the work

In the survey, you mentioned that you do [these] kinds of jobs in [these] kinds of settings…

Can you tell me a bit more about where you do this work?

What kinds of work do you do there?

Approaches, beliefs about consequences, knowledge paradigms

What sorts of things do you think about/ do you think are important to think about when you do this kind of work?

[Note beliefs that seem important to worker, paradigms of knowledge that they draw on, using past experiences, using elements of language or culture]

Issues for workers

What sorts of issues come up <u>for you</u> when doing this work?

Could you think about what happens when [issue] arises?

Would you be able to give an example of [a challenging situation] and how it worked out?

Who, if anyone, have you talked to about these issues?

What has helped you do this kind of work?

What has hindered you in doing this kind of work?

What has changed, if anything, since you started doing this kind of work?

Closing questions

How do you think your work makes a difference to others [individuals, families, other members of the community, co-workers, organization, etc.]?

Would you be able to give an example?

Is there something else you would like to say?

If it's OK, could you tell me a bit about what it's been like for you being involved in this study?

Is there something you would like to ask me?

Schedule of questions (set two)

As you know, I am looking at how people use their cultural or faith background or language skills when helping people are experiencing mental health issues or facing any kind of emotional issue who are from a similar background to them.

Opening questions

[If needed to clarify any survey responses provided by particular individual] I know some things about you and your work from your answers to the survey, could you explain some more about...

How did you come to be doing this kind of work?
[Explore links between lived experience, ethical dimensions and work role e.g. expressing self-belief, commitment, and motivations]

Could you consider how you might be aiming to make a difference in the lives of others by performing your role?

Who do you try to help or influence (e.g. clients/ families, community, co-workers, service more broadly, society more broadly)? In what ways?

What issues come up for you in trying to have an impact on or influence others?

Which individuals or groups are particularly challenging to work with?

What frameworks or theories about change do you have in mind?

[E.g. mental health recovery, mental health early intervention, rights-based approach to health care, multicultural access and equity framework, structural/ social determinates of disadvantage, community development principles]

How does your cultural background or life experiences or family history come up when you perform your role?

What issues come up for you in deciding what to disclose about yourself to others? to service users, community members, co-workers?

What aspects of yourself do you tend to share with others? In general, which aspects do you prefer to not openly discuss?

How do you let others know that you have a background or experiences in common?

What issues come up for you in working with people who strongly identify with you?

How do you use your background and life experiences – e.g. intuitively to sense what's important to others, to elicit others' stories, to offer life lessons, as source of insider knowledge

How do you adapt the way that you work? Do you use other knowledge and practices? Do you avoid certain practices and approaches?

I've learnt from other culture workers that they are aware of speaking in particular ways, acting in certain ways when encountering people of similar background to them in a work role. Does this ring true for you?

What kinds of things do you say or do to connect with the other person

How do these kinds of encounters help the other person? You?

Do they present any risks for the other person? You?

How aware are you of getting close to or keeping some distance between yourself and others? Some people talk of "keeping boundaries" or "negotiating boundaries" between your personal life and what others know about you, or where work role and community

expectations overlap. Do these things come up? Do they concern you? How do you resolve these issues?

How do your encounters with others influence the way they encounter the world? e.g. their sense of being an insider/ outsider or belonging.

How would you describe the atmosphere in which these encounters happen? e.g. "safe-space", reminder of home.

> *How do you think others – such as clients, colleagues, or community members – see you when you are performing your role? What do you think you performing your role means to others?*

Describe ways you have extended your role? e.g. – mentoring others, leadership role, spokesperson, other.

Consider ways in which you may represent something new, unexpected and positive?– e.g. consider when you have inspired others to think or act differently.

Consider times when you have been a target for others' negativity, fear or rejection– e.g. disapproval from community members, racial abuse from service users or micro-aggressions by co-workers. Discuss.

> *Closing*

Is there something else you would like to say?

If it's OK, could you tell me a bit about what it's been like for you being involved in this study?

Is there something you would like to ask me?

Schedule of questions (set three)

As you know, I am looking at how people use their cultural or faith background or language skills when helping people are experiencing mental health issues or facing any kind of emotional issue who are from a similar background to them.

Opening questions

[If needed to clarify any survey responses provided by particular individual] I know some things about you and your work from your answers to the survey, could you explain some more about...

How did you come to be doing this kind of work?
[Explore links between lived experience, ethical dimensions and work role e.g. expressing self-belief, commitment, and motivations]

Discuss explanations provided so far

In speaking with other workers so far, they have raised some themes that I'd like to share with you so I can hear your views on these as well [Discuss each in turn, using these open-ended prompts.]

Does the idea of "wanting to make a difference" resonate with you? How would you describe the ethical dimensions of your work?

Do you/ how do you use your personal or family story or experiences when working with others?

When might you use a shared language, kinship forms of address, and cultural or spiritual practices? How do you use your 'insider' knowledge or perspective?

What sense do you have of how others see you and the work you do? Supervisors? Colleagues? Clients? Community members who may also know you informally?

What tensions come up for you when doing this work?

Closing

Is there something else you would like to say?

If it's OK, could you tell me a bit about what it's been like for you being involved in this study?

Is there something you would like to ask me?

Appendix D Codes

Table 25 Overview of Initial and Intermediate Codes, and Categories

Analysis	Sample of themes and initial and intermediate codes	Abstract codes	Category and relational statements
		Situational features	
(A) (B)		Addressing needs Acting in solidarity Enabling exchange Adjusting services Extending reach	*What bicultural professionals do and the responsibilities they assume* Culturally-oriented activities and responsibilities are integrated into the formal positions that they hold
(C)	Starting out in migrant services Moving to mainstream service provider Working across sectors Health qualified then cultural interest piqued Stepping into a new field Tertiary qualification and career Designated position Known by peers to have an interest Volunteering Caring for self Managing tensions Appreciating allies Feeling unsupported at work Being self-reliant Seeking support elsewhere	Career trajectories, designations, professional development themes	*Ways of becoming bicultural professionals* Bicultural professionals follow common career trajectories, are appointed to positions that (variably) acknowledge their cultural expertise that is enhanced by training, supervision and support

Analysis	Sample of themes and initial and intermediate codes	Abstract codes	Category and relational statements
	Situational features (cont.)		
(A) (C) (D)	Positions Qualifications Visibility Reputation Having insider knowledge Sharing past experiences Providing advice based on 'insider' knowledge Language skills Using influence to effect change, Creating links and forming relationships Smoothing referral pathways Harnessing additional resources Feeling capable Feel useful when others show appreciation Realising the organisation doesn't care Keeping quiet Persisting Invalidating 'migration' experiences Underestimated by others Validating the efforts of others Being treated differently by peers Aggression from others at work Being racially attacked Feeling physically ill Expecting a repeat Wanting it to be over Feeling set apart from my peer Being judged by others Sensing myself dissociate Dreading the gaze of others Learning to cope Drawing on all my resources Learning to live with it	Formal service settings and community perspectives Respected Recognised Minimised Disregarded Devalued Underestimated Verbally Abused Being strategic Negotiating	*Getting recognised by doing bicultural professionals work* The work of bicultural professionals is amplified or undermined by the extent to which that service users, professional peers and wider society recognises or diminish them and their work

Analysis	Sample of themes and initial and intermediate codes	Abstract codes	Category and relational statements
		Situational features (cont.)	
(A) (C) (D)	Psychotherapy Counselling Inpatient care Community recovery Employment counselling Couples counselling Settlement support Community outreach Psychoeducation Youth work Clinical outpatient care	Mental health frameworks	*Locating bicultural professional practice in mental health and related sectors* Bicultural professionals work in settings that use established mental health frameworks, have their own local social worlds
	Education providers Migrant or refugee agencies Counselling agency/ private practice Mental health service Primary health care Social support agency Local government Other agencies and groups	Service settings and networks	
	Identifying service provision limitations Recommending service reforms		
(A) (B)	Cultural responsiveness Feminism Post-colonialism Faith traditions Language and meaning Policies, standards and guidelines Seeing cultural and social aspects of individuals' issues	Seeing diversity Ensuring safety Using culture Exchanging information Linking with communities Promoting mental health	*Responsive approaches* There is consensus among bicultural professionals regarding broad cultural responsiveness principles
(D)		Professionalism Specialisation Line supervision and training Workforce diversity	*Bicultural professionals in mental health discourses* The discourses that regulate bicultural professionals and their practice is evident in research and service texts

Analysis	Sample of themes and initial and intermediate codes	Abstract codes	Category and relational statements
	Culture-oriented practice – practice pathways		
(C) (D)	Conveying hope Drawing a line Discouraging 'whinging' We are close but far apart Allowing people do things their own way Noticing distress Taking a pragmatic approach She wants to be me Offering opportunities Being ambitious	Establishing boundaries	*Culture-oriented practice pathways* Emerge from human capacities within ecosystems. These are ways in which professionals embody practices and relate to others. They exist within and influence three social domains - health and wellbeing of individuals and groups; responses of organisations and other professionals; and service provider 'cultures' and wider society
(C) (D)	Evoking kin Offering safety It takes a village Getting exhausted Taking it all on Starting something new Envisioning Knowing what to expect Politically engaged	Creating safe worlds	
(C) (D)	Restoring my soul Leaving violence behind Turning toward peace Feeling homesick Exploring family relationships Wanting to belong Actualising Finding acceptance Connecting back Locating self	Guiding returns	

Analysis	Sample of themes and initial and intermediate codes	Abstract codes	Category and relational statements
	Culture-oriented practice – generated by dispositions		
(C) (D)	Seeing a horizon of opportunities Enjoying dialogue with others Seeing new perspectives Having a strong interest Responding deftly Choosing freely 'Going freelance'	Seeking freedom	*Ethical dispositions to culture-oriented practice* Professionals aim to perform roles at work in ways that express who they fully are, and acknowledge their relationships with others They spoke of seeking the freedom at work to meet the obligations they believe they have toward others
(C) (D)	Wanting to make a difference 'Stepping into the fray' Showing solidarity with service users Being all things to everyone Adjusting approaches Negotiating changes to service rules Affirming human dignity Wanting justice	Meeting obligations	

Analysis	Sample of themes and initial and intermediate codes	Abstract codes	Category and relational statements
	Culture-oriented practices – in service encounters		
(C) (D)	Relating human-to-human Being open and transparent Putting formalities aside Taking a pragmatic approach Creating safety Providing reassurance Listening attentively Paying due regard Using a LOTE	Having conversations	*Relational practices* They were using "being with", bonding and belonging practices: creating trust, awareness of proximity and distance.
(C) (D)	Evoking kin and safety Using kinship terms and structures Using faith rituals Sharing a religious world view Using a shared language Using unifying words and gestures Using LOTE to increase intimacy Imparting healing	Building rapport	
(C) (D)	Conveying hope Using meaningful self-disclosure Weighing up the costs and benefits (not) using own stories to impress Ways of knowing and not knowing Being aware of time passing Using stories to validate Using stories to motivate Teaching life lessons Showing alternatives Discouraging 'whinging' Acknowledging reality Making plans Mentoring and coaching Noticing common themes	Sharing experiences and stories	

Note: Types of analyses used: (A) Quantitative analysis - survey closed questions; (B) Exploring structures in the quantitative data; (C) Qualitative cGTM analysis; and (D) Situational and discourse analyses.

Table 26 Overview of Categories and Sub-categories

Category	Subcategories and their qualities
Situational features	
The work that bicultural professionals do Their culturally-oriented activities, have strategic purpose. The perform roles.	*Layers of related activities, strategies and roles* The strategies are Addressing needs Expressing solidarity Enabling flow and exchange Adjusting services Extending reach
Ways of organising bicultural professionals Bicultural professionals follow common career trajectories, are appointed to positions that (variably) acknowledge their cultural expertise and have varying access to supervision, informal support and training.	*Two main career pathways taken by bicultural professional* From migrant service to 'mainstream' From mainstream positions to cultural or diversity focus *Designations* Specified in position title Common knowledge within organisation Privately held knowledge *Forms of professional development and support for bicultural professionals* Training Supervision Informal support
Getting recognised for bicultural work and practices The work of bicultural professionals is amplified or undermined by the extent to which service users, professional peers and wider society recognises or diminish them and their work	*Forms and fields of recognition at play for bicultural professionals* Economic capital – qualifications and field of expertise Cultural capital at work – facilitate transactions Cultural capital in community – relationships *Ways of experiencing disregard* Agency not caring enough (neglected) Invalidating experiences (minimised) Spotlight on difference (exposed) *Responding to disregard* Speaking up (explaining) Digging in (persisting) Staying out of view (being covert) Finding another place (leaving) *Experiencing exclusion and racism* *Responding to exclusion and racism* Internalise or share the responsibility Focus on immediate concerns Model endurance

Category	Subcategories and their qualities
Situational features (cont.)	
Locating bicultural professional practice in service settings Bicultural professionals work in settings that use established mental health frameworks, have their own local social worlds	*The mental health frameworks that bicultural professionals utilise* Clinical and psychosocial interventions Providing psychosocial support Counselling Community engagement and development *The local worlds of bicultural professionals include* Organisations Communities The networks between agencies and sectors
Bicultural professionals in mental health discourses The discourses that shape recognition of bicultural professionals is evident in research and service texts	*Discourses about bicultural professionals express four concerns* Legitimacy Importance Autonomy Inclusion
Culture-oriented practice	
Ways of embodying bicultural professional practices There is consensus among bicultural professionals regarding broad cultural responsiveness principles The three main principles that underpin culture-oriented practice of bicultural professionals include	Seeing diversity Ensuring safety Using culture
Applying principles in service encounters	1. Pathway of managing boundaries *"be realistic"* 2. Pathway of creating safe worlds *"always be there for them"'* 3. Pathway of using identity and heritage *"connecting back"*
Culture-oriented practices – generated by dispositions	
Ethics in practice Integrating sense of one's own agency with responsibilities toward others	*Integrating entails* Becoming more intentional Regulating requests demands Caring for self Seeking out more ethically-aligned workplaces *Enacted when* Locating practices within existing frameworks and program approaches Finding frameworks that resonate Choosing a career pathway *Implicitly embodied as* Being emotionally and cognitively attuned Standing alongside clients Empowering clients, families, and communities Going above and beyond

Category	Subcategories and their qualities
Culture-oriented practices – in service encounters	
Relational practices Being with, bonding and belonging practices: intentional uses of proximity and distance	*Being in conversation entails* Relating "human-to-human'" Being genuine, ordinary and imperfect Creating a comfortable space Listening attentively Paying due regard Keeping the conversation going Shared LOTE conversations are richer
	Building rapport entails Doing face-work Signalling social connection
	Sharing experiences and stories entails Disclosing self and sharing stories Exploring archetypal themes Mentoring and coaching

Appendix E Survey findings and analysis

Discussed in Chapter 4 Description of participants and setting

Hours typically worked area and proportion of job focus

Table 27 Number of Hours Typically Worked and Proportion of job Focus – Spearman's rho

			Number of hours worked in a typical week	Proportion of focus on working with PeMH/EI of similar background
Spearman's rho	Number of hours worked in a typical week	Correlation Coefficient	1.000	**.226**
		Sig. (2-tailed)	.	**.055**
		N	82	73
	Proportion of focus on working with PeMH/EI of similar background	Correlation Coefficient	.226	1.000
		Sig. (2-tailed)	.055	.
		N	73	73

Table 28 Number of Hours Typically Worked and Proportion of Job Focus – Descriptive Statistics

	Number of hours worked in a typical week							
					95% Confidence Interval for Mean			
	N	Mean	Std. Deviation	Std. Error	Lower Bound	Upper Bound	Minimum	Maximum
Very small amount (less than 20%)	17	**15.53**	15.776	3.826	7.42	23.64	1	40
Some (20-30%)	8	**16.38**	15.937	5.635	3.05	29.70	1	40
About half (40-59%)	25	**16.56**	13.787	2.757	10.87	22.25	2	38
Large amount (60-79%)	12	**19.00**	13.598	3.925	10.36	27.64	1	40
All or almost all (80-100%)	11	**25.45**	11.639	3.509	17.64	33.27	8	40
Total	73	**18.04**	14.196	1.662	14.73	21.35	1	40

Discussed in Chapter 5 Survey Findings

LOTE capability and carrying out general tasks

Table 29 LOTE Capability and Performing General Tasks that Involve Working Directly with PeMH/EI – Crosstab

			LOTE capability			
			No other language spoken	Other language but not at work	Other language spoken at work	Total
Directly help PeMH/EI	No	Count	0	1	5	6
		% within LOTE capability	0.0%	12.5%	20.0%	15.4%
	Yes	Count	6	7	20	33
		% within LOTE capability	100.0%	87.5%	80.0%	84.6%
Total		Count	6	8	25	39
		% within LOTE capability	100.0%	100.0%	100.0%	100.0%

Table 30 LOTE Capability and Performing General Tasks Involving Advocating on Behalf of PeMH/EI – Crosstab

			LOTE capability			
			No other language spoken	Other language but not at work	Other language spoken at work	Total
Advocating on behalf of PeMH/EI	No	Count	0	0	6	6
		% within LOTE capability	0.0%	0.0%	24.0%	15.4%
	Yes	Count	6	8	19	33
		% within LOTE capability	100.0%	100.0%	76.0%	84.6%
Total		Count	6	8	25	39
		% within LOTE capability	100.0%	100.0%	100.0%	100.0%

Table 31 LOTE Capability and Performing General Tasks Involving Facilitating Interactions Between PeMH/EI and Other Professionals – Crosstab

			LOTE capability			
			No other language spoken	Other language but not at work	Other language spoken at work	Total
Facilitating interactions between PeMH/EI and other professionals	No	Count	0	1	2	3
		% within LOTE capability	0.0%	12.5%	8.0%	7.7%
	Yes	Count	6	7	23	36
		% within LOTE capability	100.0%	87.5%	92.0%	92.3%
Total		Count	6	8	25	39
		% within LOTE capability	100.0%	100.0%	100.0%	100.0%

Table 32 LOTE Capability and Performing General Tasks Involving Assisting Service Providers to Work With PeMH/EI- Crosstab

			LOTE capability			
			No other language spoken	Other language but not at work	Other language spoken at work	Total
Assisting service providers to work with PeMH/EI	No	Count	1	1	3	5
		% within LOTE capability	16.7%	12.5%	12.0%	12.8%
	Yes	Count	5	7	22	34
		% within LOTE capability	83.3%	87.5%	88.0%	87.2%
Total		Count	6	8	25	39
		% within LOTE capability	100.0%	100.0%	100.0%	100.0%

Table 33 LOTE Capability and Performing General Tasks Involving Assisting Ethnic, Faith and Multicultural Groups to Respond to MHI/EI – Crosstab

			LOTE capability			
			No other language spoken	Other language but not at work	Other language spoken at work	Total
Assisting ethnic, faith and multicultural groups to respond to MHI/EI	No	Count	1	4	8	13
		% within LOTE capability	16.7%	50.0%	32.0%	33.3%
	Yes	Count	5	4	17	26
		% within LOTE capability	83.3%	50.0%	68.0%	66.7%
Total		Count	6	8	25	39
		% within LOTE capability	100.0%	100.0%	100.0%	100.0%

Specific tasks

Table 34 Specific Tasks Survey Questions – Pearson's correlations

Specific task	***Significant at** p<.01 to:*	
1.1 'Directly helping PeMH/EI by providing service information and making referrals'		1.2 'Directly helping by providing information about mental health and recovery' r(.696)= .000, n=34; 2.1 'Advocating on behalf of PeMH/EI by ensuring people get a good quality service' r(.695)= .000 n=30; and 3.4 'Facilitating interactions between PeMH/EI and other professionals by being a mediator' r(.486)= .006, n=31
1.4 'Directly helping PeMH/EI by doing outreach to those at risk'		1.7 'Directly helping PeMH/EI by mediating conflicts in families' r(.497)= .008, n=27
1.5 'Directly helping PeMH/EI by working alongside other professionals to provide individualised assistance'		5.4 'Assisting ethnic, faith and multicultural groups to respond to MH/EI by implementing community initiatives' r(.667)= .005, n=16
2.1 'Advocating on behalf of PeMH/EI by ensuring people get a good quality service'		3.4 'Facilitating interactions between PeMH/EI and other professionals by being a mediator' r(.486)= .006, n=31.
2.2 'Advocating on behalf of PeMH/EI by assisting individuals who are especially disempowered'		5.2 'Assisting ethnic, faith and multicultural groups to respond to MHI/EI by informing them about services' r(.526)= .008, n=24
3.1 'Facilitating interactions between PeMH/EI and other professionals by promoting contact with other professionals'		4.2 'Assisting service providers to work with PeMH/EI by advising the organisation on cultural responsiveness' r(.476)= .005, n=33; and 4.8 'Assisting service providers to work with PeMH/EI by participating in partnerships and networks' r(.451)= .007, n=34
3.2 'Facilitating interactions between PeMH/EI and other professionals by interpreting'		3.5 'Facilitating interactions between PeMH/EI and other professionals by providing advice to professionals' r(.634)= .000, n=37; 4.2 'Assisting service providers to work with PeMH/EI by advising the organisation on cultural responsiveness' r(.451)= .008, n=33; and 5.5 'Assisting ethnic, faith and multicultural groups by mediating disputes within communities' r(.575)= .003, n=24
3.3 'Facilitating interactions between PeMH/EI and other professionals by explaining perspectives'		3.4 'Facilitating interactions between PeMH/EI and other professionals by being a mediator' r(.514)= .002, n=35
3.5 Facilitating interactions between PeMH/EI and other		4.5 'Assisting service providers to work with PeMH/EI by supporting service user

professionals by providing advice to professionals'		representatives' r(.503)= .005, n=30; 5.2 'Assisting ethnic, faith and multicultural groups to respond to MHI/EI by informing them about services' r(.553)= .003, n=26; 5.5 'Assisting ethnic, faith and multicultural groups by mediating disputes within communities' r(.672)= .000, n=24
4.2 'Assisting service providers to work with PeMH/EI by advising the organisation on cultural responsiveness'		4.8 'Assisting service providers to work with PeMH/EI by participating in partnerships and networks' r(.446)= .007, n=35
4.3 'Assisting service providers to work with PeMH/EI by implementing quality improvements'		4.5 'Assisting service providers to work with PeMH/EI by supporting service user representatives' r(.470)= .008, n=31 4.7 'Assisting service providers to work with PeMH/EI by educating the workforce' r(.572)= .001, n=30
4.4 'Assisting service providers to work with PeMH/EI by providing information about the preferences of an ethnocultural group'		4.5 'Assisting service providers to work with PeMH/EI by supporting service user representatives' r(.742)= .000, n=31; ' 4.6 'Assisting service providers to work with PeMH/EI by mediating mistrust between service and ethnocultural group' r(.530)= .003, n=29; 4.7 'Assisting service providers to work with PeMH/EI by educating the workforce' r(.457)= .010, n=31; and 4.8 'Assisting service providers to work with PeMH/EI by participating in partnerships and networks' r(.505)= .003, n=33.
4.5 'Assisting service providers to work with PeMH/EI by supporting service user representatives'		4.6 'Assisting service providers to work with PeMH/EI by mediating mistrust between service and ethnocultural group' r(.651)= .000, n=29; and 4.7 'Assisting service providers to work with PeMH/EI by educating the workforce' r(.612)= .000, n=30;
4.6 'Assisting service providers to work with PeMH/EI by mediating mistrust between service and ethnocultural group'		5.4 'Assisting ethnic, faith and multicultural groups to respond to MH/EI by implementing community initiatives' r(.745)= .001, n=16;
4.7 'Assisting service providers to work with PeMH/EI by educating the workforce'		4.8 'Assisting service providers to work with PeMH/EI by participating in partnerships and networks' r(.517)= .003, n=31
5.2 'Assisting ethnic, faith and multicultural groups to respond to MH/EI by informing them about services'		5.5 'Assisting ethnic, faith and multicultural groups by mediating disputes within communities' r(.642)= .001, n=24
Specific task	***Significant at*** *p<.05*	
1.3 'Directly helping PeMH/EI by being the primary person providing individualised care'		3.1 'Facilitating interactions between PeMH/EI and other professionals by promoting contact with other professionals' r(.368)= .035, n=33.

1.4 'Directly helping PeMH/EI by doing outreach to those at risk'		1.5 'Directly helping by working alongside other professionals to provide individualised assistance' r(.444)= .016, n=29; 4.6 'Assisting service providers to work with PeMH/EI by mediating mistrust between service and ethnocultural group' r(.469)= .024, n=23; and 5.4 'Assisting ethnic, faith and multicultural groups to respond to MH/EI by implementing community initiatives' r(.588)= .013, n=17.
1.5 'Directly helping PeMH/EI by working alongside other professionals to provide individualised assistance'		4.6 'Assisting service providers to work with PeMH/EI by mediating mistrust between service and an ethnocultural group' r(.447)= .028, n=24; and 5.1 'Assisting ethnic, faith and multicultural groups to respond to MHI/EI by building relationships' r(.456)= .049, n=19
1.7 'Directly helping PeMH/EI by mediating conflict within families'		4.6 'Assisting service providers to work with PeMH/EI by mediating mistrust between service and an ethnocultural group' r(.389)= .049, n=26
2.4 'Advocating on behalf of PeMH/EI by representing the interests of ethnocultural group'		4.2 'Assisting service providers to work with PeMH/EI by advising the organisation on cultural responsiveness' r(.435)= .043, n=22; 4.3 'Assisting service providers to work with PeMH/EI by implementing quality improvements' r(.523)= .015, n=21; 4.5 'Assisting service providers to work with PeMH/EI by supporting service user representatives' r(.449)= .036, n=22; and 4.7 'Assisting service providers to work with PeMH/EI by educating the workforce' r(.509)= .019, n=21
2.5 'Advocating on behalf of PeMH/EI by assisting to manage finances, housing, social security arrangements'		3.5 'Facilitating interactions between PeMH/EI and other professionals by providing advice to professionals' r(.423)= .035, n=25
3.1 'Facilitating interactions between PeMH/EI and other professionals by promoting contact with other professionals'		4.4 'Assisting service providers to work with PeMH/EI by providing information about the preferences of an ethnocultural group' r(.373)= .039, n=31; and 4.7 'Assisting service providers to work with PeMH/EI by educating the workforce' r(.414)= .026, n=29
3.2 'Facilitating interactions between PeMH/EI and other professionals by interpreting'		5.2 'Assisting ethnic, faith and multicultural groups to respond to MHI/EI by informing them about services' r(.457)= .019, n=26
3.3 'Facilitating interactions between PeMH/EI and other professionals by explaining perspectives'		4.2 'Assisting service providers to work with PeMH/EI by providing information about the preferences of an ethnocultural group' r(.447)= .013, n=30
3.5 Facilitating interactions between PeMH/EI and other professionals by providing advice to professionals'		4.2 'Assisting service providers to work with PeMH/EI by advising the organisation on cultural responsiveness' r(.440)= .010, n=33

4.2 'Assisting service providers to work with PeMH/EI by advising the organisation on cultural responsiveness'		4.3 'Assisting service providers to work with PeMH/EI by implementing quality improvements' r(.385)= .032, n=31; 4.5 'Assisting service providers to work with PeMH/EI by supporting service user representatives' r(.389)= .028, n=32; 4.7 'Assisting service providers to work with PeMH/EI by educating the workforce' r(.392)= .029, n=31; 5.2 'Assisting ethnic, faith and multicultural groups to respond to MHI/EI by informing them about services' r(.402)= .042, n=26; and 5.4 'Assisting ethnic, faith and multicultural groups to respond to MH/EI by implementing community initiatives' r(.459)= .042, n=20
4.3 'Assisting service providers to work with PeMH/EI by implementing quality improvements'		4.4 'Assisting service providers to work with PeMH/EI by providing information about the preferences of an ethnocultural group' r(.385)= .035, n=30; 4.6 'Assisting service providers to work with PeMH/EI by mediating mistrust between service and ethnocultural group' r(.426)= .024, n=28; 5.4 'Assisting ethnic, faith and multicultural groups to respond to MH/EI by implementing community initiatives' r(.472)= .048, n=18
4.5 'Assisting service providers to work with PeMH/EI by supporting service user representatives'		4.8 'Assisting service providers to work with PeMH/EI by participating in partnerships and networks' r(.404)= .022, n=32
4.6 'Assisting service providers to work with PeMH/EI by mediating mistrust between service and ethnocultural group'		4.7 'Assisting service providers to work with PeMH/EI by educating the workforce' r(.386)= .042, n=28; and 5.6 'Assisting ethnic, faith and multicultural groups to respond to MH/EI by using media' r(.592)= .016, n=16
4.8 'Assisting service providers to work with PeMH/EI by participating in partnerships and networks'		5.5 'Assisting ethnic, faith and multicultural groups by mediating disputes within communities' r(.459)= .024, n=24
5.1 'Assisting ethnic, faith and multicultural groups to respond to MH/EI by building relationships'		5.3 'Assisting ethnic, faith and multicultural groups by advising them about mental health issues' r(.548)= .010, n=21; and 5.4 'Assisting ethnic, faith and multicultural groups to respond to MH/EI by implementing community initiatives r(.459)= .042, n=20
5.3 'Assisting ethnic, faith and multicultural groups by advising them about mental health issues'		5.4 'Assisting ethnic, faith and multicultural groups by implementing community initiatives r(.478)= .045, n=18

LOTE capability and carrying out specific tasks

Table 35 LOTE Capability and T3.2 "Facilitating Interactions Between PeMH/EI and Other Professionals by Interpreting" – Crosstab

			LOTE capability			
			No other language spoken	*Other language but not at work*	*Other language spoken at work*	Total
Facilitating interactions between PeMH/EI and other professionals by interpreting	0	Count	1	1	1	3
		% within LOTE capability	16.7%	14.3%	4.3%	8.3%
	No	Count	5	4	4	13
		% within LOTE capability	83.3%	57.1%	17.4%	36.1%
	Yes	Count	0	2	18	20
		% within LOTE capability	0.0%	28.6%	78.3%	55.6%
Total		Count	6	7	23	36
		% within LOTE capability	100.0%	100.0%	100.0%	100.0%

Table 36 LOTE Capability and T3.2 "Facilitating Interactions Between PeMH/EI and Other Professionals by Interpreting" – Chi-Square Tests

	LOTE capability		
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	14.416[a]	4	.006
Likelihood Ratio	17.028	4	.002
Linear-by-Linear Association	11.085	1	.001
N of Valid Cases	36		

Notes. [a] 7 cells (77.8%) have expected count less than 5. The minimum expected count is .50.

Table 37 LOTE Capability and T4.6 "Assisting service providers to work with PeMH/EI by mediating mistrust between a service provider and an ethnocultural group" – Crosstab

LOTE and Question 4.6						
			LOTE capability			
			No other language spoken	Other language but not at work	Other language spoken at work	Total
Assisting service providers to work with PeMH/EI by mediating mistrust between service and an ethnocultural group	No	Count	4	2	6	12
		% within LOTE capability	100.0%	40.0%	31.6%	42.9%
	Yes	Count	0	3	13	16
		% within LOTE capability	0.0%	60.0%	68.4%	57.1%
Total		Count	4	5	19	28
		% within LOTE capability	100.0%	100.0%	100.0%	100.0%

Table 38 LOTE Capability and T4.6 "Assisting service providers to work with PeMH/EI by mediating mistrust between service and an ethnocultural group" –Chi-Square tests

LOTE and Question 4.6			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	6.337[a]	2	.042
Likelihood Ratio	7.814	2	.020
Linear-by-Linear Association	5.161	1	.023
N of Valid Cases	28		

Notes. [a.] 4 cells (66.7%) have expected count less than 5. The minimum expected count is 1.71.

Table 39 Approaches, Beliefs and Knowledge Paradigms – Descriptive Statistics and Pearson's Correlations

Questions	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.	18.	19.	20.	21.
Correlations																					
1. Building trust with PeMH/EI	-																				
2. Building trust between PeMH/EI and other professionals	.595**	-																			
3. Discussing stigma and unhelpful beliefs	.242	.141	-																		
4. Enlisting community	-.086	.092	.115	-				*													
5. Explaining how mental health services help	.055	-.066	.410**	.572**	-		.														
6. Connecting PeMH/EI with their traditions	.084	.000	-.016	.319*	.051	-															
7. Making community connections	.245	.359*	.245	.485**	.371*	.139	-														
8. Addressing racism	.391*	.437**	.310	.391*	.259	.606**	.356*	-													
9. Ensuring equal treatment	.074	.044	.083	.209	.159	.437**	-.034	.542**	-												
10. Valuing pluralism	-.097	.013	.182	.047	-.238	.287	-.218	.164	.468**	-											
11. Increasing workforce diversity	.013	.080	.371*	.050	.056	.322*	.029	.367*	.537**	.625**	-										
12. Explaining co-workers' viewpoints to service users	-.018	-.033	.480**	.272	.172	.349*	-.071	.412**	.299	.449**	.549**	-									

Questions (cont.)	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.	18.	19.	20.	21.
Correlations (cont.)																					
13. Explaining service users' concerns to co-workers	.187	.337*	.081	.335*	.309	-.325*	.197	.120	-.004	.025	-.063	-.081	-								
14. Facilitating two-way conversations	.124	.187	.397*	.018	-.043	-.013	.147	.057	.366*	.452**	.363*	.151	.026	-							
15. Improving service's responsiveness	.253	.293	.188	.157	.247	.164	.291	.199	.206	.142	.229	.096	.158	.293	-						
16. Educating co-workers	-.073	.306	.161	.059	.119	.172	.080	.273	.487**	.492**	.523**	.123	.172	.254	.534**	-					
17. Supporting my [i.e. the worker's] community	-.039	.236	-.019	.182	-.132	.042	-.021	.007	.124	.395*	.206	-.115	.109	.101	.272	.521**	-				
18. Improving service access	.222	.137	.764**	.031	.144	.074	.077	.068	.032	.268	.398*	.414**	-.086	.420**	.130	.147	-.006	-			
19. Applying 'Western' knowledge & practice paradigms	.143	.084	.477**	.040	.286	-.134	.068	.116	.513**	.179	.338*	.097	.100	.383*	.231	.445**	.264	.392*	-		
20. Using knowledge of 'cultural' or faith traditions	-.164	.197	-.015	.360*	-.028	.533**	.055	.332*	.166	.265	.185	.166	.000	.013	.193	.260	.519**	-.018	.067	-	
21. Using understanding of social structures	-.113	.128	-.192	.243	.015	-.076	-.036	-.035	-.059	.083	-.162	-.181	.323*	-.145	-.129	-.019	.208	-.167	-.061	.260	-
Descriptive statistics																					
Valid responses (n)	40	40	38	40	40	39	40	39	38	35	35	36	40	37	40	40	39	39	39	40	39
Median	6	6	6	5.5	6	5	6	6	6	6	6	6	6	6	6	6	6	6	6	5	6
Mean	5.90	5.60	5.45	5.23	5.65	5.26	5.43	5.36	5.66	5.20	5.42	5.42	5.68	5.41	5.45	5.20	5.18	5.33	5.28	5.00	5.38
Standard Deviation	.379	.841	.795	.862	.736	.880	.747	1.008	.582	.933	1.268	.937	.616	.798	.749	1.114	1.11	.806	.916	1.240	.847
Min	4	3	3	4	3	3	4	2	4	3	1	1	4	4	4	2	2	4	2	1	3
Max	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6

Notes.

** Correlation is significant at the 0.01 level (2-tailed)

* Correlation is significant at the 0.05 level (2-tailed)

Table 40 Statements about Approaches, Beliefs and Knowledge and LOTE Capability

Q. 21 Statements about Approaches, Beliefs and Knowledge and LOTE Capability								
				Std.		95% Confidence Interval for Mean		Minimum	Maximum
		N	Mean	Deviation	Std. Error	Lower Bound	Upper Bound		
1. When I do this work I aim to build trust with PeMH/EI	No other language spoken	6	6.00	.000	.000	6.00	6.00	6	6
	Other language but not at work	8	6.00	.000	.000	6.00	6.00	6	6
	Other language spoken at work	25	5.84	.473	.095	5.64	6.04	4	6
	Total	39	5.90	.384	.061	5.77	6.02	4	6
2. When I do this work I aim to build trust between PeMH/EI and other professionals	No other language spoken	6	5.67	.516	.211	5.12	6.21	5	6
	Other language but not at work	8	5.50	1.069	.378	4.61	6.39	3	6
	Other language spoken at work	25	5.60	.866	.173	5.24	5.96	3	6
	Total	39	5.59	.850	.136	5.31	5.87	3	6
3. When I do this work I aim to help PeMH/EI talk about stigma and negative beliefs about mental health issues	No other language spoken	6	5.00	1.095	.447	3.85	6.15	3	6
	Other language but not at work	8	5.75	.463	.164	5.36	6.14	5	6
	Other language spoken at work	24	5.25	1.189	.243	4.75	5.75	1	6
	Total	38	5.32	1.068	.173	4.96	5.67	1	6

Q.21 Statements about Approaches, Beliefs and Knowledge and LOTE Capability								
		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean	Minimum	Maximum
4. When I do this work I aim to help PeMH/EI get informal support from their ethnocultural or faith community	No other language spoken	6	4.67	.816	.333	3.81 5.52	4	6
	Other language but not at work	8	4.88	.835	.295	4.18 5.57	4	6
	Other language spoken at work	25	5.44	.821	.164	5.10 5.78	4	6
	Total	39	5.21	.864	.138	4.93 5.49	4	6
5. When I do this work I aim to help PeMH/EI find out how mental health services can help	No other language spoken	6	5.50	.837	.342	4.62 6.38	4	6
	Other language but not at work	8	5.88	.354	.125	5.58 6.17	5	6
	Other language spoken at work	25	5.60	.816	.163	5.26 5.94	3	6
	Total	39	5.64	.743	.119	5.40 5.88	3	6
6. When I do this work I aim to help PeMH/EI connect with their own cultural traditions	No other language spoken	6	5.00	.894	.365	4.06 5.94	4	6
	Other language but not at work	8	5.25	.886	.313	4.51 5.99	4	6
	Other language spoken at work	24	5.33	.917	.187	4.95 5.72	3	6
	Total	38	5.26	.891	.145	4.97 5.56	3	6
7. When I do this work I aim to help PeMH/EI connect with other cultural groups and form wider social networks	No other language spoken	6	5.33	.516	.211	4.79 5.88	5	6
	Other language but not at work	8	5.38	.916	.324	4.61 6.14	4	6
	Other language spoken at work	25	5.44	.768	.154	5.12 5.76	4	6
	Total	39	5.41	.751	.120	5.17 5.65	4	6

Q.21 Statements about Approaches, Beliefs and Knowledge and LOTE Capability								
		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean	Minimum	Maximum
8. When I do this work I aim to ensure PeMH/EI do not experience racism when using services	No other language spoken	6	5.33	.816	.333	4.48 6.19	4	6
	Other language but not at work	8	5.38	.916	.324	4.61 6.14	4	6
	Other language spoken at work	24	5.33	1.239	.253	4.81 5.86	2	6
	Total	38	5.34	1.097	.178	4.98 5.70	2	6
9. When I do this work I aim to ensure PeMH/EI are not disadvantaged when using services	No other language spoken	6	5.83	.408	.167	5.40 6.26	5	6
	Other language but not at work	7	5.71	.488	.184	5.26 6.17	5	6
	Other language spoken at work	24	5.58	.654	.133	5.31 5.86	4	6
	Total	37	5.65	.588	.097	5.45 5.84	4	6
10. When I do this work I aim to help create services that value pluralism	No other language spoken	5	4.60	.894	.400	3.49 5.71	4	6
	Other language but not at work	7	4.57	1.134	.429	3.52 5.62	3	6
	Other language spoken at work	22	5.59	.666	.142	5.30 5.89	4	6
	Total	34	5.24	.923	.158	4.91 5.56	3	6
11. When I do this work I aim to help increase the diversity of the mental health workforce	No other language spoken	5	5.80	.447	.200	5.24 6.36	5	6
	Other language but not at work	7	5.00	1.155	.436	3.93 6.07	3	6
	Other language spoken at work	22	5.23	1.445	.308	4.59 5.87	1	6
	Total	34	5.26	1.286	.221	4.82 5.71	1	6

Q.21 Statements about Approaches, Beliefs and Knowledge and LOTE Capability								
		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean	Minimum	Maximum
12. When I do this work I aim to let service users know about the recommendations of other health professionals	No other language spoken	5	5.20	.447	.200	4.64 5.76	5	6
	Other language but not at work	8	5.75	.463	.164	5.36 6.14	5	6
	Other language spoken at work	22	5.32	1.129	.241	4.82 5.82	1	6
	Total	35	5.40	.946	.160	5.08 5.72	1	6
13. When I do this work I aim to tell other professionals about the needs and concerns that PeMH/EI express	No other language spoken	6	5.83	.408	.167	5.40 6.26	5	6
	Other language but not at work	8	5.50	.926	.327	4.73 6.27	4	6
	Other language spoken at work	25	5.68	.557	.111	5.45 5.91	4	6
	Total	39	5.67	.621	.099	5.47 5.87	4	6
14. When I do this work I aim to facilitate two-way exchanges between PeMH/EI and other professionals	No other language spoken	5	5.20	1.095	.490	3.84 6.56	4	6
	Other language but not at work	7	5.29	.951	.360	4.41 6.17	4	6
	Other language spoken at work	24	5.46	.721	.147	5.15 5.76	4	6
	Total	36	5.39	.803	.134	5.12 5.66	4	6
15. I believe that my work makes service providers more culturally responsive	No other language spoken	6	5.17	.753	.307	4.38 5.96	4	6
	Other language but not at work	8	5.38	.744	.263	4.75 6.00	4	6
	Other language spoken at work	25	5.52	.770	.154	5.20 5.84	4	6
	Total	39	5.44	.754	.121	5.19 5.68	4	6

Q. 21 Statements about Approaches, Beliefs and Knowledge and LOTE Capability								
		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean	Minimum	Maximum
16. I believe that my work improves the cultural competence of other workers and professionals	No other language spoken	6	5.33	.816	.333	4.48 6.19	4	6
	Other language but not at work	8	4.75	1.753	.620	3.28 6.22	2	6
	Other language spoken at work	25	5.36	.907	.181	4.99 5.73	3	6
	Total	39	5.23	1.111	.178	4.87 5.59	2	6
17. I believe that my work supports my ethnocultural or faith community	No other language spoken	6	4.83	1.472	.601	3.29 6.38	3	6
	Other language but not at work	7	3.86	1.464	.553	2.50 5.21	2	6
	Other language spoken at work	25	5.64	.569	.114	5.41 5.87	4	6
	Total	38	5.18	1.159	.188	4.80 5.57	2	6
18. I believe that my work increases rates of mental health service use by PeMH/EI	No other language spoken	6	5.17	.983	.401	4.13 6.20	4	6
	Other language but not at work	8	5.50	.756	.267	4.87 6.13	4	6
	Other language spoken at work	24	5.38	.770	.157	5.05 5.70	4	6
	Total	38	5.37	.786	.127	5.11 5.63	4	6
19. I use knowledge and practices about mental health and / recovery that come from my understanding of Western bio-medicine and psychology	No other language spoken	6	5.67	.516	.211	5.12 6.21	5	6
	Other language but not at work	7	5.57	.787	.297	4.84 6.30	4	6
	Other language spoken at work	25	5.12	1.013	.203	4.70 5.54	2	6
	Total	38	5.29	.927	.150	4.98 5.59	2	6

Q. 21 Statements about Approaches, Beliefs and Knowledge and LOTE Capability								
		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean	Minimum	Maximum
20. I use knowledge and practices about mental health and / recovery that come from my understanding of the ethnocultural or faith-based traditions with which I identify	No other language spoken	6	5.00	.894	.365	4.06 5.94	4	6
	Other language but not at work	8	4.38	1.768	.625	2.90 5.85	1	6
	Other language spoken at work	25	5.16	1.106	.221	4.70 5.62	2	6
	Total	39	4.97	1.246	.199	4.57 5.38	1	6
21. I use knowledge and practices about mental health and / recovery that come from my understanding of the links between social context and personal issues	No other language spoken	5	5.60	.548	.245	4.92 6.28	5	6
	Other language but not at work	8	4.75	1.035	.366	3.88 5.62	3	6
	Other language spoken at work	25	5.52	.770	.154	5.20 5.84	4	6
	Total	38	5.37	.852	.138	5.09 5.65	3	6

Table 41 Statements about Approaches, Beliefs and Knowledge – ANOVA

Q. 21 Statements about Approaches, Beliefs and Knowledge		Sum of Squares	df	Mean Square	F	Sig.
1. When I do this work I aim to build trust with PeMH/EI	Between Groups	.230	2	.115	.772	.470
	Within Groups	5.360	36	.149		
	Total	5.590	38			
2. When I do this work I aim to build trust between PeMH/EI and other professionals	Between Groups	.103	2	.051	.068	.935
	Within Groups	27.333	36	.759		
	Total	27.436	38			
3. When I do this work I aim to help PeMH/EI talk about stigma and negative beliefs about mental health issues	Between Groups	2.211	2	1.105	.967	.390
	Within Groups	40.000	35	1.143		
	Total	42.211	37			
4. When I do this work I aim to help PeMH/EI get informal support from their ethnocultural or faith community	Between Groups	3.991	2	1.995	2.948	.065
	Within Groups	24.368	36	.677		
	Total	28.359	38			
5. When I do this work I aim to help PeMH/EI find out how mental health services can help	Between Groups	.599	2	.300	.529	.593
	Within Groups	20.375	36	.566		
	Total	20.974	38			
6. When I do this work I aim to help PeMH/EI connect with their own cultural traditions	Between Groups	.535	2	.268	.325	.725
	Within Groups	28.833	35	.824		
	Total	29.368	37			
7. When I do this work I aim to help PeMH/EI connect with other cultural groups and form wider social networks	Between Groups	.068	2	.034	.057	.945
	Within Groups	21.368	36	.594		
	Total	21.436	38			
8. When I do this work I aim to ensure PeMH/EI do not experience racism when using services	Between Groups	.011	2	.005	.004	.996
	Within Groups	44.542	35	1.273		
	Total	44.553	37			
9. When I do this work I aim to ensure PeMH/EI are not disadvantaged when using services	Between Groups	.337	2	.169	.474	.627
	Within Groups	12.095	34	.356		
	Total	12.432	36			

Q. 21 Statements about Approaches, Beliefs and Knowledge						
		Sum of Squares	df	Mean Square	F	Sig.
10. When I do this work I aim to help create services that value pluralism	**Between Groups**	**7.885**	**2**	**3.943**	**6.041**	**.006**
	Within Groups	**20.232**	**31**	**.653**		
	Total	28.118	33			
11. When I do this work I aim to help increase the diversity of the mental health workforce	Between Groups	1.954	2	.977	.575	.569
	Within Groups	52.664	31	1.699		
	Total	54.618	33			
12. When I do this work I aim to let service users know about the recommendations of other health professionals	Between Groups	1.327	2	.664	.730	.490
	Within Groups	29.073	32	.909		
	Total	30.400	34			
13. When I do this work I aim to tell other professionals about the needs and concerns that PeMH/EI express	Between Groups	.393	2	.197	.496	.613
	Within Groups	14.273	36	.396		
	Total	14.667	38			
14. When I do this work I aim to facilitate two-way exchanges between PeMH/EI and other professionals	Between Groups	.369	2	.184	.274	.762
	Within Groups	22.187	33	.672		
	Total	22.556	35			
15. I believe that my work makes service providers more culturally responsive	Between Groups	.641	2	.321	.551	.581
	Within Groups	20.948	36	.582		
	Total	21.590	38			
16. I believe that my work improves the cultural competence of other workers and professionals	Between Groups	2.330	2	1.165	.940	.400
	Within Groups	44.593	36	1.239		
	Total	46.923	38			
17. I believe that my work supports my ethnocultural or faith community	**Between Groups**	**18.260**	**2**	**9.130**	**10.160**	**.000**
	Within Groups	**31.450**	**35**	**.899**		
	Total	49.711	37			
18. I believe that my work increases rates of mental health service use by PeMH/EI	Between Groups	.384	2	.192	.299	.743
	Within Groups	22.458	35	.642		
	Total	22.842	37			
19. I use knowledge and practices about mental health and / recovery that come from my understanding of Western bio-medicine and psychology	Between Groups	2.128	2	1.064	1.254	.298
	Within Groups	29.688	35	.848		
	Total	31.816	37			

Q. 21 Statements about Approaches, Beliefs and Knowledge						
		Sum of Squares	df	Mean Square	F	Sig.
20. I use knowledge and practices about mental health and / recovery that come from my understanding of the ethnocultural or faith-based traditions with which I identify	Between Groups	3.739	2	1.870	1.219	.308
	Within Groups	55.235	36	1.534		
	Total	58.974	38			
21 I use knowledge and practices about mental health and / recovery that come from my understanding of the links between social context and personal issues	Between Groups	3.902	2	1.951	2.977	.064
	Within Groups	22.940	35	.655		
	Total	26.842	37			

Training undertaken and access to supervision or informal support

Table 42 Training – Frequency and Properties

Gets Training					
		Total sample		*Nested sample*	
		N	%	N	%
Get sTraining - yes		24	61.5%	14	73.7%
	Session topics				
	Cultural responsiveness or working with immigrant, refugee populations	12		9	
	Mental health issues (including AOD)	8		2	
	Suicide, violence, trauma	6		4	
	Practice in mental health or community development	4		5	
	Other skills and general topics	3		0	
	Other learning				
	Self-directed	1		0	
	Follow social & political issues related to cultural group	1		1	
	Community events	1		1	
	Learning from service users and community members	1		1	
Training – no		15	38.5%	5	26.3%
Total individuals		39	100.0%	19	100.0%

Table 43 Supervision or Informal Support – Properties

Gets Supervision					
		Total sample		*Nested sample*	
		N	%	N	%
Gets supervision or informal support – yes		31	79.5%	14	73.7%
Supervision	*Method*				
	Meet supervisor one-to-one only	19		8	
	Group based only	4		3	
	One to one and group based	8		3	
	Regularity				
	Monthly	7		3	
	Fortnightly	4		1	
	Weekly	3			
Informal support	*Extra-agency sources of support*				
	Attending education events	4		1	
	Membership of a transcultural network or group	3		3	
	Collaboration and collegiality	2		3	
	Links with ethnocultural or faith communities	2		1	
Gets supervision or informal support – no		8	20.5%	5	26.3%
Total individuals		39	100.0%	19	100.0%

Table 44 Supervision or Informal support: Type of Industry (2 categories) – Crosstab

			MH*	Not MH	Total
Gets supervision or informal support	No	Count	2	6	8
		% within Gets supervision or informal support	25.0%	75.0%	100.0%
		% within Type of industry (2 categories)	9.5%	33.3%	20.5%
	Yes	Count	19	12	31
		% within Gets supervision or support	**61.3%**	**38.7%**	100.0%
		% within Type of industry (2 categories)	90.5%	66.7%	79.5%
Total		Count	21	18	39
		% within Gets supervision or support	53.8%	46.2%	100.0%
		% within Type of industry (2 categories)	100.0%	100.0%	100.0%

Note. Includes individuals who hold at least one job in a mental health (MH) service.

Table 45 Supervision or Informal Support and Type of industry (2 categories) – Chi-Square tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.370[a]	1	.066		
Continuity Correction	2.068	1	.150		
Likelihood Ratio	3.456	1	.063		
Fisher's Exact Test				.112	.075
Linear-by-Linear Association	3.283	1	.070		
N of Valid Cases	39				

Notes. [a] 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.69. [b] Computed only for a 2x2 table