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A bilingual/bicultural case management model

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The needs of people with mental health problems from culturally and linguistically diverse backgrounds were identified in a number of national and Queensland mental health policies and plans for this model. For example, the National Mental Health Policy 1992, Queensland Non-English Speaking Background (NESB) Mental Health Policy Statement 1995 and the Queensland 10-Year Mental Health Strategy 1996. The responsibility for addressing these needs in Queensland was allocated to the Queensland Transcultural Mental Health Centre (QTMHC), as the primary mechanism responsible for driving the implementation of the Queensland NESB Mental Health Policy Statement. The Queensland NESB Mental Health Policy clearly outlines that 'a pilot position would be established to evaluate the benefit of employing a bilingual/bicultural mental health worker in a District with high NESB populations'.

In implementing this policy strategy, QTMHC employed a part-time Chinese-speaking Australian-trained social worker to provide case management services to Chinese consumers in the Princess Alexandra Hospital (PAH) and District Health Service. A detailed exploration of similar service models operating in other states and territories was also conducted especially the New South Wales Bilingual Mental Health Counsellor Model. The intention from the outset was to integrate the position into the District Mental Health Service and to employ an allied mental health professional (social worker, psychologist, occupational therapist or nurse) who had similar qualifications and experience as other staff employed by the service.

The plan was to allocate to the worker the same duties and functions as any other case manager but who in this case, because of cultural and linguistic skills, would provide case management services to Chinese consumers. Models of co-case management, language aid, support worker and cultural consultants were all assessed as inappropriate.

The PAH and District Mental Health Service operates with seven distinct mental health teams and an inpatient unit. The Chinese bilingual mental health worker operated across all seven teams, which had both advantages and disadvan-
tages, as will be outlined later in this chapter. The Chinese consumer group is one of the largest non-English speaking groups in the catchment area and the utilisation of the service by this group prior to the worker’s appointment was substantial.

**Background**

Research conducted by Flaskerud and Liu (1991) and Sue, Fijno, Hu, Takeuchi, & Zane (1991) indicates that by matching mental health workers to consumers in terms of culture and language, better treatment outcomes are possible. They suggest that the possibilities of misdiagnosis and inappropriate hospitalisation decrease; there is greater understanding among consumers and carers of the treatment process, medication and side effects; there is greater adherence to the treatment plan; and there is improved rapport between the worker and his/her consumer and carer.

Additionally, research conducted by O’Sullivan, Peterson, Cox & Kirby (1989) and Takeuchi, Sue & Yeh (1995) indicates that the employment of bilingual/bicultural staff also increases the utilisation of services by consumers from the same language or cultural group. It also reduces the cost and need for interpreters.

In the Queensland experience, the bilingual/bicultural case management model also overcame consumers’ reluctance to work with interpreters because of confidentiality issues and community gossip. Consumers were not automatically transferred to the Chinese case manager. Instead, a process of negotiation and consultation occurred between the original case manager, the consumer and the family. In most instances, both parties agreed with the transfer, but in a few cases, the offer was declined and the consumer’s decision was respected. The reasons for the refusal included the interpreter issues identified above and in some instances, the consumer spoke English adequately and did not want or need a bilingual worker.

**Role of Bilingual/bicultural Case Manager**

The Chinese bilingual case manager provided a case management/care co-ordination service to Chinese consumers, similar to that offered by other clinicians to the mainstream population. The services provided were governed by the Care Co-ordination Policy of the PAH and District Mental Health Service. In addition, the Chinese case manager also provided case consultation to other clinicians and actively participated in the delivery of cross-cultural training.

**Case management**

During 1997 and 1998, the Chinese case manager maintained a caseload of between 13 and 18 cases and provided services to Chinese consumers from China, Taiwan,
Hong Kong, Malaysia, Vietnam and those born in Australia. This diversity of backgrounds brought additional complexities when dealing with Chinese consumers and their families, as the case manager not only dealt with the Chinese culture, but cultural traits from other countries where consumers resided prior to their arrival in Australia.

The duties of the case manager of the PAH and District Mental Health Service included the following:

- Ensuring that patients’ needs for services were collaboratively assessed and addressed.
- Sensitivity and responsiveness to consumers’ individual needs and formulation of comprehensive individual treatment plans in conjunction with clinical teams.
- Monitoring mental state, encouraging compliance with medication and other treatments, monitoring regulation status, conducting assertive outreach where necessary and facilitation of the provision of specialist clinical services.
- Facilitating access to, and liaison with, community services relevant to consumers’ needs.
- Liaison with carers and significant others with the permission of the consumer.
- Provision of crisis intervention services and working closely with the primary nurse and medical officer when consumers became inpatients.

To perform these duties adequately, the Chinese case manager needed to allocate a greater amount of time to case management with Chinese consumers and carers than that required by English speaking consumers and carers. There were probably numerous reasons for this, but the few which were evident in the Queensland experience were the lack of understanding amongst consumers and carers about mental health problems; lack of culturally and linguistically appropriate psycho-education programs; limited multilingual information; lack of referral options; and limited access to community and non-government support services. These experiences seem to be consistent with the findings of the evaluation of the New South Wales Bilingual Counsellor Program. In an attempt to overcome some of these shortfalls, the Chinese case manager facilitated a Family Education and Support Program for Chinese carers in conjunction with a Chinese mental health worker employed in the non-government sector.

Owing to the differences in power perception, Chinese consumers and carers often perceive that they have no power to influence treatment. In this situation the Chinese case manager spent a considerable amount of time supporting and encouraging Chinese consumers and carers to express their needs and to actively participate in the development and review of the treatment plan. On the other hand, the worker was also an advocate within the service for the utilisation of accredited interpreters, at least during crucial contacts with NESB consumers (for example, in situations of assessments, diagnosis, obtaining consent, regulation under the Act, explanation of medication and treatment, and development of treatment and
discharge plans). A considerable amount of time was also spent raising awareness amongst colleagues about cultural differences that may influence the consumers’ perception of illness, how they perceive an illness should be treated, and their perception of the long-term prognosis. In general, the role involved the encouragement of colleagues to develop an understanding of consumers’ explanatory models, which undoubtedly were different to their own.

The Chinese case manager was additionally disadvantaged, as referral options for Chinese consumers and carers were limited in terms of cultural and linguistic barriers. Even the option to refer to the non-government Chinese mental health worker was not always acceptable to consumers or their families because of stigma and other personal issues. In this situation, the bilingual case manager was required to provide most of the support needed by consumers and their families, especially in terms of accessing mainstream services. This ranged from making the initial contact with the service on behalf of consumers, accompanying consumers and family members to initial appointments and putting in place processes that enabled consumers and families to access the service directly. The intention was clearly to reduce dependency on the worker.

Tao & Drover (1997) suggest that in the West ‘need’ is often related to a notion of human agency which is equated with autonomy and understood as freedom to participate in any form of life. It has an individualistic basis. According to the same source, in the Chinese tradition, by contrast, human agency is understood in terms of the capacity to fulfil role obligations and family responsibilities. The individuality of a person is constituted by the web of unique role relationships that one possesses and agency is attained by the way role responsibilities are fulfilled in each particular set of relationships. This different understanding of the human agency required the Chinese case manager not only to work and liaise with the consumers, but a large amount of time was also spent with carers and family members. Thus, their input into treatment was facilitated to ensure compliance and better treatment outcomes. Referral of some carers to the non-government Chinese mental health worker did occur for support purposes, but contact with the Chinese case manager remained constant because of the need to maintain contact with the medical team.

In crisis situations, the worker was also the first point of contact. She assisted in getting the consumer to hospital and bridged the communication gap in the initial assessment. The worker was also involved in assisting with communication in a number of initial joint interviews, before an interpreter was arranged.

Consultancy

The Chinese case manager also engaged in case consultations with other clinicians, both in terms of Chinese and other NESB consumers. The in-service training the worker conducted identified her as an internal resource that staff consulted with when dealing with Chinese or other NESB consumers or families.
Training

As a result of the work undertaken by the QTMHC and the Chinese case manager, there was an increased awareness amongst mental health staff in the PAH and District about the needs of people from culturally and linguistically diverse backgrounds. This resulted in numerous requests for upskilling and training programs, which the worker engaged in frequently.

A considerable proportion of the worker’s time was spent on delivering an in-service training program developed by the QTMHC titled, ‘Managing Cultural Diversity in Mental Health’, to staff in the PAH and District, other districts and outside the mental health sector. The training upskilled staff in the areas of cross-cultural practice; communication across cultures; and assessment, diagnosis and treatment across cultures.

Evaluation

A comprehensive evaluation of the program was conducted in December 1997. The methodology included in-depth individual interviews with consumers and carers, Chinese community workers, the Chinese case manager, a focus group with other staff in the service, and a file audit of ten consumers.

In general, the program was highly regarded by all those interviewed and clearly highlighted the positive treatment outcomes that can be achieved when the mental health professional is matched to the consumer in terms of language and culture.

The main outcomes and benefits of the program were:

- Consumer and carers had higher levels of satisfaction. Consumer satisfaction levels increased from 8.33 to 9 out of a score of 10, while the average satisfaction for carers increased from 7 to 9.66. This was mainly because they felt better understood and catered for and because language barriers and cultural misunderstandings were overcome.

- The program’s ability to explain the symptoms of the illness and service options to consumers and carers. From the file audit, five consumers were not taking their medication, or were taking medication incorrectly before the involvement of the Chinese case manager.

- Increased family involvement with the consumer’s treatment where consumers and family members concerned desired this.

- The ability to provide greater family or carer support than was previously possible. It was found that carers needed considerable support as they were aged and ill themselves.

- The ability of the program to facilitate better and more appropriate utilisation of non-government community resources, which were previously required to undertake a de facto case management role.

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- The program’s ability to contribute to staff development and support, in relation to working with people from culturally and linguistically diverse backgrounds.
- A 25 per cent decrease in the need for hospitalisation.

Some of the difficulties, which the evaluation documented, included:
- The practical problems of working across seven different district mental health teams in terms of time management and sense of belonging for the worker.
- Unclear accountability and supervision requirements.
- The need to undertake tasks which were beyond the scope or expectation of the position’s classification. It was recommended that the position be classified as a senior position.
- The time pressures imposed by the part-time nature of the position and a workload of 13–18 cases.
- The demands and expectations placed on the worker by the Chinese community and colleagues. For example, Chinese consumers expected the worker to provide services outside the case management role and colleagues expected the worker to act as an interpreter whenever needed.

Conclusion

The Queensland experience of trialling a bilingual/bicultural mental health case manager was very positive and appeared to have produced some major quality-of-life outcomes for consumers and carers which did not seem possible through the monocultural model previously employed. The major outcomes were in the areas of higher satisfaction with the mental health service; greater carer/family understanding of the illness, treatment, medication and side effects; greater carer involvement in treatment and input into the care plan, and a considerable reduction in the need for inpatient care.

There is no doubt that a number of factors could and would have impacted on consumers’ need for inpatient care, but the involvement of the bilingual case manager and greater carer participation and understanding were two new factors which did not impact previously, or not to the same extent. The intention was not to diminish in any way the efforts and skills of previous case managers who did their utmost to assist consumers and families through the various channels available. It seems that the Queensland model clearly substantiates the original hypothesis and some of the research in the field ‘that it is possible to achieve greater treatment outcomes if the consumer is matched to the mental health professional in terms of language and culture’. This model is obviously not the answer in all settings, but is worth considering in catchment areas where there are substantial numbers of a particular NESB group accessing or not accessing the mental health services available.
References


