Australian Parliament
Joint Standing Committee on Migration
Submission no. 397

multicultural
MENTAL HEALTH AUSTRALIA

15 April 2011

Committee Secretary
Joint Standing Committee on Migration
PO Box 6021
Parliament House
Canberra ACT 2600
Australia
Email: jscm@aph.gov.au

Re: Inquiry into Multiculturalism in Australia

To the Committee Secretary,

Please find attached a response by Multicultural Mental Health Australia (MMHA) to the Inquiry into Multiculturalism in Australia. The Inquiry is welcomed by MMHA and our response is supported through MMHA's consultations with a range of stakeholders.

As the national peak body on multicultural mental health issues, MMHA's response has been primarily concerned with the needs of Australians from culturally and linguistically diverse (CALD) backgrounds who are affected by mental health problems.

This response has detailed key issues that affect this population group and makes recommendations to the Joint Standing Committee on Migration to address existing mental health disparities that many Australians from CALD backgrounds currently face.

As the national peak body funded to address multicultural mental health issues, MMHA would be please to provide further support as needed. If you have any further queries you can contact me on 02 9840 333 or via email at Georgia.Zogalis@swahs.health.nsw.gov.au

With regards,

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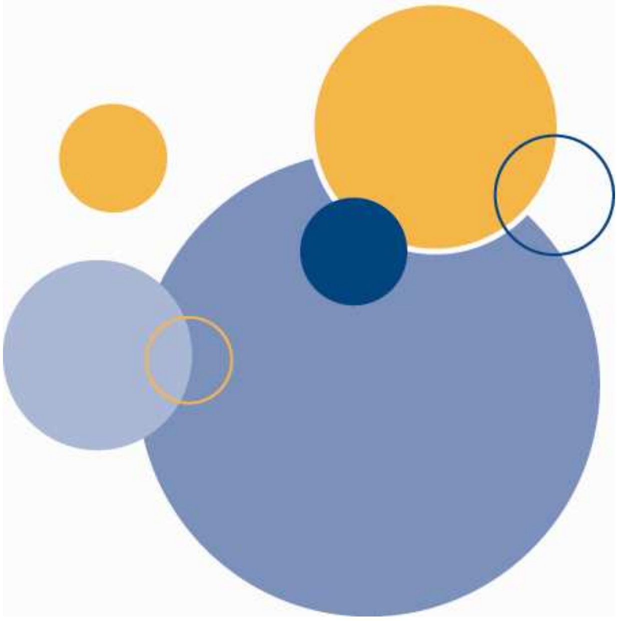
MENTAL HEALTH AUSTRALIA

Submission to the Joint Standing Committee on Migration's Inquiry into Multiculturalism in Australia

April 2011



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MULTICULTURAL MENTAL HEALTH AUSTRALIA

Multicultural Mental Health Australia (MMHA) actively promotes the mental health and well-being of Australia's diverse communities and seeks to improve access, responsiveness and quality of mental health services for these communities. It achieves this through partnerships with the Australian mental health sector, transcultural mental health and refugee services and networks, federal, state and territory governments as well as the community.

Multicultural Mental Health Australia is funded to provide national leadership in transcultural mental health under the National Mental Health Strategy and National Suicide Prevention Strategy of the Commonwealth Department of Health and Ageing.

Multicultural Mental Health Australia's Priority Areas	
Priority Area 1	Policy advice, development and implementation
Priority Area 2	Community capacity building and development
Priority Area 3	Communication, education & information dissemination
Priority Area 4	CALD carer & consumer support & representation
Priority Area 5	Workforce development

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1. EXECUTIVE SUMMARY

This submission is in response to the Joint Standing Committee on Migration's Inquiry into Multiculturalism in Australia. This submission addresses some of the key issues that impact on the social and economic participation, *and contribution*, of people from culturally and linguistically diverse backgrounds who are affected by mental illness and mental health problems in Australia.

This submission acknowledges and welcomes the recent multicultural policy by the Australian Government. However, it also considers the contribution that migrants have made to Australia and argues the need for more equitable access to mental health services. It presents evidence of the mental health disparities faced by Australians from culturally and linguistically diverse backgrounds.

The submission argues that migrants make a net positive contribution to the Commonwealth budget and enrich Australia's social capital. Yet, despite the contribution that they make, people from CALD backgrounds face significant disadvantages and social exclusion when it comes to accessing appropriate and timely health care.

While the terms of reference of the inquiry address the nexus between multiculturalism and social inclusion, and the settlement and participation of new migrants including refugees, and aspects of the productive capacity of migration, this submission focuses on the nexus between multiculturalism and social inclusion. The submission extends the terms of reference to consider some crucial issues that impact on the social inclusion of, not only new migrants, but also those who have lived here for many years (and their offspring).

In particular, it presents the case for improving Australia's social inclusion and multicultural policies in order to ensure that all Australians are able to fully participate in society, regardless of their mental health experiences, nor their cultural and linguistic backgrounds.

Firstly, this submission presents the stories of 3 people from culturally and linguistically diverse backgrounds who have been personally affected by mental illness. Their personal stories, which tell of their trials, tribulations and, importantly, contributions, are presented under section 2 (Making a Difference). Their stories are presented to the Committee, and to the public, to breakdown stereotypes and highlight the positive contributions that people from CALD backgrounds who are affected by mental illness make back to Australian society, despite the disadvantageous circumstances they have faced.

Secondly, the submission sets the scene by reviewing relevant literature related to the issues of multiculturalism, social inclusion and the role of Australia's national mental health policy (Section 3). It explores the contributions migrants to Australia have made and articulates the health disparities that Australia's migrants and their children have faced.

The next section (Section 4 - What Needs To Be Done) presents the issues that MMHA's stakeholders have raised through various consultations. Firstly, MMHA specifically consulted the following stakeholders to gather their views with regards to the Inquiry into Multiculturalism in Australia:

- Australia Federation of International Students (AFIS)
- Federation of Ethnic Communities Councils of Australia (FECCA)
- Forum of Australian Services for Survivors of Torture and Trauma (FASSTT)
- Fremantle Multicultural Centre (FMC)

- Institute for Cultural Diversity
- Multicultural Centre for Women's Health
- Multicultural Services Centre of WA (MSCWA)
- National Multicultural Youth Advocacy Network
- National Ethnic Disability Alliance (NEDA)
- NSW Transcultural Mental Health Centre (NSWTMHC)
- Settlement Council of Australia (SCOA)
- Tasmanian Transcultural Mental health Centre
- Victorian Refugee Health Network
- Victorian Transcultural Mental Health Centre (VTPU)

The group raised a number of issues with regards to the health disparities that Australians from CALD backgrounds face and the need to address these disparities if Australia's social inclusion policy is to be meaningfully enacted within a multicultural Australia. A fundamental issue that the group highlighted was the need to move from rhetoric to practical engagement of multicultural issues.

To prepare for this submission, MMHA has also brought together the findings from MMHA's previous consultations conducted, between July 2007 and June 2010, in the smaller states and territories across Australia where multicultural mental health services, networks and infrastructure were either non-existent, under-developed or fledgling (i.e. Australian Capital Territory (ACT), Northern Territory (NT), South Australia (SA), Tasmania (TAS) and Western Australia (WA)). This submission also incorporates the findings from MMHA's consultation report of national multicultural and ethno-specific peak agencies conducted in June 2010.

This submission brings the various findings together in order to highlight key issues that impact on culturally and linguistically diverse (CALD) communities affected by mental health problems and their capacity to access timely and culturally-appropriate services and fully participate in their community. The recommendations following on from the various consultations need to be taken up by Commonwealth, State and Territory governments if Australia's social inclusion policy is meant to be truly inclusive of all. Those recommendations are summarised overleaf.

Recommendations

1.

MULTICULTURAL GOVERANCE

The Australian government's social inclusion policy needs to incorporate and be aligned, in a meaningful way, with the government's new multicultural policy. This includes the need to develop, implement and monitor effective multicultural governance structures (such as those in NSW and WA) to ensure accountable application of access and equity strategies across Australia.

2.

STIGMA AND MENTAL HEALTH LITERACY

A clear vision, planning and resources are needed for reducing stigma and improving mental health literacy amongst Australia's CALD communities.

3.

CULTURALLY COMPETENT MENTAL HEALTH SERVICES

There is a need for uptake and implementation of national cultural competency standards and training amongst mental health services across Australia.

4.

CALD DATA, TARGETS AND RESEARCH

There is a need for:

- improved and consistent collection, analysis and reporting of CALD data of mental health service user demographics and outcome measures across Australia;
- targeted CALD performance benchmarks for publicly-funded mental health services;
- a funded national CALD mental health research agenda, including targeted research to analyse prevalence rates of mental health conditions amongst CALD populations across Australia.

Recommendations (Cont'd)

5.

INTERPRETER USE

There is a need for:

- mapping and coordination of the range of interpreter options and funding available for mental health services across Australia;
- training of mental health staff in the use of interpreters;
- training of existing interpreters (in all states and territories) to work in mental health settings;
- further increasing the pool of available interpreters for use in mental health settings.

6.

PARTNERSHIPS AND PATHWAYS

There is need for:

- funding Transcultural Mental Health Centres and Services in each state and territory; and
- increasing the capacity of existing transcultural mental health networks (including multicultural and ethno-specific services) to address mental health service and support gaps for CALD communities.

7.

CALD CONSUMER AND CARER PARTICIPATION AND ADVOCACY

There is need for:

- prioritising CALD consumer and carer participation at the state and territory level and fund initiatives that increase true participation; and
- prioritising CALD consumer and carer representation at the national level via the National Mental Health Consumer and Carer Forum.
- Funding for ethno-specific and illness-specific peer support groups for CALD communities

8.

TARGETTED INITIATIVES FOR SUB-POPULATIONS AND SUICIDE

Planning to meet the mental health needs of CALD populations needs to consider:

- targeted initiatives according to population groups such as men, women, youth, aged, refugee and newly emerging communities, and people with co-occurring disabilities.
- improved data collection, reporting and analysis of suicide in CALD communities; and
- targeted suicide prevention programs for CALD communities.

2. MAKING A DIFFERENCE – CALD CONSUMER AND CARER STORIES

This section presents the stories of 3 individuals from CALD backgrounds that have been personally affected by mental illness.

As part of its Consumer[1] and Carer program, Multicultural Mental Health Australia prioritised the creation of national CALD consumer and carer reference groups that would be able to advise MMHA on relevant multicultural mental health issues and on MMHA projects and also drive the consumer and carer program of the organisation. This is primarily done through MMHA's National Consumer and Carer Reference Groups. MMHA also strongly believes in consumers and carers being involved at the design stages of its consumer and carer projects and this is reflected in its work consulting with consumers and carers to prioritise the project activities at the beginning of each calendar year.

One significant example of this is the establishment of the Consumer and Carer Speakers Bureau. The Speakers Bureau is an initiative of MMHA that trains and supports CALD consumers and carers to share their stories in public forums, conferences and with the media. Around 50 consumers and carers from a range of different CALD background from across Australia are currently members of the Speakers Bureau. This work has provided a voice for CALD consumers and ensured increased visibility of CALD mental health consumers both in the mental health arena and the general CALD communities.

The MMHA's Speakers Bureau helps to raise awareness of issues surrounding mental health of people from CALD backgrounds and in turn helps break down the stigma attached to mental illness. The Speakers Bureau is inclusive of consumers and carers from CALD backgrounds and ensures their voices and views are heard across all media outlets (radio, newspapers, newsletters, internet, television) as well as public speaking at launches, conferences, forums etc

MMHA strongly believes in the value of drawing from the unique perspective of the lived experience of consumers and using the media to de-mystify mental illness due to its influence in the formation of public attitudes, and the power of journalists working in radio, newspapers and television either to dispel or to reinforce misconceptions about mental illnesses.

Members of the Reference Group have already become involved in the Speakers Bureau in a variety of ways. They have spoken out in the media and written articles for the MMHA's magazine (Synergy) on issues ranging from bipolar disorder, schizophrenia, torture and trauma, medication, co- morbidity, being a carer, being a consumer researcher and participating in the CALD mental health consumer movement.

Within this section, 3 people present their stories which tell of their struggles, tribulations, and, importantly, the contribution they have made back to Australian society. Their stories highlight the importance of personal volition in their ability to succeed, and, importantly, the role of targeted support structures that enable CALD consumer and carer participation.

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[1] Consumer, within the mental health context in Australia, refers to people who have directly experienced mental health problems.

Lilly's story: Speaking out for those who cannot…

My name is Lily Wu. In 1990, I arrived in Australia from China with my husband. I am a mother of two wonderful, successful and well-educated children. I am also employed by both government and non-government agencies as a qualified health education officer, mentor and peer support worker for people with a mental illness. I love my job. I feel so rewarded when I am able to help people, particularly people from diverse cultural backgrounds starting a new life.

In my spare time I love shopping, particularly for bright sparkling jewellery, colourful clothes and shoes. The colours cheer me up. I love listening to pop songs and love song dedications on the radio. I love listening to traditional Chinese music. Listening to it is like being carried through the atmosphere back to my home country but never leaving home.

The bursts of colour and song in my life are also over-shadowed by dark clouds. I have lived with a mental illness since my late teenage years. I was initially diagnosed with schizophrenia. After I gave birth to my two children, I was diagnosed with post-natal depression. Later it was anxiety, and most recently, bipolar and schizoaffective disorder.

Due to my illness, I know what it's like to live under dark clouds and never see the light. I know what it's like to always feel gloomy and to feel like you can't breathe. I know what it's like to never be able to see the sunrise or the sunset, even though it is a beautiful bright morning or a clear, warm evening. I know what it is to be afraid of taking your medication because it makes your legs feel like lead, too heavy to lift.

This is my lived experience of mental illness.

I had to see different doctors all the time, repeating myself. Repeating my story. Repeating my fears in an alien tongue, the words always failing to represent my true feelings.

I love living in Australia and I have never regretted my decision to leave China. Images of Australia's beauty were first conjured up in my mind by letters from an Australian pen pal. Her descriptions of Australia's beauty didn't exaggerate. But it hasn't been easy to settle in Australia. I felt like an outsider for many years and this certainly contributed to my depression.

When I first arrived, I got culture shock. My qualification wasn't recognised and I couldn't find any type of job. Everything I tried failed and it made me feel very depressed. I also became pregnant and this in itself was difficult to deal with, even though it was welcome news and my husband loved me dearly. I had to see different doctors all the time, repeating myself. Repeating my story. Repeating my fears in an alien tongue, the words always failing to represent my true feelings.

Not being able to express myself was like being trapped. It felt like a heavy stone was pressing on my heart. I tried to pry it off but I couldn't. I felt like I might have to start pinching my hands, stamping my feet to make myself understood. I didn't. I'm not a violent person but I desperately wanted to make the clinician understand just how sick I was.

Bringing up two children was also very isolating. I love my children but I was denied adult conversation for almost a decade. My husband at the time was working a full-time and part-time job to cover our expenses and had not much time for me. My neighbours would smile and wave but no-one invited me into their home, into their life, except for a few Australian and Chinese friends.

Arriving in a new country, you have all sorts of big dreams. In China, I was an assistant institute lecturer and I dreamt I was going to be a successful career woman in Australia. It was also the dream of my family and friends in China. When nobody in Sydney took notice of my achievements and professional experience, I felt like a fool. I also felt inadequate, desperate and ashamed. After my children became teenagers, I went back and retrained in childcare. I worked for a while in this sector but my health relapsed and no-one would re-employ me. I don't know why. But I do think it is sad. It implies that all people with a mental illness are a danger to children.

People have told me that my presentations have empowered them. It has made them realise they can recover and lead the life they want to lead.

Looking back on this period, I realise that this is what propelled me into my current job as a qualified health education officer, mentor and peer support worker. It was during this time that I recognised I had the capacity to speak out for people who cannot speak for themselves or whose voices are being drowned out. I wanted to work with people experiencing mental illness and help them on their journey to recovery. People have told me that my presentations have empowered them. It has made them realise they can recover and lead the life they want to lead. Recently, I spoke at an Italian restaurant and the owner came up to me later and told me my delicious chicken breast gnocchi was free. He wanted to thank me for sharing my story.

There is a Chinese proverb which illustrates why creating a community and belonging to a community is so important. Community is like a rope. The people are the small strings. All these strings tied together form one strong rope which helps people climb the highest mountain, to reach the peak, enjoy the beautiful view and to see the sunrise.

Francesca's story: Speaking out about stigma…

My name is Francesca[*]. My parents arrived from Italy in the 1950s. They came on separate boats and didn't meet until after they settled in South Australia. When my parents got married, they worked really hard to build a life together. I think Mum and Dad have really contributed to Australia because they became quite successful and paid taxes, boosted business and provided jobs for others.

For us, family is very important. I remember when we were a lot younger our home was always very open. It was a place where all of the neighbourhood children could gather. Mum and Dad were always big on sharing whatever we had. If we only had three iceblocks in the freezer and there wasn't one for every single kid visiting us, than nobody got one. There had to be enough for everyone. It was always the way. My parents would welcome everyone into their home with open arms and treat them as family.

Finding the courage to go out and find work is an exhausting and scary challenge. I feel completely alone because people almost resent the fact that I am at home. Perhaps it is not resentment but they really come down hard on you and judge you. If I had a broken arm, or something else was visibly wrong with me, they wouldn't be so critical.

Growing up as a second-generation Italian you have to constantly juggle peer, family and cultural expectations and you try to blend in. You do learn a lot from your parents' culture but you have to forge your own identity as well. Blending the Italian and the Australian culture was difficult because I was called names and ostracised. I remember as a little girl there would be a lot of ridicule from bystanders. I would be out shopping or coming home from the park and people would call out derogatory remarks, name calling and things like that. It sometimes made it difficult to embrace the beauty of the Australian culture.

As an adult, this hasn't changed. I used to work as a health professional. I had to stop working because I was bullied and ostracised. The people I worked with called me horrible names; mainly crude references about my parents' culture and derogatory remarks about being a woman. But it wasn't just me they picked on. It was other people who worked there and people accessing the health service. Australia calls itself a multicultural country but racism often rears its ugly head and maims innocent people. I don't think people are aware of how racism can affect you in the long term. It can destroy your self-confidence, your ability to embrace new experiences and new people, and can make you doubt your true worth. It's debilitating.

The incessant harassment and humiliation took its toll on my health. I started to notice that I would get quite physically ill before work. I couldn't sleep. I became quite withdrawn, grumpy and irritable, and experienced a feeling of hopelessness. It went on for eighteen long months until I couldn't take it anymore and I left my job.

Those eighteen months were the most difficult of my life. Because of what I experienced, I have since been diagnosed with anxiety and depression. I am still recovering. Finding the courage to go out and find work is an exhausting and scary challenge. I feel completely alone because people almost resent the fact that I am at home. Perhaps it is not resentment but they really come down hard on you and judge you. If I had a broken arm, or something else was visibly wrong with me, they wouldn't be so critical.

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[*] This is a pseudonym

It puts me in a really bad place when people can't understand what I have been through. It makes the recovery process really hard.

When I was first diagnosed, it was a massive learning curve for all of my family. We had never encountered mental illness first-hand. They found it really hard to cope with the days when I felt positive and self-assured, and the days I felt I could never laugh again. I call them my pink and blue days. But my Mum would come over, which was really important, and help me out with daily duties that I just kind of forgot along the way because my brain was so overloaded. My husband was very supportive, and always listened to me. My middle sister and Mum would also come with me to appointments.

My family has been great but I cannot shake the feeling that others around me are disappointed in me. I constantly get comments about being at home with nothing to do. I can't stand that. I end up carrying around all this guilt and shame and it is like a major chip on my shoulder. I will be really honest and admit I can be quite angry and bitter about it.

> *Working with MMHA has given me a voice. They have actually have asked me questions that not even my family or the closest people to me have ever asked. I think that's brilliant. They have empowered me in ways that I can't explain.*

With mental health you can feel quite ashamed and put into a corner. It's almost like you have done something wrong. Multicultural Mental Health Australia has alleviated that because I have managed to meet fantastic people through them and I have realised that it's going to be okay. I have met and identified with other people and it just has opened up a whole new world for me.

In my community you are not allowed to speak about mental illness. Working with MMHA has given me a voice. They have actually asked me questions that not even my family or the closest people to me have ever asked. I think that's brilliant. They have empowered me in ways that I can't explain. Now I am not ashamed and so embarrassed. I will talk about my illness in my community and I will talk about it in my family.

Kwilimby's story: Combating racism and stigma…

When sharing my personal experience of mental illness, I prefer to use the name Kwilimby (a pseudonym). I live in a small community in Western Australia and I would rather that people did not know that I sometimes have periods of depression. Not everybody realises that mental illness is a disease like any other and it can be treated.

I arrived in Australia in 1988. I wanted to create a better life for my children. I had 20 years professional experience as a mining engineer in both open cut and underground mining. This type of profession takes years to learn. It takes practice.

My experience meant that I had many job interview requests. But when I arrived at the interview, people would see me in person and would be surprised by what they saw. It was always a big shock. My name doesn't necessarily reflect my cultural heritage and they did not seem to have considered that a person with my skin colour could be more skilled than they were.

You can always tell when someone is reassessing your skills based on your appearance. I grew up in a colonialist society and I recognise all the tricks of the trade. When they see you, their face changes, everything changes: their eyes, the tone of their voice. You're acutely aware of the smallest change in behaviour. I have been suffering from discriminatory behaviour for decades and have learnt how to recognise the signs the hard way. The combination of workplace discrimination and an economic recession meant that I could not find secure employment for many months. When I did get employed, it was not because my skills were recognised and appreciated. It was because I knew someone, who knew someone, who knew someone.

> *I still won't tell future employers that I experience depression because I don't want them to create a false link between my illness and my ability to contribute professionally. When you talk about depression with people who don't experience it, they still consider it very dangerous. It makes it quite hard for people who do live with it.*

When you cannot achieve what you set out to do it's frustrating and it's not a good feeling. My depression increased because I was not given an opportunity to work and all of the barriers that were being erected around me aggravated my sense of isolation and failure.

Putting a label on people creates a problem. I think if we want to create a truly multicultural society, everyone needs to be accepted and it needs to start at school. Multiculturalism means treating everyone equally; not just people from different cultural backgrounds but also people who have varying levels of illness, varying levels of ability, varying levels of intelligence. It has to filter across all these categories. Everyone can contribute something positive to the community. When my children were young, I was always teaching them about our ways, our music, our culture and all this contributes to Australia's multiculturalism. My children also helped other immigrant children to integrate into the community and share their stories. They would find children who could speak the same language and explain what they know and what they like.

I think we can get better at welcoming people who experience life differently to what people sometimes label 'normal'. I still won't tell future employers that I experience depression because I don't want them to create a false link between my illness and my ability to contribute professionally. When you talk about depression with people who don't experience it, they still consider it very dangerous. It makes it quite hard for people who do live with it. But with time that will improve and more people will realise that this can happen to anyone – a mother, a brother, a daughter – and it can be treated.

3. SETTING THE SCENE – MULTICULTURALISM, SOCIAL INCLUSION AND THE HEALTH OF CALD COMMUNITIES

3.1 Multiculturalism and the contribution of immigrants

Multiculturalism has always been a highly debated concept in Australia and, overseas, in North America and Europe (Inglis, 1996; and Koleth, 2010). Economist Philippe Legrain (2006) argues that debates concerning multiculturalism have been dominated by fear of perceived difference; fear of perceived unfair distribution; and consumption of limited resources and fear of perceived cultural, religious and social colonisation by minority groups. In Australia, these same fears have fuelled debates about Australia's migration policies. These fears resulted in the White Australia Policy between the 1880s and 1970s (Henry, 2010), and, more recently, these fears were played out following the September 2001 terrorist attacks on the Twin Towers in New York (Henry, 2010; Koleth, 2010; Legrain, 2006).

Yet, immigration continues to play an important part in Australia's social, cultural and economic development. A recent analysis by Access Economics, on behalf of the Department of Immigration and Citizenship, of fiscal impacts of migration on the commonwealth budget concluded, "*The bottom line result is that new migrants provide a substantial contribution to the Commonwealth government budget initially, and this contribution grows over time in real terms*" (Access Economics, 2008, p.i).

Not only do immigrants make a significant net positive contribution to the commonwealth budget, immigrants also help alleviate economic factors that push people away from their countries of origin. At its last estimate, the World Bank estimated that remittance flows, by immigrants back to developing countries, were estimated to reach $374 billion by 2012 (World Bank, 2010).

Immigrants also make significant contributions to Australia's social capital. Research by Volunteering Australia and the Australian Multicultural Foundation (2007) found that immigrants make a significant contribution to Australia's social capital through formal and informal[2] volunteering activities, with many contributing as much as 2 to 4 days per week to unpaid volunteer work (both formally and informally), and with most contributing unpaid work to both mainstream and multicultural and/or ethno-specific volunteer organisations.

Yet, despite the significant social, economic and cultural contribution that immigrants make to Australia, immigrants, particularly those from non-English speaking backgrounds, have faced a range of hurdles in accessing supports and services when they have needed them. Hereafter, this submission will refer to Australians from culturally and linguistically diverse backgrounds (CALD)[3]. The next sections present the disparities that Australians from CALD backgrounds have faced with regards to getting appropriate support for mental health problems.

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[2] Informal volunteering refers to volunteering without a formal volunteering process such as through helping out neighbours, community members and family.

[3] For the purposes of this submission MMHA defines culturally and linguistically diverse (CALD) Australians as people who identify as being first, second or subsequent generations of non-main English speaking countries. This includes people who have emigrated directly or indirectly from non-main English speaking countries to Australia, or who are descendents of these people. It also includes humanitarian entrants, refugees, asylum seeks and people who have voluntarily elected to come to Australia for economic, social, political or lifestyle reasons. Australians with one parent, grandparent or great-grandparent from a CALD background are also included in this definition.

3.2 Multiculturalism and Australia's social inclusion agenda

As Koleth (2010) has presented, Australia's political history has been punctuated with varying levels of commitment to multiculturalism. This varying level of commitment to multiculturalism has resulted in health inequities between the mainstream population and those from culturally and linguistically diverse backgrounds.

Vichealth, a health promotion program funded by the Victorian government, succinctly defines health inequalities as "*differences in health status (such as rates of illness and death or self-rated health) that result from social, economic and geographic influences that are avoidable and unnecessary*" (VicHealth, 2005, p.1). It further conceptualises health inequalities according to three dimensions:

- *Inequality of access*
- *Inequality of opportunity*
- *Inequality of impacts and outcomes*

Vichealth further argues that "*Ensuring equality is about moving beyond equality of access (mainly understood as cost, cultural barriers such as language translation, physical modifications and culturally appropriate service delivery) to ensuring equality of opportunity (addressing economic, social, cultural and geographic influences) and measuring equality of impacts and outcomes (by collecting demographic data that analyses the different impacts for sub-populations facing inequality).*" (Vichealth, 2008)

Within this context, this submission argues that people from CALD backgrounds have been particularly disadvantaged when it comes to health access, opportunities and impacts. While it can be argued that the commonwealth's social inclusion agenda, *A Stronger, Fairer Australia* (Department of Prime Minister and Cabinet, 2009), is inclusive of all, this submission is of the view that it fails to adequately address the social exclusion of CALD communities. While the policy acknowledges some types of social exclusion that people from CALD backgrounds face, it fails to explicitly articulate strategies to address CALD disadvantage, particularly in health and mental health. These issues, and strategies to address CALD disparities in health, need to be explicitly articulated within the commonwealth's social inclusion agenda if the policy is expected to live up to its mandate.

3.3 Social inclusion and the national mental health policy

The 2008 National Mental Health Policy describes its vision for an Australian mental health system as one which 'enables recovery, prevents and detects mental illness early, and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community'. This ambitious policy describes its strategic framework as 'deliberately aspirational' and as 'a broad agenda to guide coordinated efforts in mental health reform over the next decade' (DoHA, 2009).

The development and implementation of the 2008 policy, and the ensuing Fourth National Mental Health Plan (Commonwealth of Australia, 2009), follows two decades of national reforms and improvements to mental health care, starting with national consensus on the Mental Health Statement of Rights and Responsibilities in March 1991, to a renewed bipartisan commitment to mental health reform and investment after the 43rd Australian Parliament formed in late 2010.

The scale and significance of mental health issues and the toll mental illness (or lack of mental wellbeing) can take on an individual's ability to participate socially, culturally, economically and politically are issues which have received an increasing amount of attention in Australia and internationally. Indeed, the reforms occurring in Australia stem from a series of international conferences and charters advocating for a health system underpinned by principles of equity, access, and meaningful consultative participation and community engagement.

Arguably the impetus to building such a system began in 1946 when the World Health Organisation (WHO), in the preamble of its Constitution, defined 'health' as a state of complete physical, mental and social wellbeing; not merely the absence of disease or infirmity. Moreover, it stipulated that enjoying the highest attainable standard of health is the fundamental right of every human being, regardless of their race, religious or political beliefs, economic or social situation (WHO, 1946).

This rights-based approach to health and service access was further developed in 1986 at the first international conference on health promotion (auspiced by the WHO) in Ottawa, Canada. Significant progress was made on the way health and its attainment is understood and the resulting Ottawa Charter for Health Promotion states that political, economic, social, cultural, environmental, behavioural and biological factors can either work to support good health, or they can harm it. Furthermore, the charter nominates the following as essential health enablers: supportive environments, access to information, life skills, and opportunities to make healthy choices. Within this context of facilitating good health, the Ottawa Charter outlines five action areas for health promotion: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorienting health services (WHO, 1986).

The principles of the Ottawa Charter and the nominated action areas have since been promoted by the WHO and the international health community and have become an international benchmark for health promotion and planning, including mental health, and are recognised and accepted in Australia.

In the case of Australian mental health reform, the need to safeguard the rights of mental health consumers, promote mental health and prevent mental illness, and reduce the overall impact of mental illness on the community are principles which have guided policy makers since 1992, when the National Mental Health Strategy was supported by the Australian Health Ministers' Conference (AHMC) (DoHA, 2010). Since then, these principles have acted as a foundation for the development of all National Mental Health Plans, including the 2009-2014 Fourth National Mental Health Plan.

The most recent National Mental Health Plan differs in one fundamental aspect to its predecessors, namely its commitment to social inclusion as a priority area with specific outcomes, actions and indicators for monitoring change. A nominated target group for this priority area is all members of the community 'from culturally and linguistically diverse backgrounds and new arrivals' (Commonwealth of Australia, 2009). In addition, the overall plan is guided by a number of socially inclusive principles, which include:

- Respect for the rights and needs of consumers, carers and their families
- Services delivered with a commitment to a recovery approach
- Social inclusion
- Recognition of social, cultural and geographic diversity and experience
- Recognition that the focus of care may be different across the life span
- Services delivered to support continuity and coordination of care
- Service equity across areas, communities and age groups
- Consideration of the spectrum of mental health, mental health problems and mental illness

Given that almost a quarter of Australia's population is born overseas (or 4.4 million), almost 15 per cent are born in a non-English speaking country and a further one-fifth of the population have at least one parent born overseas (Coghlan, 2006), the specific health – and mental health – needs of these members of the Australian community require an increased amount of government attention and need to be incorporated into mainstream policy and planning. While there have been some positive developments to target these groups (including the NSW Multicultural Mental Health Plan, which builds on the Framework for the Implementation of the National Mental Health Plan 2003–2008 in Multicultural Australia, the Multicultural Mental health Australia project, and the revised 2010 National Standards for Mental Health Services which includes 'Standard 4: Diversity Responsiveness') more systematic and mandated improvements are required.

3.4 The health of CALD communities

People from CALD backgrounds have been significantly disadvantaged in Australia's health system. Systematic barriers, such as a lack of prioritising the health needs of CALD communities, have excluded these communities from basic health care services available to others. The argument of "the healthy migrant effect" has been inappropriately used to redirect health policy away from targeting CALD communities. Yet, Julian (2004) argues that further analysis of the health status of immigrants, beyond this initial effect, reveals that immigrants tend to be overrepresented in lower socioeconomic status categories and are therefore susceptible to poor health. A concern is that, after initial "healthy migrant effect, the health status of most immigrants tends to become aligned with that of the general population as their length of stay in Australia increases (Julian, 2010), and immigrants experience more barriers to appropriate health care than the Australian born (AIHW, 2010). In addition, Australian literature (AIHW, 2010; Vic DHS, 2008; NSW Refugee Health Service, 2006; NEDA, 2010) indicates that:

- People born in Southern and Eastern Europe had a higher prevalence of health risk factors;
- People from Oceania, UK and Southern and Eastern Europe were more likely to be overweight or obese; and
- Death rates for those born overseas were higher than Australian-born for:
    - lung cancer among those born in the Netherlands, the UK and Ireland;
    - diabetes among those born in Germany, Greece, India, Italy, Lebanon and Poland; and
    - coronary heart disease among those born in Poland.
- People from refugee backgrounds tend to have multiple and complex health problems on arrival in Australia and tend to have higher rates of long-term medical and psychological conditions than other immigrants; and
- Older people from refuge backgrounds are likely to be at higher risk of poorer psychological and psychical health than the mainstream population.
- People from CALD backgrounds over 45 acquire a greater rate of disability than their English speaking counterparts.

Furthermore, culturally sensitive research has indicated that people from CALD backgrounds have higher levels of depression and anxiety than Anglo-Australians (Kiropoulos et al, 2005).

Given this health context for people from CALD backgrounds, a crucial aspect of planning for local health needs, is the collection, analysis and reporting of CALD data on local health needs, as well data on the outcomes of health interventions. However, people of CALD backgrounds often miss out on important health care services as adequate data on CALD demographics, prevalence rates of health problems and the outcomes of treatment is not collected, analysed and reported on. This prevents health planners from adequately planning and designing health services to meet the needs of a diverse Australia. In addition, culturally sensitive research and data collection methods are often not used. For example, the National Mental Health and Wellbeing Survey makes the erroneous conclusion that there is little difference in prevalence rates of high-prevalence mental health disorders between people from CALD backgrounds and the Australian born due to the fact that the survey failed to include those with low English proficiency (Kiropoulos et al, 2005).

This hinders the development of evidenced-based health interventions that targets health disparities for people from CALD communities (Blignault & Haghshenas, 2005; Nerenz et al, 2006; Garrett et al, 2010).

While the Australian Bureau of Statistics' *Standards for Statistics on Cultural and Language Diversity* (1999) recommends the collection of twelve CALD data variables (with four minimum core sets being: Country of birth; main language other than English spoken at home; proficiency in spoken English and Indigenous status), there are considerable variations in the quality and extent of CALD data variables that are collected across Australia's health system (Blignault & Haghshenas, 2005).

This lack of adequate CALD data collection, analysis and research within Australia's mental health system is symptomatic of the lack of prioritising of adequate CALD data collection, analysis and research within the broader health system as well. For example, a review by Garrett at al (2010) of coverage of non-English-speaking immigrants and multicultural issues in three major Australian Health Care publications (*The Medical Journal of Australia, The Australian Health Review*, and *The Australian and New Zealand Journal of Public Health*) revealed that only 2.2% of articles were primarily based on multicultural issues.

A lack of adequate CALD data collection, analysis and reporting will hinder the capacity for Australian and State and Territory governments to meaningfully analyse, report on and plan for improved health outcomes for Australia's diverse communities.

3.5 Patterns of access to mental health services

While research by Bruxner, Burvill, Fazio and Febbo (1997), of psychiatric admissions of CALD patients to hospitals in Western Australia, showed widely varying treated prevalence according to ethnicity, most Australian literature (Minas, Lambert, Kostov, & Boranga, 1996; Klimidis et al, 1999; Stolk, Minas, & Klimidis, 2008; Minas, Silove, Kunst, 1993; Sozomenou, Mitchell, Fitzgerald, Malak & Silove, 2000; DOHA, 2004) tends to identify the following patterns of use of clinical mental health services across Australia:

- There tend to be higher rates of involuntary and lower rates of voluntary admissions by consumers from CALD backgrounds;
- There are lower rates of access to community and inpatient services compared with Australian-born people;
- People from CALD backgrounds with mental illness tend to be hospitalised for longer;
- People from CALD backgrounds with mental illness are more likely to present for treatment at the acute, crisis end of treatment.

Delayed treatment can be traumatic and can cost individuals and their families their health and wellbeing. It can also delay recovery rates and possibly worsen prognosis. Longer and involuntary hospital stays also increases the costs of care that may have been prevented through early and preventative interventions.

3.6 Barriers to getting help when it is needed

Australian and international research on the perceptions of consumers and carers from CALD backgrounds, CALD communities, and mental health staff[4] tend to attribute the persistence of the previously outlined disparities to the following categories of factors:

- cultural perceptions, beliefs, stigma and knowledge of mental illness, its causes and treatment options (which can influence whether the person decides to seek help for their mental health problems in the first place); and
- cultural responsiveness of services and, more broadly, the mental health system (which can influence the experience people have with the mental health service and whether or not they will return or recommend it to others) .

Clearly, disparities in mental health outcomes have been evident for Australians from CALD backgrounds despite the contributions that Australians from CALD backgrounds make to Australia. The next section presents key issues raised by MMHA's stakeholder consultations and the ensuing recommendations in order to enact Australia social inclusion policy for all Australians.

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[4] For ease of reading the references are listed in this footnote: Minas, Stuart & Klimidis, 1994; Rooney, O'Neil, Bakshi, & Tan-Quigley, 1997; Bower, 1998; Khalidi & Challenger, 1998; Fan 1999; Collins, Stolk, Saunders, Garlick, Stankovska, & Lynagh, 2002; Carers Victoria, 2003; MMHA 2004; Wynaden, Chapman, Orb, McGowan, Zeeman, & Yeak, 2005; Kokanovic, Petersen, & Klimidis, 2006; and Rooney, Wright, & O'Neil, 2006; Alvidrez, 1999; The Sainsbury Centre for Mental Health, 2002; and Scheppers, Dongen, Dekker, Geertzen & Dekker, 2006

4. WHAT NEEDS TO BE DONE – STAKEHOLDER FEEDBACK

This section draws on a national teleconference consultation, held by MMHA, with key stakeholders in the multicultural health sector and from previous State and Territory consultations organised and reported by MMHA. It presents key priority areas, as identified by stakeholders, which need to be addressed by Commonwealth and State and Territory governments in order to reduce health, and in particular mental health, disparities faced by CALD communities across Australia. It is clear that addressing these disparities needs to be prioritised if Australia's multicultural policy and social inclusion policies are to be meaningfully enacted.

4.1 From rhetoric to practical engagement

On the 23 March 2010, MMHA hosted a teleconference consultation with key stakeholders involved in multicultural health and welfare issues to specifically gather their views with regards to the Inquiry into Multiculturalism in Australia. Stakeholders also provided feedback via email.

The following stakeholders participated in the consultations:

- Australia federation of International Students (AFIS)
- Federation of Ethnic Communities Councils of Australia (FECCA)
- Forum of Australian Services for Survivors of Torture and Trauma (FASSTT)
- Fremantle Multicultural Centre (FMC)
- Institute for Cultural Diversity
- Multicultural Centre for Women's Health
- Multicultural Services Centre of WA (MSCWA)
- National Multicultural Youth Advocacy Network
- National Ethnic Disability Alliance (NEDA)
- NSW Transcultural Mental Health Centre (NSWTMHC)
- Settlement Council of Australia (SCOA)
- Tasmanian Transcultural Mental Health Centre
- Victorian Refugee Health Network
- Victorian Transcultural Mental Health Centre (VTPU)

The group raised a number of issues of concern such as the need for:

- Targeted multicultural services
- Development of the cultural competency of mainstream services to work cross culturally
- Targeted research in multicultural issues, including the development of better multicultural data collection, analysis and reporting that will enable better planning for the delivery of services to Australia's CALD populations.

Participants also recognised the lack of access to professional interpreters in many government programs. For example, a Tasmanian representative provided feedback that a portion of the population in Tasmania (Non-English speakers, or those not confident communicating about sensitive mental health topics in English) are not able to access the `Better Access to Mental Health' scheme because interpreters are not provided for private allied health practitioners. Therefore a large proportion of people from CALD backgrounds do not have equitable access to appropriate mental health care. These and many other themes are further captured in the next section (section 4.2).

However, a fundamental issue that the group highlighted was the need to move from rhetoric to practical engagement of multicultural issues. Stakeholders articulated the need for better alignment between Australia's recent multicultural policy and the government's existing social inclusion agenda. Participants commented on the lack of focus on CALD issues within the social inclusion agenda and the lack of targeted strategies within the social inclusion agenda to address some of the experiences of social exclusion, particularly around health, faced by CALD communities (as previously outlined in section 4).

It was also suggested that CALD representation at various levels of community feedback and input structures such as government committees, advisory and reference groups, and boards, seem to be lacking and dominated by monocultural participants. This can be seen to be Anglo-centric, and in this context multiculturalism seems to be tokenistic.

In addition, while there are various frameworks for multicultural governance (such as the WA Policy Framework for Substantive Equality and the NSW Multicultural Policies and Services Program), participants noted the lack of consistent application of multicultural policies across states and territories with some performing better then others with regards to practical multicultural governance structures. An example was provided of the Multicultural Policies and Services Program within New South Wales (previously called the Ethnic Affairs Priority Statements). The model has proved to be an effective structure for reviewing progress and demonstrating accountability for public sector agencies against their multicultural access and equity strategies.   A recent review of the program (Community relations Commission, 2009) concluded that:

" *..EAPS is still a strong governance model for multiculturalism and access and equity and participation strategies across the NSW public sector*." (Community Relations Commission, 2009, p. 7)

Participants therefore called on the Inquiry to consider the development of effective governance structures, similar to NSW and WA, to ensure the practical application of Australia's multicultural and social inclusion policies within a multicultural Australia.

Recommendation 1:

The Australian government's social inclusion policy needs to incorporate and be aligned, in a meaningful way, with the government's new multicultural policy. This includes the need to develop, implement and monitor effective multicultural governance structures (such as those in NSW and WA) to ensure accountable application of access and equity strategies across Australia.

The next section further highlights key issues that are of concern to those working in the multicultural health sector, particularly with regards to the mental health and wellbeing of Australians from CALD backgrounds.   It also recommends key strategies that will work towards decreasing mental health disparities and increasing the capacity of those from CALD backgrounds who are affected by mental health problems to be socially included in Australian society.

4.2 Key social inclusion strategies to address health disparities

This section draws on feedback gathered by MMHA through consultations with stakeholders held in each of the smaller states and territories (ACT, NT, SA, TAS, WA) between July 2007 and June 2010 (MMHA, 2007, 2008a, 2008b, 2009, 2010a). MMHA also conducted a specific consultation with various national multicultural and ethno-specific peaks in Melbourne in June 2010. The consultation with national multicultural and ethno-specific peaks was an important avenue to gaining insight and feedback into the mental health issues and needs of their diverse constituents that may otherwise have not been captured via the state and territory consultations.

The MMHA consultation program was designed to gather the views of key stakeholders engaged with multicultural mental health issues in states and territories where multicultural mental health services, networks and infrastructure were either non-existent, under-developed or fledgling (ACT, NT, SA, TAS, WA).

The MMHA consultations targeted key stakeholders involved with or who are concerned with the mental health issues and needs of CALD communities within each of the smaller states and territories. This ranged from NGOs (multicultural and mainstream, mental health and generalist), clinical mental health services, community health services, government departments, consumers and carers, and educational institutions.

Potential participants and agencies were identified from MMHA's existing networks in each state and territory. This included transcultural networks (where they existed), key contacts that MMHA had established through previous projects and through contacts via the MMHA Joint Officers Group.

In total, 379 individuals attended the various consultations (see Figure 4.1 overleaf for a distribution of numbers according to consultation). Most were representatives of various agencies, while some (4.5%) did not identify as being a representative of any particular agency (these include interested individuals and consumers and carers).

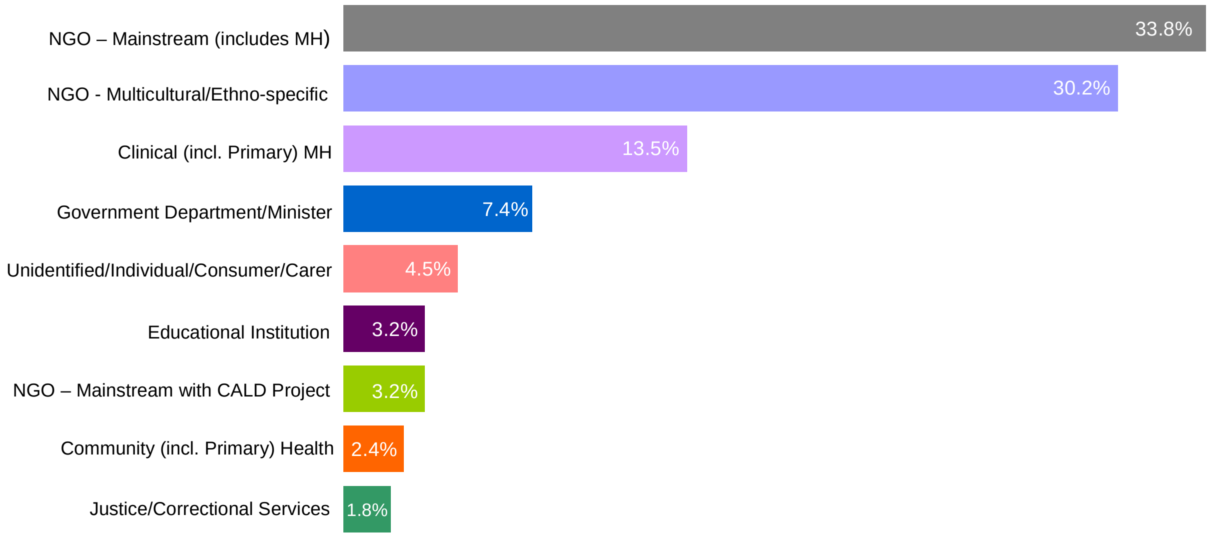
Figure 4.1 below outlines the various state and territory consultations timelines and attendance numbers.

Figure 4.1 – MMHA Consultation Timelines & Attendance Numbers

Timeline	Consultation	Attendance numbers
31 July 2007	Tasmania (as part of the FECCA conference)	40
17 March 2008	South Australia	120
23 May 2008	Northern Territory	78
9 March 2009	Western Australia (as part of Immigrant & Refugee Women's Conference)	80
6 June 2010	National Multicultural & Ethno-specific Peaks (as part of the Diversity in Health Conference)	16
25 June 2010	Australian Capital Territory	45
	Total:	379

Figure 4.2 below gives the aggregated distribution of the types of participants who attended the various consultations. In total, the largest group consisted of participants from mainstream Non-Government Organisations (NGOs) (33.8%) followed by NGOs specifically targeting multicultural or ethno-specific groups (30.2%). Clinical services represented 13.5% of all attendees and government departments represented 7.4% of all attendees. Smaller proportions were from community health services and justice/correctional services (2.4 % and 1.8% respectively).

Figure 4.2 – Distribution of Participants by Agency Type/Role



This section presents the aggregated findings of the various consultations conducted by MMHA as they identify key themes about disparities and the social exclusion that CALD communities face with regards to their mental health and wellbeing. Relevant research and policy documents were also reviewed to ascertain the knowledge base on the identified issues and their policy status.

Figure 4.3 below presents a snapshot of the key themes identified through the consultations.

Figure 4.3 – Key Themes Identified
Stigma & Mental Health Literacy
Culturally Competent Mental Health Services
CALD Data, Targets & Research
Interpreter Use
Partnerships & Pathways ▪ The Role of Multicultural & Ethno-specific Services & Models ▪ The Role of Transcultural Mental Health Networks & Services
CALD Consumer & Carer Participation & Advocacy
Population specific issues (men, women, rural & remote communities, youth, aged, refuges & emerging communities, etc)
Suicide and CALD communities

4.2.1 Stigma and Mental Health Literacy

All of the consultations highlighted stigma about mental illness as a key barrier that prevents those affected by mental illness within CALD communities from seeking help from mental health services and from participating in the community. The lack of culturally appropriate mental health information and stigma-reduction initiatives was also highlighted as a barrier to breaking down stigma and building the capacity of CALD communities to address mental health problems within their communities. For example, the consultations highlighted that:

- There is a *"Lack of knowledge of availability of services, they don't know where to go"* - ACT Consult
- There is a *"Lack of information on service provision and mental health topics"* - TAS Consult
- *"Stigma was identified as an ongoing issue for CALD consumers and carers that needs to be targeted and addressed"* - WA Consult
- There is a need for the *"recognition of the cultural barriers/stigma"*- NT Consult
- There is a need for *"stigma reduction and education in mental health and wellbeing"*- SA Consult
- *"The stigma associated with mental illness in CALD communities and the low rates of presenting needs to be addressed…states and territory jurisdictions to fund the on-going implementation of the national MMHA project, Stepping Out of the Shadows Stigma Reduction."* – National CALD Peaks Consult

A literature review, conducted as part of the development of the MMHA Stepping Out of the Shadows stigma reduction training package (see appendix 1 in MMHA's Stepping Out of the Shadows Project Report, MMHA, 2010a), supports the perceptions of consultation participants, i.e. that CALD communities tend to have low levels of knowledge around mental health issues/illnesses and tend to have lower rates of participation in health promotion, prevention and treatment programs that are not culturally appropriate.

A number of strategies were also proposed by consultation participants to address the issues of stigma and low mental health literacy in CALD communities. These included community education and ethnic media campaigns targeting CALD communities. However, a key issue identified within the consultations is the lack of systematic initiatives to reduce stigma and promote mental health literacy within CALD communities.

As part of the *Framework for the Implementation of the National Mental Health Plan (2003- 2008) in Multicultural Australia* (DoHA, 2004), the Commonwealth Department of Health and Ageing funded MMHA to develop a national stigma reduction initiative specifically targeting CALD communities – the MMHA Stepping Out of the Shadows stigma reduction initiative – resulting in a comprehensive training package. The package is clearly aligned with goals of the *Fourth National Mental Health Plan* which identifies the need for a "sustained and comprehensive national stigma reduction strategy" (Commonwealth of Australia, 2009, p. 26). However, MMHA's experience, backed by an evaluation of the initiative, revealed that a key issue has been the inconsistent implementation of this initiative across states and territories, with lack of funding being a key barrier to consistent implementation of the project (MMHA, 2010b).

Recommendation 2:

A clear vision, planning and resources are needed for reducing stigma and improving mental health literacy amongst Australia's CALD communities.

4.2.2 Culturally Competent Mental Health Services

The cultural competence of mental health services was raised at each of the consultations as a key barrier for CALD communities to access timely, safe and culturally appropriate services. For example:

- *"Clinicians have difficulty communicating with people of CALD background and are reluctant to use interpreters. Communication needs are not properly understood"*- ACT Consult
- There is a need to *"educate mental health services"*- NT Consult
- There is a need *"to improve the leadership and coordination of cultural competency training"*- SA Consult
- *"The Department of Health and Human Services Tasmania and its Mental Health Services Branch need to provide regular education sessions to public hospital staff, GPs, health educators, etc, especially those who are the first point of contact for CALD consumers with a mental illness"*- TAS Consult
- *"Mainstream providers have difficulty in communicating with people from CALD backgrounds and understanding their needs…there is a need for culturally competent and appropriate mental health services for people from CALD backgrounds"*- WA Consult
- *"The National Cultural Competency Tool to be implemented by all mental health services with support from state and territory governments, including funding support."* – National CALD Peaks Consult

Participants gave various examples of where a lack of cultural competence in mental health services has led to:

- Stereotyping due to the lack of understanding of the cultural diversity of their client groups;
- Misdiagnosis and/or culturally inappropriate treatment plans due to a lack of understanding of the experiences clients from torture and trauma backgrounds bring with them and/or due to variations in the explanatory frameworks used to understand and conceptualise mental illness and mental wellbeing;
- Misdiagnosis and/or culturally inappropriate treatment plans due to communication barriers resulting from a failure to use interpreters appropriately where needed.

The need for culturally competent mental health service systems was also raised. This included ensuring that pathways to mental health services were also culturally competent to ensure timely, safe and culturally appropriate service pathways. The use of bilingual professionals and overseas-qualified mental health professionals and the cultural competence training of GPs and police could assist with improving pathways.

Another key issue that was raised was the need for consistent cultural competence training that is benchmarked against national standards. Within the states and territories consulted, it was noted that inadequate and inconsistent levels of cultural competence training was available for mental health staff.

Standard 4 (Diversity Responsiveness) of the newly revised *National Standards for Mental Health Services* (Commonwealth of Australia, 2010) articulates the need for mental health services to be culturally competent. Within this context, the Commonwealth Department of Health and Ageing funded MMHA to develop a *National Culturally Competency Tool* (MMHA, 2010c). The tool has been developed to be aligned with the revised national standards and articulates a set of cultural competency standards. Yet, a key gap exists in terms of the implementation of the tool. While a national tool exists and offers the potential for standardisation of cultural competency training across Australia, a national implementation plan is yet to be supported by the Australian government. MMHA strongly believes this will redress the inconsistent quality of cultural competency training across Australia.

Recommendation 3:

There is a need for uptake and implementation of national cultural competency standards and training amongst mental health services across Australia.

4.2.3 CALD Data, Targets, and Research

(i) CALD data collection needs to be improved

Consultation participants clearly articulated the need for increased quality of data collected about CALD clients who use mental health services. For example:

- *"Need better collection of data/information"*- NT Consult
- The *"Commonwealth and the ACT Health should mandate CALD data collection to update profiles of CALD communities and better understand their requirements"*- ACT Consult
- *"Uniform ethnicity data is not being collected by mental health agencies and that restricts effective planning and delivery of culturally and linguistically appropriate services"*- WA Consult
- *"The accurate measurement of the mental health status of CALD communities is fundamental to the provision of quality mental health services for CALD communities"* – National CALD Peaks consult

High quality data that identifies the cultural and linguistic diversity of mental health service users, as well as their mental health outcomes, is necessary for the identification and monitoring of mental health concerns for specific population groups (Lurie & Fremont, 2006).

However, there has been concern over the lack of adequate collection, reporting and analysis of CALD data variables within mental health data sets (DoHA, 2004). For example, the National Coroners Information System currently only collects one CALD data variable (Country of Birth) (NCIS, 2009). It also collects data on period of residence. However this does not provide adequate information on cultural or linguistic diversity. This lack of consistent CALD data collection is symptomatic of broader issues in CALD data collection in Australia's health system. For example, a survey in NSW with 119 individuals involved in health research with a cultural component identified that only a few used the Sets of Diversity Variables as recommended by the Australian Bureau of Statistics (Luckett et al., 2005).

The Australian Bureau of Statistics' Standards for Statistics on Cultural and Language Diversity (ABS, 1999) recommends the collection of twelve CALD data variables (with four minimum core sets being: Country of birth; main language other than English spoken at home; proficiency in spoken English and Indigenous status). Indicators on the use of interpreters are also another important feature of quality and safety improvement initiatives within mental health services (Miletic et al, 2006).

Yet, a review of national minimum data sets collected by the Australian Institute of Health and Welfare revealed that *Country of Birth* was the only CALD data variable listed within mental health data sets (Blignault and Hagshenas, 2005). The lack of collection and reporting of data variables other than *Country of Birth* may restrict the accurate identification of someone's cultural and/or linguistic background. For example, the data variable *Country of Birth* alone does not accurately identify the cultural identity of someone who was born in Australia and identifies as speaking English but whose parents were immigrants or refugees and who were from a non-English speaking background. This makes it difficult to identify patterns of mental illness between generations. This is particularly important given that international research indicates that second generation immigrants are at greater risk of suicide death than their parental generation (Hjern & Allebeck, 2002).

The Australian Bureau of Statistics has the following to say about the importance of including a comprehensive list of variables in order to identify ethnicity or cultural background:

> *"For those born overseas, their year of arrival in Australia…and their country of birth provides a useful indication of a person's likely ethnic or cultural background. However, for some overseas-born people their country of birth may be different from their ethnicity, such as people of Chinese ethnicity born in Malaysia, or people of Indian ethnicity born in England. Furthermore, for Australian-born residents, additional information is needed to uncover their diverse ethnic or cultural backgrounds, arising from their parents' or grandparents' migration to Australia."* (ABS, 2006)

Despite the lack of adequate CALD data within mental health data sets at the national level, anecdotal evidence suggests that there are variations in the quality and extent of CALD data variables collected, reported and analysed by mental health services: (i) between state, territory and Commonwealth jurisdictions and (ii) between service types (e.g. the NGO mental health sector vis-à-vis the public clinical mental health sector).

(ii) Targets need to be set

Participants suggested that government departments set CALD performance targets for publicly-funded mental health services (including NGOs) as a mechanism to improve access for CALD communities. For example:

- There is a need for *"recognising its importance within service agreements"*- SA Consult
- There is a need to "*advocate to Territory and Commonwealth Governments that they and their funded services have specific, measurable CALD performance targets. Service delivery must demonstrably meet CALD needs"* – ACT Consult

(iii) Research is needed

Consultation participants also identified the lack of knowledge about mental health service use and prevalence rates of mental illness and mental health problems amongst CALD communities due to the lack of targeted research addressing these issues. For example:

- *"DoHA and the Department of Health and Human Services Tasmania to make provisions and allocate funds for research projects to ascertain the extent of mental illness in CALD Tasmanian communities, the type of mental illness prevalent in CALD communities, the therapies most useful to CALD consumers"* – TAS consult
- *"The lack of funding for CALD research means CALD mental health issues slip off the agenda. The result is that adequate mental health services and systems are not planned for all Australians, as all governments require evidence to substantiate funding allocations"* – National CALD Peaks consult

A review of research priorities in mental health, conducted on behalf of the Commonwealth Department of Health and Aged Care, revealed that, in comparison to research about mental health issues in Australia's majority English speaking population, there was a lack of mental health research dealing with non-English speaking population groups, with these groups included in only 2.2% of published articles and attracting only 1.5% of competitive research grant funding (Griffiths et al, 2002). This fact was also recognised in the *Framework for the Implementation of the National Mental Health Plan 2003 – 2008 in Multicultural Australia* (DOHA, 2004).

A more recent review of suicide prevention research by Robinson et al (2008) for the period between1999 and 2006 identified that, of 209 published journal articles and 26 funded grants, none targeted CALD populations. Only 2% of people who conduct suicide prevention research were identified as targeting CALD (see figure 4.4).

Figure 4.4 - Australian suicide prevention research targeting CALD, 1999 to 2006 (Source: Robinson et al, 2008)

	Total number	**% Targeting CALD**
Published journal articles	209	0 %
Funded grants	26	0 %
People who conduct suicide prevention research	45	2%

The *Framework for the Implementation of the National Mental Health Plan (2003- 2008) in Multicultural Australia* (DoHA, 2004), which guides the MMHA program, articulates the need for enhanced CALD data collection within mental health service systems and for a national CALD mental health research agenda. Standard 4.2 of the National Standards for Mental Health Services (Commonwealth of Australia, 2010) also requires mental health services to utilise available and reliable data on identified diverse groups in order to document and review the needs of those groups.

Mental health outcome measurement has also been seen as an information priority that assists in improving service quality and planning for service prioritization and costing (DoHA, 2005). While there has been some work done in various jurisdictions around the use of outcome measures with CALD populations (Prasad-Ildes & Wright, 2004; QTMHC, 2005; & Vic DoH, 2006), there has been no aggregation of such work at the national level thereby preventing meaningful analysis for national application. Whilst there are lessons to be learnt from the development of outcome measurements that are culturally relevant for indigenous populations (Nagel & Trauer, 2010), researchers have acknowledged that further work is needed with regards to the transcultural applications of outcome measures with CALD populations (Pirkis & Callaly, 2010).

To this end, MMHA was invited by the Mental Health Information Strategy Sub-committee to provide input to the development of information priorities and outcome measures via the National Mental Health Information Development Expert Advisory Panel (NMHIDEAP). As an initial step, MMHA has also partnered with the Australian Mental Health Outcomes and Classification Network to develop a research project to analyse mental health outcome measurement issues and data collection issues as they relate to CALD communities.

Recommendation 4:

There is a need for:

- improved and consistent collection, analysis and reporting of CALD data of mental health service user demographics and outcome measures across Australia;
- targeted CALD performance benchmarks for publicly-funded mental health services;
- a funded national CALD mental health research agenda, including targeted research to analyse prevalence rates amongst CALD populations across Australia.

4.2.4 Interpreters

(i) Availability and use of interpreters in mental health settings

The consultations highlighted the lack of availability of mental health trained interpreters across the smaller states and territories. Participants commented on the lack of a coordinated approach to the provision of interpreter services across the range of mental health service providers. For example, in some circumstances there seemed to be a disparity in access to interpreter services between commonwealth-funded and state-funded mental health services. There also seemed to be disparities in access to interpreter services between government-provided mental health services (via the Area Mental Health Services) and the NGO sector. For example:

- *"The community mental health NGO sector does not have full access to interpreter services due to a lack of dedicated funds"* – ACT consult
- *"The budgets of NGOs are also impacted when they need to use interpreter services and this may be a prohibiting factor for many NGOs in using interpreters when seeing consumers from CALD backgrounds"* – WA consult
- *"Poor access to interpreters presents a major barrier in the utilisation of mental health services and has a direct impact on the quality and safety of mental health service provision to CALD communities." –* National CALD Peaks consult

(ii) Training in the use of interpreters

The consultation participants also highlighted that mental health staff were often unaware of the processes in which to engage and use interpreter services even when it was available. Comments were made on the lack of understanding of the importance of using interpreters. Some commented that there was limited training on when and how to use interpreters. For example:

- There is need for *"training for sector workers on how to work effectively with interpreters in mental health settings"* – TAS consult

(iii) Training of interpreters in mental health settings

Another issue that arose was the availability of interpreters trained to work in mental health settings. The consultation participants felt that there were not enough interpreters trained to work in mental health settings, especially those from new and emerging communities. Comments were also made about the accreditation, standardisation and quality monitoring processes for interpreters with participants sharing concerns over the ability of interpreters to maintain confidentiality within smaller communities. For example:

- There is *"difficulty accessing suitable interpreters. Community is small and confidentiality is an issue"* – NT consult
- There is a need to *"upgrade the interpreter system – more interpreter training and accreditation to minimise the use of volunteers and untrained people to ensure that interpreter knowledge base is current on mental health and general health"* – SA Consult
- *"The WA and Australian Governments must work together to find a solution to the urgent need for more interpreters and who are trained in mental health terminology and concepts"* – WA consult

There is a knowledge gap about the use of and access to interpreter services in mental health settings. This presents a major barrier to planning for quality and safe mental health service provision. Access to mental health staff who are trained to use interpreters and access to interpreters trained to work in mental health settings is particularly important as this has a direct impact on the quality and safety of mental health service provision to CALD communities:

> *"In a clinical setting the key instrument for assessment and treatment is communication. In the absence of excellent communication between clinician, client and family, high quality clinical work is impossible. Where there are limits in the quality of communication, assessment of the nature and severity of the mental health problem, and assessment of risk, will be superficial, frequently incomplete and sometimes dangerously wrong."*
>
> (Miletic et al, 2006, p. 8)

Research has also shown that general practitioners (GPs) in Australia generally tend not to be aware of or choose not to use the Department of Immigration and Citizenship's Doctors Priority Line and tend to use family members as interpreters rather than professional interpreters and this is despite the service being free of charge (Atkin, 2008; Bird, 2008; and Huang and Phillips, 2009).

MMHA has begun preliminary scoping (via MMHA's Joint Officers Group[5]) of the range interpreter services available and the gaps across states and territories. This preliminary scoping has highlighted that a range of interpreter policies exist with some under review. A range of noteworthy interpreter training projects have also been initiated in some states and territories (e.g.VTPU (Milteic et al, 2006) and QTMHC (The Collegial Model of Interpreting within Culture – QTMHC, 2010). WA also have an annual training program for health interpreting and mental health interpreting that is conducted by the Central Institute of Technology in partnership with the WA Transcultural Mental Health Service. The National Ethnic Disability Alliance (NEDA) have also drafted a proposal for funds needed ($51m per annum) to provide free telephone and on site interpreter services within the government's proposed long-term disability care and support scheme (NEDA, 2011)

As previously noted for the issue on cultural competency, national uniform standards on interpreter use in mental health settings do not exist. However, MMHA's *National Culturally Competency Tool* does recommend standards on language services policies and training on use of interpreters (Cultural Competency Standard 5, NCCT, MMHA 2010b).

Recommendation 5:

There is a need for:

- mapping and coordination of the range of interpreter options and funding available for mental health services across Australia;
- training of mental health staff in the use of interpreters;
- training of existing interpreters (in all states and territories) to work in mental health settings;
- further increasing the pool of available interpreters for use in mental health settings.

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[5] The Group is convened by MMHA and consists of State and Territory Mental Health Departments, the Commonwealth Department of Health and Ageing (DoHA), the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), the Federation of Ethnic Communities Councils of Australia (FECCA), and consumer and carer representatives.

4.2.5 Partnerships and Pathways

The consultations found that there is a need for stronger partnerships and collaborations between the mainstream and multicultural, clinical and NGO sectors in order to improve mental health outcomes for CALD communities. Other key stakeholders that need to be involved in collaborative efforts include the police and GPs. Participants also highlighted that government needs to be at the forefront of creating such partnerships. The key intention of this theme was to identify and map systemic issues that affect the mental health outcomes of CALD consumers and carers, including the pathways to care for CALD consumers and carers. For example:

- *"Mainstream agencies should involve and partner with ethno-specific and multicultural organisations to provide better services to CALD communities"* – ACT consult

(i) The Role of Multicultural and Ethno-specific Models and Services

The consultation also clearly highlighted the need for multicultural and ethno-specific service models to be funded as a key part of the mental health system. This included suggestions of fostering the growth of bilingual staff in mental health services and also of having dedicated multicultural services and program targets. Participants commented on how multicultural and ethno-specific services were often a gateway to the mental health system, especially for communities from refugee or newly-arrived backgrounds. And while such services were a key part of the mental health system, they often relied on volunteer and poorly trained staff to address some of the gaps in the current mental health system. For example:

- *"Too many volunteers are used in the CALD context, which is unsustainable"* – ACT consult
- *"When working with a refugee community it is important to use a cultural consultant/bilingual worker"* – NT consult
- There is a need to *"employ bilingual workers who are appropriate in delivering services"* – SA consult
- There is a need to *"stop the loss of strong community leaders who, due to work opportunities emigrate interstate – need to provide financial and workforce incentives to keep them in Tasmania"* – TAS consult
- *"The WA government has to substantially increase the resources it provides for the delivery of professional multicultural mental health services within the community and public mental health sectors"* – WA consult

Despite these concerns, multicultural and ethno-specific services have increasingly been marginalised in recent commonwealth mental health funding rounds. For example, in July 2006, the Council of Australian Governments (COAG) agreed to dedicate $1.9 billion to improve services for people with a mental illness, their families and carers. Under this national action plan, the Federal Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) implemented three community-based mental health programs: Personal Helpers and Mentors; Mental Health Respite program; and Mental Health Community Based Program. As at April 2010, only two out of 277 mental health services funded under PHAMs were ethno-specific or multicultural organisations (MMHA, 2010d). This represents just 0.72% of the PHAMs funded services at that time. This is vastly disproportionate to the number of people from CALD backgrounds around Australia who may need multicultural or ethno-specific mental health services.

(ii) The role of Transcultural Mental Health Services & Networks

Participants also commented on the role that Transcultural Mental Health Services had in other states and territories (such as QLD, VIC & NSW) in terms of assisting the mental health system to better meet the mental health needs of CALD population groups. Within the smaller states and territories it was acknowledged that transcultural mental health networks played an important initial role in bringing key stakeholders together to address the mental health gaps for CALD communities. However, these networks operate on a voluntary basis and do not provide client services. Participants therefore commented on the need to fund transcultural mental health centres to begin the work required to address existing mental health gaps for CALD communities (such as research, cross-cultural training and development). This includes the need to upscale existing networks so that services are proportionate to what CALD communities in the bigger states receive with their transcultural mental health centres. There were also suggestions for transcultural mental health networks to be scaled up to facilitate better networking (e.g. through building and training networks of bilingual mental health staff). For example:

- There is need to *"provide the ACT Transcultural Mental Health Network with resources to establish and expand its network activities"; "Lobby for a Transcultural Mental Health service in the ACT"* – ACT consult
- There is need to *"place pressure on the Health Department and decision makers on the need for transcultural mental health centre or network"* – SA consult
- There is a need to *"lobby the Department of Health and Human Services Tasmania to allocate ongoing funding to support the network via a designated full time permanent position to guide/lead the Tasmania Transcultural Mental Health Network"* – TAS consult
- *"Significant changes are required in the public mental health sector in WA using a more formal cohesive and inclusive approach modelled on the brokerage model already implemented and positively evaluated in New South Wales and Queensland"* – WA consult

Since MMHA began the various consultations, and with the help and support of MMHA, some of the states and territories have begun to develop transcultural mental health networks and positions as a strategy to increase consultative mechanisms with CALD communities and key stakeholders and to begin mapping and identifying systemic issues with regards to addressing the mental health needs of CALD consumers and carers within their states and territories. Yet, as figure 4.5 below shows, disparities in transcultural mental health services exist between states and territories.

Figure 4.5– Transcultural Mental Health Centres, Services, & Networks – Oct 2010

Service type	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Transcultural Mental Health Centre		✓		✓			✓	
Transcultural Mental Health Service (Under review)								✓
Transcultural Mental Health Network (voluntary network – do not provide direct client services)	✓					✓		
None existent			✓		✓			

Recommendation 6:

There is need for

- funding Transcultural Mental Health Centres and Services in each state and territory; and
- increasing the capacity of existing transcultural mental health networks (including multicultural and ethno-specific services) to address mental health service and support gaps for CALD communities.

4.2.6 CALD Consumer and Carer Participation and Advocacy

Consultation participants advocated for the need for increased CALD consumer and carer and participation in the development and delivery of services. Participants commented on the need to set up structures to increase CALD consumer and carer participation within state and territory policy making forums. Participants highlighted the need for concerted efforts to engage CALD consumers and carers, especially in smaller states and territories where CALD consumers and carers may not be supported and trained to advocate or participate in policy making forums or where stigma prevents CALD consumers and carers from being willing to participate for fear of being identified within small communities. For example:

- There is need for *"advocacy training to be funded for CALD consumers through the ACT Consumer Network"* – ACT consult
- There is a need for *"employment and education of CALD consumer/carers…."* and *"consumer/carer participation at all levels of decision making and getting a broad voice to improve the services"* – SA consult
- *"The Mental Health Branch to develop a CALD Mental Health Consultative Group and include CALD consumers and carers"* – TAS consult
- There is a *"need to give CALD consumers the opportunity to participate in decision-making processes of mental health services"* – WA consult
- *"Inclusion and participation will not work if we cannot communicate with clients from CALD backgrounds, yet we need to have more effective consumer participation if we are expected to be inclusive in our service provision."* – WA consult

Consumer and Carer participation within the development, planning, delivery and evaluation of mental health services is a key part of the National Standards for Mental Health Services (Standards 6.17 and 7.14 respectively - Commonwealth of Australia, 2010). CALD consumer and carer participation is also articulated as a key Cultural Competency Standard (Standard 7) within the National Cultural Competency Tool (MMHA, 2010b). However, CALD consumer and carer participation has tended to lag behind the mainstream (DOHA, 2004).

In 2006, the Senate Select Committee on Mental Health noted a submission that stated "*consumer and carer participation in the development and delivery of mental health programmes continues to lag behind for CALD communities relative to the mainstream*" (Senate Select Committee on Mental Health, 2006, p.430)

CALD consumer and carer participation has been a key priority for MMHA, with MMHA developing the first national CALD consumer and carer reference groups. This has included the development and training of a Speakers Bureau. MMHA has also been supporting the national reference group members to set up state and territory based reference and peer support groups. Yet building the capacity of CALD consumers and carers to participate at the state and territory level has been difficult with lack of funding being a key barrier (see figure 4.6 overleaf).

There is also a lack of CALD consumer and carer participation in mainstream networks at the national level. MMHA has been advocating for CALD representation on the National Mental Health Consumer and Carer Forum since April 2009. Whilst every state and territory has a consumer and a carer representative, and every national mainstream mental health peak has a representative, there is no official CALD consumer or carer representative or MMHA representative (as Australia's only national multicultural mental health funded program).

Figure4.6 – CALD Consumer & Carer Reference Groups

Jurisdiction	Status
ACT	▪ No CALD Consumer and Carer Reference groups
NT	▪ No CALD Consumer and Carer Reference groups
NSW	▪ No CALD Carer Reference group ▪ CALD consumer group to be set up in June 2011
QLD	▪ CALD Consumer and Carer Reference set up as part of QTMHC
SA	▪ CALD Consumer and Carer Reference Groups set up ▪ Unfunded
TAS	▪ CALD Consumer and Carer Reference Groups currently being set up ▪ Unfunded
VIC	▪ CALD Consumer only Reference Group set up by VTPU ▪ Funded until December 2011 through VMIAC
WA	▪ No CALD Consumer and Carer Reference groups
National	▪ No MMHA CALD consumer or carer representation on the National Mental Health Consumer and Carer Forum

Recommendation 7:

There is need for:

- prioritising CALD consumer and carer participation at the state and territory level and fund initiatives that increase true participation; and
- prioritising CALD consumer and carer representation at the national level via the National Mental Health Consumer and Carer Forum.
- Funding for ethno-specific and illness-specific peer support groups for CALD communities.

4.2.7 Targeted initiatives for sub Populations and suicide

The following population specific issues were also mentioned in the consultations.

(i) Age-based issues

The consultations raised the need to be aware of age-related issues for CALD communities. For example, participants stated that the mental health system needs to be aware of older Australians from CALD backgrounds who may lose their English proficiency as they age. For example:

- *"The ageing CALD population whose English proficiency is poor has increased vulnerability with respect to mental health issues. They often revert back to their first language, become more isolated, and thus become depressed."* – ACT consult
- There is a need to be aware of *"Older people from CALD backgrounds – especially those from Dutch or German backgrounds who have experienced trauma from WWII. "* – TAS consult

Despite the fact that the proportion of older people from CALD backgrounds is projected to increase by 2050 (Access Economics, 2006), there is a lack of research on how mental health issues impact older Australians from CALD backgrounds.

Rao et al (2006) highlighted that there has been a lack of research into the health needs of older Australians from CALD backgrounds in spite of the fact that social and cultural diversity was recognised as one of the priority areas for ageing research by a report prepared for the Community Services Minister's Advisory Council in 2000. Some issues for older people' from CALD backgrounds include:

- Research indicates higher rates of suicide at old age, among some immigrant communities (McDonald and Steel, 1997).
- Older Australians from CALD backgrounds may revert back to their birth language as they get older and are more likely to come from countries where English language proficiency is low (Rao et al, 2006)
- Anecdotal evidence suggests that CALD older Australians experience high rates of depression due to increased levels of isolation and due to decline in their physical health.

A recent report into CALD dementia[6] research (Cheng et al, 2009) also noted the following:

- There is a lack of epidemiological research of incidence and prevalence rates amongst CALD communities;
- There is a lack of service utilisation of mainstream services; and
- There is a lack of knowledge about dementia

As the Mental Health Council of Australia has noted:

"Given people from CALD backgrounds are the fastest growing sub-group of older people, the need to implement policy initiatives specifically targeting this group is imperative" (MHCA, 2009)

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[6] While dementia itself is not a mental illness, dementia can result in behavioural and psychological symptoms that may require psychiatric intervention (Rural Health Education Foundation, 2007).

The mental health issues of young people, especially those from newly arrived and/or refugee backgrounds were also raised:

- *"Young people from refugee backgrounds are a particularly vulnerable group"* – ACT consult

While there has been a lack of research on CALD youth mental health issues (Francis & Cornfoot, 2007), some preliminary analysis of access data to Child and Adolescent Mental Health Services (CAMHS) in Victoria reveals that rates of access by refugee and immigrant communities are on average one third of those born in Australia, thereby indicating a proportionately lower rate of involvement in CAMHS services. This was also accompanied by patterns of higher acute admissions and longer periods of admission indicating that CAMHS clients from CALD backgrounds may be more severely unwell when they gain admission (Presentation by Dr Yvonne Stolk, VTPU - see CMY & ADEC, 2008).

The Mental Health Council of Australia, in its submission to the 2009 Senate Inquiry into suicide in Australia also stated that:

"…services consistently report a high level of self-harming behaviour and suicide attempts by young people from refugee backgrounds. The lack of early prevention services to refugee youth, who constitute the largest proportion of humanitarian entrants, poses particular challenges in relation to suicide prevention." (MHCA, 2009)

Feedback received from the Tasmanian Transcultural Mental Health Network also noted the discrepancies in access to English language classes for young people from refugee backgrounds. The Network commented that the system for placing young people from refugee backgrounds in schools differs across between states and territories. For example, students in Queensland are placed in Intensive English schools for up to 12 months, where they are able to work on their English literacy in a supportive environment, and where mental health needs can be detected and addressed at an early stage. When the young people are ready they are then transferred into mainstream education. However, students from refugee backgrounds in Tasmania are placed directly into mainstream education soon after arrival. The Network has observed that mental health needs of these young people then take longer to be noticed and therefore may be at a more chronic state once intervention is provided.

(ii) Refugee and emerging communities

The consultations highlighted that the mental health issues of people from refugee backgrounds and newly emerging communities need special consideration, especially in order to alleviate potential future problems. For example:

- *"Refugees can experience "stress (related to accommodation, family, cultural expectations, job, finances) which can be prolonged, in turn leading to co-morbidity issues."* – ACT consult
- *"Resettlement is a tough process – moving from one culture to another can affect people's mental wellbeing. PTSD can kick in unless services step in to support refugees early."* – TAS consult
- *"Settlement issues are often confused with clinical issues resulting in accurate diagnoses of people from CALD backgrounds presenting at a mental health facility"* – WA consult

The experiences people from refugee backgrounds have prior to displacement, post-displacement, and on arrival in Australia can put them at high risk of post-traumatic stress disorder, depression, substance use disorders and other social dysfunctions (DOHA, 2004).

Australian research by Davidson, Murray & Schweitzer (2008) suggests that the mental health and well being outcomes for those from refugee backgrounds are influenced by mix of pre-displacement, displacement, resettlement and systemic factors, with the availability of timely and appropriate refugee services significantly impacting on those outcomes.

(iii) Regional (rural & remote) issues

Consultation participants also noted that planning to meet the mental health needs of CALD populations need to take into account issues faced by CALD communities living in rural or remote regions – an issue for smaller states and territories. For example:

- *"Isolation, especially for people living in rural and remote areas."* – TAS consult

An example of an innovative model to address the mental health needs of CALD populations in rural and remote region is the Transcultural Rural and remote Outreach Project (TRROP) of NSW. The project aimed to explore models of service delivery for culturally and linguistically diverse (CALD) communities in rural areas and is a partnership between the Transcultural Mental Health Centre (TMHC) a unit of Sydney West Area Health Service (SWAHS), the Centre for Rural and Remote Mental Health (CRRMH), and Greater Southern Area Health Service (GSAHS), Greater Western Area Health Service (GWAHS), Hunter New England Area Health Service (HNEAHS), and North Coast Area Health Service (NCAHS). The project resulted in an increase in the use of professional health care interpreters across participating sites, and increased referrals from rural Area Health Services to the NSW TMHC clinical program (CRRMH and TMHC, 2010). It should be noted that, while there are been innovative models piloted, the Commonwealth and State and Territory governments are yet to fund a consistent and sustainable program to address the mental health needs of CALD communities in rural and remote regions across Australia.

(v) Other issues for consideration

While the consultations did not explicitly identify the following issues, it is important to consider such issues within the context of the consultations as they have a direct impact on policy and planning that needs to be done in order to meet the mental health needs of CALD populations

(a) CALD women and mental health issues

Women from CALD backgrounds with mental illness are one of the most disadvantaged and disempowered groups in Australia, because of the triple barriers of gender, disability and ethnicity. While many outside the workforce may be financially dependent on men, those in paid work tend to have low wages, limited opportunities for English language training and poor working conditions. Women from CALD backgrounds may also be at risk of poor reproductive and sexual health due to cultural factors (Julian, 2004).

Women from CALD backgrounds are also significantly more at risk of post-natal distress and depression (DOHA, 2004). A review of literature by the Mental Health Council of Australia for its submission into the Senate Inquiry into Suicide in Australia also noted that women from some ethnic backgrounds have a significantly higher relative risk of suicide and that risk was more pronounced amongst older age cohorts as well (MHCA, 2009)

(b) People with co-occurring disabilities from CALD backgrounds

The National Ethnic Disability Alliance estimates that there are more than 1 million people with a disability (including psychiatric) from a CALD background (NEDA, 2010). Their report, *What Does the Data Say?,* included some of the following findings:

- Quality data, which identifies the impact of disability and ethnicity, is not consistently collected;
- There is a higher prevalence of impairment for people born in a non-English speaking country aged over 45 than those born in Australia;

NEDA also raise the point that, when a person has a disability, including mental health illness, sometimes the mental health issue can go unrecognized and, when unwell, their behaviours may be attributed to their disability rather than the mental illness. This means that the mental illness does not get treated further exacerbating their disability.

(c) Suicide and CALD communities

Suicide was specifically identified as a key issue of concern within some of the consultations. Participants commented on the lack of data collection that accurately records suicide amongst CALD communities. Participants further commented on the lack of suicide prevention programs and strategies that target CALD communities. For example:

- *"There are no culturally and linguistically appropriate suicide prevention programs in WA"* – WA consult
- There is a need to *"develop projects on mental health taboos, beliefs, explanations (of suicide)…."* – ACT consult
- *"Culturally-appropriate suicide projects to be funded in every jurisdiction to help reduce the suicide rates in CALD communities"* – National CALD Peaks consult
- *"DoHA to mandate the systemic collection of data relating to suicide and suicide attempts by all relevant jurisdictions"* – National CALD Peaks consult

Early research into the significance of suicide in CALD populations in Australia is provided by Macdonald and Steel (1997) who used aggregated data from the NSW Department of Health to analyse suicide over a 23 year period from 1970 to 1992. They found that, out of 13,580 deaths by suicide, 26.5% were overseas born, with 56.9% of those born from non-English speaking countries.

A later literature review on the suicide of immigrants in Australia by McDonald and Steel in 2000 highlighted the diversity in rates and methods of suicide amongst ethnic groups. The review also highlighted differences in suicide patterns according to gender and age.

Understanding the true scale of the problem is difficult because some cultures may not report deaths as suicides due to stigma, resulting in some suicides reported as unintentional or accidental deaths (Walker et al, 2008).

Despite difficulties in data collection, recent research by De Leo et al (2010) into rates of suicide amongst first-generation Australian immigrants has indicated:

- Male immigrants born in Eastern Europe, Northern Europe, Western Europe and New Zealand have shown higher suicide rates compared to Australian-born males.
- Since the late 1980s, the suicide rates of Eastern European males are higher compared to other county of birth groups.
- Female immigrants born in Eastern Europe, Northern Europe and New Zealand have shown higher suicide rates compared to Australian-born females.
- The highest rates among females were among those born in Western Europe and the UK and Ireland.

Certain age groups are also more vulnerable than others, with research indicating high suicide rates amongst older immigrants (McDonald and Steel,1997). International research also suggests second generation immigrants have a higher risk of suicide death than their parents (Hjern and Allebeck, 2002).

The Commonwealth Department of Health and Ageing (DoHA, 2008) acknowledges that suicide prevention in CALD communities needs special consideration because:

- The stress on immigrants of adapting to new cultural beliefs, language, values and customs and/or being separated from their culture and land of birth can increase the risks of suicide;
- The above stressors can be compounded for people from CALD backgrounds who are elderly, socially isolated, suffer health problems or are unemployed; and
- People with refugee experiences face a higher risk of post traumatic stress disorder or depression and therefore may be at greater risk of suicide.

The Commonwealth Department of Health and Ageing also articulates that:

> *"…a significant number of people from CALD backgrounds do not seek help for their mental health problem, or are reluctant to do so. Often, they miss out on suicide support services because information is not available in community languages, or there is no culturally appropriate service available. They may also find it difficult to use mainstream services because of language and cultural barriers, [and] may be confused about how services operate, or simply unaware of the range of services and supports that are available."* (DoHA, 2008, p. 39)

Suicide costs all Australians dearly in terms of the trauma and grief for those left behind and for the loss of a valuable human being to society. While stigma and shame around suicide exists for many communities, it may be particularly strong for those from CALD backgrounds. The stigma and shame around suicide may prevent individuals and families from CALD backgrounds getting the support they need after attempted and/or completed suicides. This may further isolate those individuals and families and further deepen the disparity of access to timely and appropriate health services.

Recommendation 8:

Planning to meet the mental health needs of CALD populations needs to consider:

- targeted initiatives according to population groups such as men, women, youth, aged, refugee and newly emerging communities, and people with co-occurring disabilities.
- improved data collection, reporting and analysis of suicide in CALD communities; and
- targeted suicide prevention programs for CALD communities.

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