Roses in the Ocean
stemming the tide of suicide

An **Innovation Paper** by Roses in the Ocean

Building capacity within culturally and linguistically diverse (CALD) communities through the lived experience of suicide.

Acknowledgements
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OVERVIEW

Roses in the Ocean is a lived experience of suicide organisation dedicated to informing, influencing and enhancing suicide prevention in the community and in workplaces. A large focus of our work involves empowering individuals and communities to better recognise and respond to suicide, and to use their expertise to be the change they need. Innovative services, system reform and cultural change are co-designed and delivered through the unique lens and collective expertise of people with a lived experience of suicide.

Over the years we have connected with communities through Primary Health Networks including working with South Eastern Melbourne Primary Health Network (SEMPHN) to deliver a selection of our capacity-building workshops (Voices of In-Sight, Our Voice in Action and TouchPoints). In November 2018, due to an identified need for support in a number of refugee communities, significant community consultation led to the delivery of the Voices of Insight workshop to members of Melbourne's Tamil community. The project was led by Layne Stretton (Senior Facilitator – Roses in the Ocean) in collaboration with Alison Asche (former Suicide Prevention lead of the Place Based Suicide Prevention trial at SEMPHN)

In 2019 an urgent need arose to build the capacity of the South Sudanese Australian community to respond to suicidal distress. SEMPHN and Roses in the Ocean agreed to shift focus and, following a period of consultation and co-design with community leaders, TouchPoints was delivered to faith leaders of the South Sudanese Australian community in December 2019. A further Touchpoints is currently in co-design for South Sudanese Australian women and additional workshops are planned for youth.

Considerable engagement with community in both formal and informal settings preceded the workshops, which assisted in gaining community trust and participation. Our investment in genuine community engagement fostered strong relationships with community and faith leaders which in turn opened up opportunities for collaborative re-design of existing content and co-design of new components of our Voices of Insight (speakers training) and TouchPoints (gatekeeper training). The relationship also resulted in upskilling of community leaders to co-deliver workshops, and, most recently, working to co-design ways to reach community during COVID-19.

Through the processes of consultation, collaboration, co-design and delivery of workshops to two disparate culturally and linguistically diverse (CALD) communities, we have identified four main areas of consideration when engaging CALD communities. While these focal points are neither exhaustive nor universal, they form a sound basis for further exploration of working with and engaging with CALD communities in suicide prevention.

- Politics, Religion and Societal Structures
- Linguistics, Literacy and Understanding
- Stigma and Discrimination
- Migration and Acculturation

Suffice to say, no culture or community is homogenous, and each member of a broader community must be regarded according to their specific context, background and circumstances. Even within one ethnic community, variations exist for example between tribal groups, generations and genders and are affected by other social structures including caste/class. As such, generalisations about cultural background, identity and religion must be countered with sensitivity and awareness of local and individual circumstances (Evason, 2018).

CULTURALLY AND LINGUISTICALLY DIVERSE COMMUNITIES

Since 1945, almost 7 million people have immigrated to Australia, making it one of the most multicultural countries in the world (*Immigration to Australia*, 2020). According to the 2016 Census of Population and Housing, 45% of Australians were either born overseas (26%) or had one or both parents who were born overseas (19%) (Statistics, 2017). Together, these groups of migrants - who come from a different country, speak a language other than English and represent different cultural backgrounds or religious beliefs - are known as culturally and linguistically diverse (CALD) populations.

A recent systematic review found no Australian studies on suicidality or suicide prevention in CALD populations (Bowden et al., 2019). However, Humanitarian Settlement Agencies and other organisations that provide direct care support to humanitarian migrants (refugees and people seeking asylum) in Dandenong have reported heightened vulnerability and suicidal distress in some communities over the past few years.

In their submission to the Royal Commission into Victoria's Mental Health system, the City of Greater Dandenong referred to the need for "greater investment in capacity building of community leaders and cultural groups in order to build mental health literacy in a culturally appropriate and sensitive way that accounts for beliefs from different countries of origin" (*City of Greater Dandenong Submission to the Royal Commission into Victoria's Mental Health System*, n.d.).

Of all CALD groups, humanitarian migrants are some of the most vulnerable to poor mental and physical health, and at higher risk of suicidal distress (Welfare, 2018). Much of this can be attributed to a history of previous trauma. In many cases, humanitarian migrants are fleeing some form of conflict. Previous traumatic experience in their country of origin may include armed combat, violence, imprisonment, sexual assault, persecution, or loss. The experience of displacement and forced migration - and the journey itself – further exacerbates risk of suicide (Byrow et al., 2019).

On arrival in Australia, migrants may face cultural bereavement and culture shock. Post migration factors such as detention, discrimination and destitution can lead to an experience of profound hopelessness. Acculturation - the process by which subjects acquire the attitudes, values, customs, beliefs, and behaviours of a different culture - may also play a role in the development of a suicidal crisis among migrants and ethnic minorities.

Stigma and discrimination also contribute to individuals from CALD communities having lower usage rates of mental health services. When individuals do use the services, they tend to have more acute mental health issues and are likely to spend longer in inpatient units.

Refugees in Melbourne were found to be 3.1 times more likely to have a mental disorder and twice as likely to have post-traumatic stress disorder (PTSD) compared with Australian-born individuals. Rates of PTSD, depression and anxiety were 3–4 times higher among Tamil asylum seekers than other immigrants. As well, Iraqi and sub-Saharan African refugees in Australia were found to have lower levels of mental health literacy compared with the general Australian population, indicating that targeted mental health promotion would benefit these refugee populations.

COMMUNITY ENGAGEMENT PRINCIPLES

Roses in the Ocean's approach to community engagement and capacity-building within the Tamil and South Sudanese Australian communities aligns with our organisational values (deep listening, authenticity, connection, humility, learning, collaboration, health) and our unique lived experience lens.

The foundational principles on which Roses in the Ocean workshops are developed – capacity-building, empowerment, sustainability, valuing every story/ insight - align with the needs of CALD communities in several ways. Additionally, storytelling sits at the core of all Roses in the Ocean workshops and activities, as it does in many CALD communities.

Specifically, we know that people with a lived experience of suicide bring insight, wisdom and perspective that is critical to informing the best approaches to reducing emotional distress and pain and saving lives. Participants have the potential, once enabled with training and support, to facilitate impactful local suicide prevention solutions that drive positive change in addressing stigmatising attitudes and culture, while contributing to healthy and sustainable communities.

This sits comfortably alongside the recognised "need for greater investment in capacity-building of community leaders and cultural groups in order to build mental health literacy in a culturally appropriate and sensitive way that accounts for beliefs from different countries of origin".

We believe it is essential to engage with local communities in the development, co-design and delivery of any capacity-building workshops or any other suicide prevention activity. Roses in the Ocean engaged individuals and organisations across the CALD communities in order to build trusting relationships in an endeavour to maximise community involvement. This included attendance at community forums, youth gatherings and social events, as well as forming partnerships with local ethno-specific organisations that had existing and established relationships with key community influencers. Productive relationships with bicultural workers and community leaders provided further leverage into the community, deeper insights into important cultural considerations, and a cultural lens throughout the development process.

Ongoing, deep engagement with community ensures that support is nuanced to cultural understandings of mental health and suicide prevention. Over time, this also provides the space to identify risk and protective factors specific to each community. It also allows for differences within a community (eg nuances in terms of gender, generations, ethnicity, faith) to be understood and training to be further adapted to meet these differences.

Embedding co-design at all stages of the workshop development and delivery and a co-facilitation/train the trainer model, ensures that the knowledge intrinsic to community guides all aspects of the workshops. The transfer of knowledge to the community further empowers and enables its members to contribute to suicide prevention and increases the likelihood that the knowledge base will be sustained. Having workshop developers and facilitators with a lived experience of suicide ensures that lived experience is central to the design, implementation, delivery and evaluation of initiatives. Our facilitators also bring a lived understanding of faith and an empathy and understanding that allows then to view challenges through the lens of trauma.

Building capacity within communities and in natural touchpoints (faith settings, youth groups, sporting clubs) contributes to ongoing sustainability as the necessary knowledge and skills related to suicide prevention are embedded in the community. This allows communities to determine and

develop their own solutions and acknowledges that they are best positioned to do so. It also provides opportunities to engage and educate recognised community leaders in mental health literacy and suicide prevention to become voices of influence and lead conversations in their respective communities. Community touchpoints may also provide additional 'safe spaces' for individuals to seek support when in suicidal distress, complementing mainstream mental health services.

COMMUNITY CULTURAL CONTEXT

Whenever we seek to train, share knowledge with or engage CALD communities in suicide prevention, it is essential that we know and understand the specific backgrounds and needs of the communities we are working with.

Based on our experience working with Tamil communities initially, and to a greater extent with the South Sundanese Australian community, we have identified four main areas that we feel require deeper consideration when engaging CALD communities in suicide prevention.

It must be noted that distinct variations exist across tribal groups within communities, as well as generations and the diaspora. As such, generalisations about identity and religion must be countered with sensitivity and awareness of local and individual circumstances. The observations that follow came from first-hand experience with the community by our workshop facilitators. They are not intended to represent all members of any particular community.

Politics, Religion and Societal Structures

The South Sudanese Australian community, as well as Tamil communities from Sri Lanka, represent two groups of humanitarian migrants (refugees and people seeking asylum) who have fled war and persecution in their home countries. While the disparate groups may share motivations – to flee persecution – they each bring with them a specific cultural overlay that must be acknowledged and reflected during all forms of community engagement.

In order to inform learning it was necessary for us to understand different political and social structures and how they might relate to or differ from western society's individualistic and capitalist culture. The Tamil community adheres to a caste system South Sudan's collectivist culture manifests as community interdependence, self-determination and autonomy. For the South Sudanese there is a heavy reliance on kin and community to look after the individual, and a broad mistrust of authority and government involvement in people's personal lives.

Due to the prevalence of religion in both communities, faith leaders hold significant positions of influence and were integral to planning and implementing our community capacity building workshops. South Sudanese Australians are predominantly Christian with some remnants of animism; the belief that objects, places, and creatures all possess a distinct spiritual essence. Conversely, many Tamil migrants in Australia generally adhere to Hinduism, which brings with it a divinely ordained caste system that pre-determines occupation and subsequently socio-economic standing. Social standing and influence can also be lost during migration as international qualifications of doctors and engineers for example may not be recognised in Australia.

When death by suicide occurs within these communities, it challenges many assumptive world views that have been part of the community for many generations. In the case of the South Sudanese community, our lead facilitator drew from his own religious background to guide relevant faith

leaders through parts of the Bible that discuss suicide. This investigative exercise helped break down some of the barriers to understanding and accepting suicidal behaviours.

The existence of a generational divide within CALD communities also influenced how we approach capacity-building. New migrants can face intergenerational conflict as older members of the community are more likely anchored in history and tradition and may find it more difficult to acculturate with Australian society. Younger migrants often find themselves 'between two worlds', having to straddle the past and the future.

Linguistics, Literacy and Understanding

While a basic level of proficiency in English was generally expected, several participants from the Tamil community were non-English speakers who required a translator. This raised concerns around the accuracy of translation given generally lower levels of literacy, reduced vocabulary, nuanced interpretation and inherent challenges in comprehending sector terminology (jargon).

Although the South Sudanese Australian participants had sound English language skills, there were still challenges around limited vocabulary and potentially poor comprehension of terms, ideas and concepts - specifically around suicide and suicide prevention. This may be attributed to differences in culture as well as language itself.

Beyond language skills, it was evident that members of these migrant communities had low levels of mental health literacy and limited understanding of Australian systems. With limited experience or exposure to mental health issues in their counties of origin, both Tamil and South Sudanese leaders shared common perceptions of individuals with poor mental health as being 'crazy' and 'treated by Witch Doctors' who 'exorcise the devil'. Alternative attitudes and beliefs included: 'medication will make the problem worse', 'counselling or talking about the problem won't fix it', and that 'only God will fix the problem'. The prevailing view is that those living with mental disorders cannot be treated, accompanying the belief that depression is a Western phenomenon.

Stigma and Discrimination

We found, and were told, that stigma surrounding mental health often manifests as discrimination, marginalisation and minimisation in these communities. For the South Sudanese Australian community their limited experience with mental health generates a healthy scepticism of accepted western prevention or intervention modalities such as therapy, GP consultations, emergency services or intervention by authorities. The cultural stigma as well as the disconnect between the community and the system can further hinder initial and ongoing help-seeking behaviours.

The normalisation or desensitisation of violence and death that arises within war-torn countries brings specific challenges to discussion on suicide. It was apparent during the workshop that the South Sudanese were open in their discussion of suicide deaths including graphic detail around method. It was also noticed that the language Tamils used to describe someone else's suicidal behaviour was sometimes harsh and stigmatising, and many participants were reluctant to share their own lived experience of suicide for fear of such discrimination.

Prejudice and racism against new arrivals to Australia is also problematic. Stigma and prejudice may further isolate those individuals and families and deepen the disparity of access to timely and appropriate health services. The labelling of 'African Gangs' in Melbourne is a particularly divisive generalisation that has been propagated by elements of the media.

Migration and Acculturation

It was noted that many humanitarian migrants (refugees and people seeking asylum) – as opposed to economic migrants – were often incumbered with historical trauma that can accentuate emotions and heighten the expression of grief and pain. This is exacerbated by feelings of disenfranchisement, with people expressing doubt as to whether they had made the right move to migrate. The younger generation may be more prone to a new trauma as they experience a disconnect from their new environment. Other acculturation pressures that were evident include insecurity of tenure, residency status and other immigration policies.

WORKSHOPS AND OUTCOMES

The Tamil Community Program was delivered in two workshops held in Melbourne over two weekends in November 2018, in partnership with SEMPHN.

Day one focussed on storytelling, structure and presentation. Participants and facilitators discussed and broke down their reluctance to share their stories. By the end of the day it became clear to participants how powerful stories can be and how they needed to develop the courage and skill to be examples of open and honest dialogue within their community.

Day two continued to discuss storytelling and messaging before moving onto a discussion about potential support for the community. A focus on Touchpoints and identifying touchpoints in the community followed. The group discussed what to do in situations of high distress and how they could establish a collaborative network of support and what strategies they might like to implement in the future. Two new non-English speaking participants joined the Tamil workshop on day two. While this slowed down the process due to the need for a language translator their presence was valued by all.

The South Sudanese Australian community program resulted in a TouchPoints (community gatekeeper) workshop being held at St Mary's Church on 14 December 2019. Attendees (8 men and 1 woman) came from a variety of faith-based environments including the Catholic Church, Uniting Church, Baptist Church and The Salvation Army.

The imperative of collaboration and co-ownership resulted in up to 20 hours co-design of workshop content and delivery as well as mental health and suicide prevention resources for the South Sudanese Australian community. Resources shared at workshops, included information on mainstream mental health services, resource packs and crisis cards that used infographics to meet the needs of individuals with lower English language literacy.

The desired outcomes from the TouchPoints workshop remained the same: to understand the complexity of suicide, learn warning signs and invitations for help, increase participant's confidence to help a person in crisis, learn the importance of self-care, challenge common myths about suicide with facts and lived experience, apply the 5 steps of supporting someone: Reach out, Listen, Risk, Action and Get Help, and learn practical ways to support someone grieving after a suicide.

Two South Sudanese Australian community leaders opened and endorsed the workshop commenting 'the fact that Layne and Alison are here is testimony that the government is listening'. This was an important moment in building connection and credibility across community.

The workshop started by addressing faith and its compatibility with mental health, suicidal ideation and suicide, important because faith leaders are often the first point of contact for many people living with suicidal ideations and other types of risk.

During the course of the workshop, there was a shift in thinking around where suicidal ideation and suicide sat within the community's faith-based environment.

Both the Tamil and South Sudanese Australian workshops were affected by time constraints due, in large part, to communication challenges. While large chunks of material had been removed from the workshops to support literacy levels, conversations generally took longer as ideas and concepts needed to be translated, explained or simplified.

Although neither of the workshops covered all the intended material, they were successful in opening dialogue with the two communities about mental health and suicide prevention. Subsequently, we received encouraging client feedback including significant desire to continue with the next phase of development.

LEARNINGS

Whenever we are given the opportunity to work with people from a CALD background, Roses in the Ocean believes it is essential that we acknowledge the situational limitations of our own 'western' views and adopt a culturally appropriate mindset and approach to vastly different cultural and societal mores. Our key learnings to date are:

1. No culture can be removed from its history. Participants' world views are as important as context, and time must be spent exploring the culture, respecting historical context and root cause of challenges, while dealing with the current situation.

2. By definition CALD communities in Australia can differ greatly from our traditional western views, requiring a deeper understanding of the way faith and cultural beliefs influence how mental health and suicide are perceived in these communities.

3. Workshops and programs that are developed and delivered need to be culturally aligned and able to be delivered by members of the community. No change will occur until the community has the experience and capacity to establish community-based systems that work.

4. Working with CALD Communities requires flexibility across all areas of design, preparation and delivery. Both parties need to be prepared to allow things to flow naturally in order to achieve outcomes. The workshop facilitator needs to raise and discuss cultural nuances and unpack any barriers to acceptance of new ideas and subsequent action.

5. In order to effect change and to create space for new ideas, theoretical models or even system intervention, broad agreement needs to be found that is compatible with faith. Faith and faith leaders are an integral part of the communication and influencing process. They a trusted point of contact and have broad influence across the community, particularly with the older generation.

6. Perceptions of mental health and suicide as 'demonic possessions' or 'punishments by god' are barriers to help-seeking behaviours. e.g. parents may be reluctant to seek support for their child for fear of being ostracised by their community at large and/or blamed for poor parenting.

7. Language barriers as well as low health literacy can contribute to reluctance seeking support or reduced understanding of services on offer and how to navigate them.

8. Past negative experiences with authority – either in country of origin, during migration or in Australia – may result in distrust of mental health services and government agencies.

9. Understanding of complicated grief and the way that the community processes loss and grief is a critical component of the design and development process. Normalising conversations about mental health and loss through suicide and understanding grief, means that we understand how to build the right content and the right conversations.

10. Broad communications need to target the community as a whole, but education needs to be specific to the demographic concerned.

11. Stigma is a major issue and influences how the community uses the services that are currently available.

12. Communities have their own way of speaking about the subject and a part of their culture is the recounting of stories. These stories will often involve details that we might normally exclude, including discussion about method.

13. Need for use of concise, simple plain English followed up with constant clarification of meaning being understood

RECOMMENDATIONS

From our experience to date working with CALD communities in the South East Melbourne region, we recommend the following:

Work with people of Influence: In many CALD communities, faith leaders are among the most influential and respected individuals in the community. Faith leaders are often the first point of contact for many people living with suicidal ideation and other types of risk. Not only are they a trusted point of contact, they also have broad influence across the community, particularly in the older generation.

Open Dialogue: The extent to which all parties are prepared to listen, and respect alternative positions is integral to reaching consensus. The facilitation style needs to be adjusted to make allowance for the way that the community functions, with more focus on open lines of dialogue and less on education on accepted Western positions. This also allows for and encourages differing views and opinions to be put forward in a deep listening environment where the intent is to understand alternative points of view rather than to solve problems.

Be Patient: Patience - from both parties - is essential when managing and enhancing relationships in CALD communities. Interaction between parties needs to have degree of elasticity, as expectations and reality are often quite different. Many African cultures, including South Sudan, are polychronic in their orientation, meaning they value the simultaneous occurrence of many things and the involvement of many people (Duranti & Prata, 2009). For some Westerners this may be perceived as erratic or chaotic with input coming from many sources or decisions being made and overturned in short succession. It may also result in a lot of people wanting to input into the process.

Capability will Vary: It's not uncommon for refugee communities to lack the understanding and confidence to support an individual at risk, as is often the case in all community settings across Australia. Limited understanding of mental health and suicide may result in minimising or ignoring symptoms. A lack of understanding of Australia's health care system, including basics such as where to get help, can act as a barrier or deterrent to help-seeking. Likewise, societal and cultural mores that manifest as stigma often impede an individual's willingness to seek help.

Time is of the essence: Understanding cultural mores and the nuances that come with diversity of experience requires significant investment. Time and visibility are critical in building respectful and robust relationships that build trust within the community. This foundational trust provides the platform for community willingness to be honest and open to receiving different narratives.

Grief and Loss Nuances: There is a need to be conscious of the fact that there are cultural issues around grief and loss that present significant barriers to talking about one's lived experience. We need to encourage people within the community to find the courage to talk about their personal journey.

STRATEGIC RECOMMENDATIONS

- Enhance access to mainstream mental health services through ongoing dialogue with community leaders to understand some of the challenges to help seeking.
- Explore alternative modalities of support that may better meet the needs of more collective cultures eg Group/family work as opposed to 1:1 therapeutic support
- Assist organisations and individual workers to evaluate their cultural responsiveness and enhance their delivery of services for CALD communities
- Improve the quality of mental health support for people from CALD backgrounds by improving cultural responsiveness and accessibility of mental health services.

NEXT STEPS FOR ROSES IN THE OCEAN

- Continue to work collaboratively with a range of ethnically diverse communities offering to co-design workshops such as Touchpoints and Voices of Insight with community members who are natural first responders eg faith leaders, youth ambassadors.

- Enhance early intervention opportunities by supporting community responders to develop the skills and confidence to respond to individuals before their distress elevates to the level of requiring tertiary suicide prevention services.

- Continue to identify national and international initiatives that may have synergies with Roses in the Ocean's capacity building workshops, in order to share learnings and explore opportunities to build capacity through partnerships.

- Continue to explore ways of scaling up the work through leveraging the engagement of community and trust already established via the workshops.

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