Diversity Health Institute
Quality Health Care for a Diverse Australia

25 June 2010

Committee Secretary
Standing Committee on Health and Ageing
House of Representatives
PO Box 6021
Parliament House
CANBERRA ACT 2600
AUSTRALIA

RE: Parliament of Australia House of Representatives
Roundtable Forum on Youth Suicide Prevention

The Diversity Health Institute (DHI) wish to thank the House of Representatives Standing Committee on Health and Ageing, for the opportunity to present a written submission for consideration as part of their Roundtable Forum on Youth Suicide Prevention.

The DHI is a coalition of public health organizations that work together to improve the health and wellbeing of Australia's culturally and linguistically diverse (CALD) community. This submission has been compiled with significant input from the Transcultural Mental Health Centre (NSW).

The 2006 Australian census identified that 22% of the total population had been born overseas and that 25% of the population were second generation immigrants, in comparison to 18% of people in 1976 and 20% in 1996. Of those born overseas 62% were born in non-main English speaking countries and 16% spoke a language spoke a language other than English at home.

Australia's CALD population greatly contributes to the wealth, productivity and strength of our society. However, with such a diverse population comes a range of influences that may impact on an individual's physical health, mental health status and suicidal behaviour. These influences also extend beyond the first generation migrant to subsequent generations born into culturally diverse communities. The experiences, which immigrants and humanitarian entrants bring with them to Australia, influence the way they approach health and other human service agencies and the way that they connect and remain connected with these agencies.

Previous research conducted by the Transcultural Mental Health Centre based in NSW in 1997, indicated that 25% of suicide deaths (for the period 1979 – 1994) were people born overseas, 60% of whom were from a non-English speaking background (NESB). When exploring suicidal behaviour in overseas born NESB young people (15-24) the researchers found a diversity in rates amongst the groups. Suicide death rates were higher amongst young males than young females and there were higher rates of suicide attempts amongst NESB females (15-24) compared to NESB males (15-24). There was also a diversity of rates among different region of birth groupings of NESB young people, with rates amongst some groups being higher than the Australian born.

It should be noted however that this research was undertaken over ten years ago and was based on data which was 20 years old. Additionally, the study was not able to consider NESB youth beyond the first generation of overseas born, as data on country of birth of mother and father is not collected. This is of great concern considering the growing and changing diversity of the Australian community.

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The DHI strongly supports the need for up to date research to inform suicide prevention programmes and the development of initiatives which are appropriate and considerate of CALD young people from established and emerging communities needs, and also first and second generation immigrants. This research should include epidemiological studies into the current rates and trends of suicidal behaviour, and investigations into the risk and protective factors which may be associated with suicidal behaviour.

Specific comments have been made within this submission to issues concerning data collection and epidemiological research regarding suicidal behaviour in CALD young people (15-24) living in Australia. The DHI has also offered recommendations on how the identified issues, may be addressed.

The DHI urges the Committee to be considerate of the unique, varied and changing needs of CALD communities when reviewing programmes and services related to suicide and suicide prevention in Australia. The DHI through its member organisations would be pleased to be involved with any future suicide prevention initiatives targeting CALD communities that the Committee may wish to develop as a result of the roundtable forum.

If you would like to discuss any aspects of this submission further, please do not hesitate to contact me via email: A.Malak@swahs.health.nsw.gov.au or on (02) 9840 3757.

Yours sincerely,

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Overview

- Estimated that in 2007, 33% of the Australian population were born overseas (ABS, 2008).
- The 2006 Census identified 3.6 million second generation immigrants, 25% of the Australian population, in comparison, 18% of people in 1976 and 20% in 1996. (ABS, 2006a).
- Suicide prevention strategies and programmes recognise a spectrum of suicidal behaviour which includes suicide, suicide attempts, suicidal ideation and intentional self harm.
- Whilst care needs to be taken when interpreting suicide figures because of limitation such as coding issues (ABS, 2010), figures released by the ABS indicate that in 2008 approximately 25% of suicide deaths were people who were born overseas.
- The Australian Institute of Health and Welfare(2008) suggest that the number of suicide deaths is likely to be underestimated for young people but figures for 2005, indicate that 14% of all suicide deaths were of young people, and suicide accounted for one-fifth of all deaths of young people (AIHW, 2008).
- In 2005, the most common external causes of injury leading to death for young people aged 12-24 years were transport accidents (419 or 44% of injury deaths). Suicide was responsible for 299 deaths (nearly one-third) and young males accounted for 80% (239) of suicide deaths (AIHW, 2008).
- The suicide death rate for males aged 15-24 in 2008 was 14.3 per 100,000 and for females 4.2 per 100,000 (AIHW, 2008).
- Young females are more likely to be hospitalised for intentional self-harm than young males, 2.5 times in 2005-06. (AIHW, 2008).
- Death and hospital inpatient statistics data is currently only collected on country of birth which means that it is not possible to identify suicidal behaviour amongst second generation immigrants, this current situation is of great concern as research from overseas suggests that: *"Second-generation immigrants are at greater risk for suicide death than their parental generation"* (Hjern and Allebeck, 2002).
- Additionally, there are a range of factors that impact on an immigrant individuals (first and second generation) physical health, mental health status and suicidal behaviour. However, *"the scale of the problem of suicidal behaviour in young migrants is unknown because of the paucity of literature on this topic"* (Fry, 2000).

A) Background information

i) Definitions

- Suicidal behaviour: suicide, suicide attempts and suicidal ideation
- CALD Youth: Young (15-24) migrants and refugees from CALD communities and second generation migrants (those born in Australia with at least one parent born overseas). Previous research has explored suicidal behaviour among non-English speaking background (NESB) young people, and refers to those aged 15-24 who are born in a non-English speaking country (NESC) as well as Australian-born children of immigrants born in NESC, and principally this refers to second generation (Dusevic, Baume, Malak and Cassaniti, 2001a).
- Mortality statistics – suicide deaths
- Morbidity statistics – suicide attempts resulting in admission to a hospital

ii) A Public Health approach to suicide prevention

The World Health Organisation (WHO) has stated that the prevention of suicidal behaviour requires a public health approach. This includes:

- The measurement of base rates and identifying groups at risk
- Consideration of specific interventions for different groups at risk
- The need for policy-oriented research and evaluation of suicide programmes.

A study undertaken by the WHO in 2008, examined the epidemiology of suicide in Asia and evaluated suicide prevention strategies aimed at developing and implementing effective culturally sensitive suicide prevention programmes and concluded that: *"describing the epidemiology of suicide in these countries and understanding the weakness of the current mortality monitoring systems in the target countries is an important first step"* (WHO, 2008).

In line with the approach adopted by WHO, Australia's National Suicide Prevention strategy, the *Living is for Everyone (LIFE) Framework,* and Australian Suicide prevention policies and initiatives at a national and state and territory based level use a public health approach.

However, and keeping the public health framework in mind, this submission argues that whilst members from CALD communities have been identified as at a high risk of suicide, the 'baseline' information that is available, is extremely limited due to the paucity of CALD variables which are currently collected and the situation is exacerbated by the scarcity of updated and appropriate epidemiological research which has explored suicidal behaviour within and between people from CALD communities.

This public health void is of great concern considering the growing cultural and linguistic diversity of the Australian population. In particular, it impacts greatly on the ability to implement efficacious resource allocation and the development of appropriate policies and programmes for CALD communities.

iii) Cultural Diversity within the Australian

- Currently the census is the major source of data for obtaining information on immigrants.
- At 30 June 2007, one–quarter of the estimated resident population (ERP) of Australia were born overseas, (ABS, 2008) and the 2006 Census identified 3.6 million people were second generation immigrants. This figure accounted for 25% of the Australian population in comparison to 18% of people in 1976 and 20% in 1996. (ABS, 2006a).
- However, the 2006 Census did not ask for the country of birth of an individual's parents, only whether they were born in Australia or overseas. Whilst ancestry was reported on, people self reported and were allowed up to two responses. Consequently, an individual could be counted in more than one category (ABS, 2006a). Notwithstanding this, ancestries which were most likely to be reported on (excluding British, Irish and Australian) were Italian, German, Greek, Chinese, Dutch, Lebanese and Vietnamese.
- In the 2006 Census 1.7 million Australians (9%) did not state either their birthplace or their parents birthplace (ABS, 2006a).
- Data from the 2006 Census, indicates that approximately 14% of the Australian population were aged 15-24. In Australia, 22% were born overseas, 25% of 15-24 year olds were born overseas.
- Therefore, CALD young people (15-24) constitute a significant population group, who have been born in countries from all over the world and have experienced diverse pre and post migration experiences. It is crucial to have a thorough understanding of the psycho social cultural influences on a persons physical and mental wellbeing and their present and future needs.
- Cohorts of young people (15-24) are associated with different patterns of migration to Australia. For example, if we are considering second generation immigrants, currently aged 15-24, they would be born during 1985 to 1995 this would coincide with a wave of people migrating from Asia, Middle East and Oceania compared to previous waves of migration largely from European or Mediterranean countries (Khoo et al., 20023). Therefore, it is crucial that waves of migration are understood and fully taken into account when considering the risk and protective factors for suicidal behaviour within second generation immigrants and consequently the design of suicide prevention strategies.

B) A public health approach to exploring youth (15-24) suicide in Australia - NSW as a Case Study

i) Public Health Surveillance – Data collection

Suicide Mortality Registers Data Status

Whilst it is widely contended that suicide figures published by the Australian Bureau of Statistics underestimate true suicide rates (AIHW, 2009) because of issues such as coding, criteria used to determine intent and length of time taken to classify a death as suicide, there is also a dearth of data collected related to CALD communities, thus creating a void between what we know and what we need to know about our culturally diverse populations.

A preliminary audit of the major sources of suicide death indicates the following:

- Causes of Death catalogue (ABS, 2007) – only 2 variable are collected
    - country of birth
    - duration of residence (comparable to year of arrival in Australia)
- Australian Institute of Health and Welfare – 2 variables
    - country of birth

    - duration of residence
- National Coroner's Information System – 1 Variable
    - country of birth

Suicide Morbidity statistics

The main source of data for those who attempt suicide is hospital inpatient statistics. In NSW it has been estimated that only 20-50% of people who attempt suicide receive hospital treatment. However it is not known whether there are differences between and within CALD communities (McDonald and Steel, 1997). A preliminary scoping study of the NSW Health Emergency Department Data Dictionary – only 2 variables are collected:

- Country of birth
- Language spoken at home

Limitations of data currently collected

- The National Committee for Standardised Reporting on Suicide was established in 2009 by Suicide Prevention Australia and in its submission to the Commonwealth Senate Inquiry, they highlighted that "whilst there is evidence that certain social and cultural factors provide increased risk of suicide, they are currently not consistently or routinely collected or reported on".
- The dearth of CALD variables which are collected, impacts greatly on our understanding of what may be occurring. For example, for second generation populations, currently country of mother or father information is not collected, and this is of great concern as:
    - there appears to be vulnerability amongst second generations in relation to attempted suicide (Fry, 2000); and
    - research undertaken in Sweden also suggests that second generation immigrants are at a higher risk of suicide death than their parents (Hjern and Allebeck, 2002).

Recommendations:

- Data needs to be collected which is able to be used to explore potentially very important differences between and within CALD youth, for example, country of birth of mother and father for second generation immigrants (McDonald & Steel, 1997) and ancestry.

  The implementation of the "Standards for Statistics on Cultural and Language Diversity (ABS, 1999) by data collection agencies, which were endorsed by the Council of Ministers for Immigration and Multicultural Affairs to provide a standardised framework for the collection and comparing of CALD data . These Standards have not been adopted uniformly or in some cases at all and therefore there are major gaps in public health surveillance indicators, which are able to inform suicide prevention initiatives for CALD populations, as well as other areas of research for CALD populations.

  The set of variables consists of a Minimum Core Set (4) which is drawn from a standard set of 12:

Minimum Core Set (4)	*Standard Set (12):* minimum core set plus:
- country of birth - main language other than English spoken at home - proficiency in spoken English - Indigenous status	- ancestry - country of birth mother - country of birth father - first language spoken - languages spoken at home - main language spoken at home - religious affiliation - year of arrival in Australia

- Liaison with the National Statistical Service to explore the adoption of standards amongst data collection agencies such as the ABS and Surveys such as the National Survey of Mental Health and Wellbeing which collected limited CALD demographic information such as country of birth and year of arrival (ABS, 2009).
- Additionally, even though the quality of information currently collected may be suboptimal, strategies which can be put into place and which facilitate a useful exploration of existing data, include record linkage techniques. For example, in 2009 the ABS assessed the quality of linking migrant settlement records to Census data (ABS, 2009).

ii) Epidemiological research

Epidemiological research is concerned with exploring the rates, trends and distribution of suicidal behaviour within CALD communities and possibly as a consequence of the lack of baseline information, there has been very limited epidemiological research on suicidal behaviour within CALD communities. In particular, there has been a scarcity of migrant studies which have explored suicidal behaviour and risk factors among young people (Cantor and Neulinger,2000; Dusevic et al., 2001a). For example:

- Robinson et al., (2008) found that during the period 1999-2006, there were 209 Australian published journal articles and 26 funded grants on suicide prevention and whilst 28% of articles and 49% of grants explored suicide prevention and young people (aged 24 or less), none targeted people from CALD backgrounds.
- Additionally, a study by Garrett and colleagues in 2010, reviewed the extent of coverage of multicultural health issues in Australian health care research, by undertaking a systematic review of the literature in three major health care journals. They found that out of a total of 4146 articles published during the period 1996-2008, only 2.2% were primarily concerned with multicultural issues. They concluded that this limited representation of multicultural populations in research studies has implications for evidence-based health and human services policy.

Public health surveys are a key instrument for obtaining information on key health indicators. For example, a report on the 2007 National Survey of Mental Health and Wellbeing (Slade et al., 2009) indicates that young females (aged 16-24) had the highest prevalence of suicidality in the previous 12 months (5.1%). However, limited data collection is unable to explore the prevalence and risk and protective factors for CALD young people.

What is known from research conducted overseas

In line with the previous research which has explored suicidal behaviour within migrant communities and identified diversity between and within CALD communities, research which has been conducted overseas has

" found differences in suicide risk among different generations of immigrants" (Kennedy et al., 2005)

For example,

- Hjern and Allebeck (2002), in a study conducted in Sweden found that second generation immigrants have a higher rate of suicide than their parent's generation;
- The results from study undertaken in England by Crawford et al., (2005) found that "lifetime suicidal ideation was greater in immigrants who were born in the UK compared to those who had migrated to England as adults";
- Kim and Singh (2004) found diversity in gender rates between countries and in particular that for girls "suicide rates are higher in Southern India than boys…also observed in China and Singapore" and they pose the question whether politico-economical and sociocultural upheaval affects the younger population especially girls;
- Merrill and Owens (1986), (as cited in McDonald and Steel, 1997) found in a comparative study of Asian patients and British-born white self-poisoners, that there were higher rates of Asian patients and that culture problems were common and of a particular issue for 60.7% of the Asian female sample. Commonly the focus of the culture conflict was around family friction over the perceived incongruence between lifestyles (McDonald & Steel, 1997).

Therefore, "differences in religion, demographic, geographical, financial and cultural differences, contribute to the need for disaggregation and up-to-date research" (Ineichen, 2008).

What do we know from research conducted in NSW

As previously highlighted there is a paucity of research, conducted at a national and state level, however findings from a NSW study, which explored suicide in immigrant populations from 1970 – 1994 (McDonald and Steel, 1997) found that when exploring overseas-born NESB young people in the age group 15-24, that the numbers were too low to examine differences among specific NESB communities, and thus data was also aggregated into regions of birth e.g. Eastern Europe. Additionally, they were not able to consider NESB youth beyond the first generation of overseas born (Dusevic et al., 2001a). However, their findings indicated that:

- non-English –speaking male migrants in NSW, aged 15-24 years, had lower suicide rates than total NSW male population aged 15-24 years and higher suicide rates than NESB females,
- NESB females had similar rates to the average female rate in that age range.

- there was a diversity of rates among different groups of NESB young people. For example. Suicide rates were higher amongst youth from Western Europe and Eastern Europe compared to all NSW and lower amongst youth from Southern Europe, Middle East, Southeast Asia and Northeast Asia,

With reference to suicide attempts, McDonald and Steel (1997) found from those people who accessed health facilities during the period 1988/89 to 1993/94, that immigrants of NESB are generally at a lower risk of being hospitalised after a suicide attempt (which may be associated with significantly lower rates of access to public community and inpatient mental health services by ethnic communities, Stolk et al., 2008) and that:

- young people had rates which were up to six times grater than the aged, and
- higher rates were seen amongst NESB females (15-24) compared to NESB males (15-24).

Additionally, The NSW Suicide Data Report (2001) Inpatient Statistics Collection (ISC) stated that in 1996-97, hospitalisation following a suicide attempt was 14 times more common than the rate of suicide death in young people. The ratio of attempted suicide that resulted in hospitalisation to suicide death was 40.3:1 in females and 6.6:1 in males

Recommendations

- Contemporary research evidence is required to examine linkage between migrant status and youth suicide in general population samples as migrantion status may be a factor in youth suicide (Beautrais, 2001).
- To carry out a study at a major hospital in Sydney, based on that conducted by Merrill and Owens (1986) which has a large CALD catchment (McDonald & Steel, 1997).

Risk factors for suicidal behaviour for CALD youth

Young people have been identified as an at risk group (LIFE, 2007) and a range of biological, psychological and social factors are associated with an increased risk of suicide among young people.

The diversity of experiences and backgrounds of those included in the groupings of young people of NESB are largely unknown (Bevan, 2000) due to the paucity of research conducted which has specifically explored this topic. Additionally, Fry (2000) suggests that the real picture of mental ill health amongst migrants and its association with suicidal behaviour is also unknown due to lack of data collection and research. For example, no comprehensive survey has been conducted regarding the mental health of migrants. Existing findings from public mental health surveys also needed to be treated with caution, as the sample may not be representative of CALD communities and additionally findings from inpatient statistics data collection may be unreliable due to low rates of service access.

However, research from overseas suggests that there may be additional factors pertinent to CALD youth. For example:

- Crawford et al., (2005) in a UK study, found that symptoms of mental distress were the most important common risk factors across ethnic groups expressing suicidal ideation along with low rates of receiving medical attention compared to their British and Irish respondents.
- In line with the Cause of Death figures for 2008 (ABS, 2010), a study conducted in the Netherlands (Burger et al., 2009) found between gender differences for suicidal behaviour. “The ratio fatal/nonfatal event was four times higher in males than females” however “for each ethnic group, the rate of attempted suicides was significantly higher for females than males … the rate of attempted suicide was particularly high among young females”.
- Differences were also found in a UK study which compared “suicide ratios of foreign born and UK-born nationals… ratios were significantly higher in Indian and East African women, in whom there were was a two to threefold excess at ages 15-34” (McKenzie et al., 2003).

Therefore, the findings which highlight diversities in rates indicate the necessity for exploring risk factors which may be pertinent for different CALD communities.

Dusevic et al (2001a) identified that migration can lead to exposure to the following factors which may be associated with a decrease in mental wellbeing:

- Social isolation and lack of support;
- Traumatic experiences or prolonged stress prior to or during migration;
- Prejudice and discrimination by the host population;
- Acculturative stress;
- Low levels of English language learning and proficiency;

- Language and cultural barriers to service access, including stigma about mental illness and lack of knowledge regarding available services; and
- Breakdown of traditional and family support structures, particularly family and relatives, with intercultural conflict being a major contributor.

It has been suggested that these factors may also be associated with increased suicide risk (Dusevic et al., 2001a) and in addition to the previously identified risk factors which may be associated with all young people, NESB young people may also experience these unique stressors and variable reasons for immigration may also have differential impacts.

Additionally, there may be differing levels of impact dependent on whether the young person is a first or second generation immigrant. For example, the negative impact for second generation immigrants of acculturation, intergenerational and cultural conflict. There may also be gender effects within risk factors, for example, females may be more at risk because of intergenerational conflict.

However, the situation for CALD youth is largely unknown due to the lack of data collected and research which has been undertaken. For example, country of birth data for mother and father is not collected. Additionally, there is very limited available information collected for first generation immigrants. For example, the National Mental Health Survey may exclude young people from NESC due to low proficiency in English language.

Research undertaken in NSW and auspiced by Transcultural Mental Health Centre and NSW Health:

- Focus group consultations were conducted by Dusveic et al., (2001b) and participants identified that young people were the most at risk NESB group. The participants also identified factors for increased suicide risk amongst NESB young people, some of which could be common amongst all young people, and some may be more specific to CALD young people. These included:
    - Cultural and language gaps between parents and children
    - Academic pressures
    - Second generation
    - Refugee issues
    - Marginalisation
    - Lack of help seeking
    - School bullying
- A study by Fry (2000), which investigated suicidal behaviour in young migrant women in Blacktown, identified risk factors related to migration that may be experienced personally by the young person or indirectly via the family distress. These may include:
    - Vulnerability to depression
    - Parental conflict linked to the stress of migration
    - Role reversal (e.g. being the spokesperson for the family)
    - Intergenerational conflicts
    - Pre migration experience
    - Lack of availability of family and social networks
    - Rigid gender roles and gender-based power relations
- Fry (2000) also identified that the focus of her study was young people born overseas, as it was not possible to collect information on the birth place of parents. Therefore, the number of second-generation Australians was unable to be determined. Fry (2000) highlighted that whilst the data must be treated with caution (due to small numbers) in line with other studies, she found that :
    - Young women born overseas in non-English speaking countries are more vulnerable for self-harming behaviour compared with young men. “cohesive family units … higher rate of suicide attempts in these young migrant women suggest that these perceived protective factors, when taken to extremes may transmute into risk factors”
    - Fry (2000) also identified that stressors related to migration may intensify the normal pressures of adolescent maturation, particularly for young immigrants from non-English speaking countries and that “it is possible that, when taken to extremes, protective factors transmute into risk factors”.

Therefore, it is crucial that data needs to be collected and research needs to be undertaken which facilitates further explorations and understandings of the risk and protective factors and to assist in the development of appropriate suicide prevention strategies for CALD young people.

Protective factors for suicidal behaviour in youth
The Ministerial Council for Suicide Prevention (Western Australia, 2009) identified the following protective factors:

- Connectedness to family and school
- The presence of a significant other
- Personal resilience and problem-solving skills
- Strong spiritual or religious faith or a sense of meaning and purpose to life
- Community and social integration
- Early identification and appropriate treatment of psychiatric illness
- Lack of access to means of self –harm

Protective factors for suicidal behaviour in CALD youth
Dusevic (2001) highlights that the lack of available data and current research on suicidal behaviour amongst young people from CALD communities, means that it is very difficult to identify rates and trends, and risk and protective factors and thus inform suicide prevention policy and practice. However, a study by Temoany (2009) cites other studies conducted in Australia, which have explored the mental health and wellbeing of Sudanese refugees and identified that coping strategies include the use of religious beliefs, social support, personal qualities, comparison with others, normalisation and acceptance of difficulties, a focus on growth, personal and political wishes.

A study by Dusevic et al., (2001) highlighted that the following protective factors were identified by focus group participants. However, these were not youth specific:

- Family cohesiveness and support
- Support
- Collectivism: family and community focus
- Religious beliefs
- Low alcohol use
- stigma regarding suicide
- Help seeking
- Employment
- Acceptance of hardship
- Resilience of at risk groups
- Self esteem and confidence
- Being a parent, having a baby

C) Major Recommendations:
The following recommendations are made in order to meet the needs of CALD youth:

Data Collection

- Scoping study to be undertaken amongst major data collecting agencies (such as the Australian Bureau of Statistics, National Coroners Information System, State and Territory Registries of Births, Deaths and Marriages and hospital data collection systems), to identify what information on cultural and linguistic diversity is currently collected and how robustly.
- Liaison with the National Statistical Service to explore the adoption of the *"Standards for Statistics on Cultural and Language Diversity"* (ABS, 1999), amongst data collection agencies such as the Australian Bureau of Statistics, National Coroners Information System, State and Territory Registries of Births, Deaths and Marriages and Health Departments, as this would provide a consistent framework for the collection and comparability of data.
- Liaison with relevant data collection agencies to explore the exploration of data using data linkage techniques.
- A rigorous system of data collection would develop the base of knowledge and understanding of suicidal behaviours within CALD youth.
- To conduct a survey amongst members of CALD communities, as their experiences may have been omitted from the National Survey of Mental Health and Wellbeing because of their English language fluency levels.

Epidemiological Research

- There is an urgent need to undertake research at a national, state and territory level, which identifies the rates and trends of suicidal behaviour, and risk and protective factors between and within CALD youth.
- To support the collection of both qualitative and quantitative information from CALD young people, within an evidence-based suicide prevention framework.
- To implement research studies / pilot project, which identify appropriate models of prevention and early intervention for young people from current and emerging CALD communities and explores the risk and protective factors within the young persons environment.
- Public Health Surveys should recruit truly representative samples of Australia's diverse population.

Individual and Community Initiatives

- To support the development of individual and community capacity building initiatives to reduce stigma, encourage help seeking behaviours and build resiliency amongst CALD youth, particularly in new and emerging communities.

Clinical Practice Issues

- To implement capacity building initiatives for service providers working with CALD youth who may be at risk of suicide.
- To implement clinician capacity building initiatives, such as suicide prevention training, which help to explore the complexities and multiple barriers that CALD youth experience.
- Targeted recruitment of bilingual /bicultural clinical staff.
- Standards are introduced in the use of interpreters in crisis situations and when assisting / supporting young people at risk of suicide.
- Workforce development training undertaken to ensure culturally sensitive and competent care for young people from CALD communities.
- Assessment tools need to be age appropriate and have cross cultural validity and reliability.
- Cultural and age relevant factors need to be included in protocols for suicide risk assessment.

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