EDAC
Ethnic Disability Advocacy Centre

RESPONSE TO THE SENATE INQUIRY INTO THE GOVERNMENT'S FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES

Mental health services and funding that are inclusive of people with disability from culturally and linguistically diverse backgrounds

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Ethnic Disability Advocacy Centre
320 Rokeby Road
Subiaco WA 6008
Phone: 08-93887455
Fax: 08-93887433
Email: admin@edac.org.au
Website: www.edac.org.au

Responding to the Senate Inquiry on Mental Health Services for the CaLD community

About EDAC

The Ethnic Disability Advocacy Centre (EDAC) is a peak, non-profit, community based agency which actively advocates for people from culturally and linguistically diverse (CaLD) backgrounds with a disability (including mental illness).

EDAC's services include,

- Individual advocacy in Metropolitan Perth, Carnarvon and W. Kimberley.
- Systemic advocacy to influence broad changes in the community to ensure the rights of people with disabilities from CaLD backgrounds are maintained.
- Provision of information and support, including a weekly radio program at 95.3 6EBA FM
- Delivering cross cultural and disability training on best practice models of service delivery and creating training opportunities for CaLD people with ALL types of disabilities (including mental illness).
- Supporting Carers/families.

EDAC would like to provide some key concerns regarding the provision of funding and services for CaLD people experiencing mental illness.

Mental health care and treatment within the CALD communities

Australia is culturally diverse, as over 40% of its population was born overseas or had at least one parent born overseas. Of those born overseas, 62.1% were born in a non-main English speaking country. The census also identified that 15.8% of the population speak a language other than English at home (ABS, 2006).

Despite evidence of a strong impact of cultural and linguistic diversity in Australia, there is little data on the prevalence of disability and mental health. According to the National Ethnic Disability Alliance's recent data and research study, *People from NESB with disability in Australia: What does the data say?* (NEDA 2010):-

- More than 1 million people with disability are from non-English speaking backgrounds.
- Some form of recent migration heritage is a characteristic for over 40% of
- people with disability.
- There is a higher prevalence of impairment for people born in a non English speaking country aged over 45 years of age, especially for 'first

wave' non English speaking migrants, up to 3 times that of the Australian born population.

- All people with disability face barriers to social participation – access to employment, technology, social activity and economic wellbeing .
- People from non English speaking countries are likely to face deeper forms of marginalisation.

Despite this diversity, not all Australians have equal access to culturally appropriate mental health treatment and care when they need it.

Studies have shown that Australians from CALD backgrounds who are affected by mental health problems tend to have lower rates of access to community and inpatient mental health services and higher rates of involuntary admission to mental health services.

There are a variety of factors that can act as barriers to people from diverse backgrounds accessing mental health services. These can be attributed to stigma associated with mental illness, lack of knowledge about available services, treatment options, language and cultural barriers and differences in cultural explanations and perceptions surrounding mental health.

Refugee and asylum seekers' experience and mental disorder

Adjustments in Australia following long term detention can bring about many psychological and mental health conditions. Asylum seekers in immigration detention centres, many of whom are already highly traumatised upon their arrival in Australia, experience or develop further mental health issues whilst in detention especially children and adolescents who came from families who have lived through the traumas of war. The mental health impact of this aspect of immigration policy appears at odds with the national mental health policy and settlement policies governing immigrants and some refugees.

People with dual or multiple disabilities and diagnosis

Currently mental health support for people with dual and multiple disabilities falls within the cracks of both mental health and disability systems. Mental health service professionals have little specialised knowledge of other disabilities such as intellectual and neurological (head injuries) conditions. The disability sector is not addressing the psychological and mental health needs of this cohort adequately. The most recent statistics from the Australian Bureau of Statistics indicate that people with physical disabilities are more likely to develop mental health problems.

Many people will get depressed at some point in their lives, and this may be related to major life events such as bereavement, stress, abuse or illness. However, depression is easily missed in people who have social and communication disabilities. It is probably more common in people with physical and intellectual disabilities and people with autism than in the general population. In people with Down's syndrome, depression may be misdiagnosed as dementia, or it could be

associated with underlying physical disorders such as hypothyroidism. The differences in the presentations and disorders in people with intellectual disability can present many challenges for clinicians and mental health service providers. Assessment tools and other treatment options may need to be modified including a detailed culturally appropriate psychiatric assessment.

Mental health advocacy

The concept and practice of advocacy has been developed to promote the human rights of people with disabilities including mental disorders, to reduce abuse and discrimination. The WA Disability Services Act 1993 and the Commonwealth Disability Services Act of 1986 had provisions of advocacy for people with disabilities. Independent advocacy agencies are subsequently funded.

The WA draft Mental Health Quality Assurance Framework has endorsed independent advocacy in supporting people with mental illness. Independent advocacy groups, when established will provide a strong voice for mental health consumers and to advocate for their rights and needs to be included in the community. The advocacy movement can influenced mental health policy and legislation in Australia as well as increasing the awareness of mental illness. Advocacy for the more marginalised group such as people from CaLD backgrounds and people from Aboriginal backgrounds should be funded to protect their rights to appropriate service access and for raising awareness of mental illness from a cultural perspective.

The following case studies illustrated some of the issues relating service access for CaLD people with mental illness.

Case Study 1*:* A migrant woman with a mental illness was referred to a psychologist from a mainstream service. The psychologist's indicated to her that the abusive relationship at home was damaging the children's lives and that she should leave her husband. When the woman refused to accept her diagnosis of the condition and her advice, she was refused further treatment. No referral was made to more culturally appropriate service and support. After that visit the woman felt she had no-one to go to in the community due to the cultural stigma associated with mental illness and had no confidence in psychologists and mainstream professionals. This prolonged incident subsequently led to her admission to hospital with a psychotic episode where she currently received psychiatric support. Her psychotic episode could have been assisted with much early appropriate support and intervention.

Case Study 2:

The case was related to an elderly couple who had migrated to Australia in the 60s and living in a farm in a regional area. They were quite isolated and had no family support. The husband had a good command of English but his wife with long term depression had reverted to speaking in her own native language. This was proving

challenging for the Mental Health Unit that was trying to treat her depression. The husband was the main carer of his wife and there had been bimonthly visit from the mental health nurse. With age, the wife was also developing dementia and the husband had difficulty managing the care, both physically and emotionally. They were embarrassed to ask for assistance even though they were not coping well. Our advocate visited the couple in their farm and had developed a good rapport with them. He discovered that the husband appeared stoic in his mannerism and had refused support but eventually acknowledged that he was not managing well. Subsequently, support services through HACC were put in place and he was able to continue caring for his wife in the own home.

Case study 3:

A client from a South East Asian origin had been diagnosed with schizophrenia (paranoid) and anxiety with periods of severe bouts of depression. He managed his condition with medication quite adequately. Client requested assistance to make an application to the Australian Industrial Relations Commission against his employer on the grounds that he was discriminated and his employment were unlawfully terminated. An application was lodged made by completing Form R27 with a written submission and request to waive the application fee despite the lapse of 21 days at the time when client approached EDAC.

The employer argued through their lawyers that the application was not made to the Australian Industrial Relation Commission within the 21 day period as required by the *Workplace Relations Act 1996* and also filed a Notice of Motion to dismiss the application for Want of Jurisdiction. The Australian Industrial Relations Commission dismissed the client's appeal on the grounds that the application was not made within 21 days and dismissed the medical reasons provided on behalf of the client. Upon discussion with a legal firm and the appeal was lodged against the employer's argument. A supporting letter from a Mental Health Practitioner was sought and outcome pending.

Case study 4:

Some young refugees attending high schools and TAFE colleges were reported as demonstrating unruly, disruptive behaviours and learning difficulties. Some of the learning difficulties were inconsistent with their developmental stage and circumstances as refugees or with mental health conditions. Due to the age factors and a lack of culturally appropriate neuropsychological assessment it was difficult to fit in the norm of mental health and disability service provision. There is also a long waiting list for such assessment for newly arrived refugees and private assessment would be too costly for them. Often the eligibility to support services in mental health and disability is based upon the completion of an assessment and determination of a right diagnosis.

Case study 5:

A mental health consumer was not taking her medication regularly and had refused support from her mental health worker. Her condition deteriorated to the extent that she was unable to provide proper care of her two young children. The Department of Child Protection intervened by removing the children from her care. Advocacy support was provided subsequently and the women was receiving counselling from a psychologist from CaLD background and steps were in place for her to be united with her children.

Funding of CaLD specific mental health services

In Western Australia there are few community organisations specifically funded by Commonwealth or State governments to meet the mental health needs of CaLD Communities.

The WA Transcultural mental health is a hospital based service located within the South Metro Health Service (not state-wide) and provides very limited mental health support and counselling to CaLD mental health consumers due to funding etc.

In terms of funded ethnic community based mental health service, there is basically two agencies, one for torture and trauma counselling and the other related to mental health access and referrals. CaLD Mental health consumers are expected to access mainstream mental health services. Independent individual advocacy in mental health for CaLD consumers is provided by EDAC in some capacity but not funded by the Mental Health Departments.

Whilst some mainstream mental health service providers had made milestones in reaching the CaLD communities, it is only a drop in the ocean as many CaLD mental health consumers and the *hidden population* with mental health conditions is not receiving appropriate information and mental health support.

Multicultural Mental Health Australia was the only national program funded to examine, address and advocate for the mental health needs of Australia's culturally and linguistically diverse (CALD) communities. They used to consult with all stakeholders and prepare detailed submissions to government regarding mental health reform. Unfortunately, after 11 years, they lost their funding. Many of their expertise, achievements and multicultural mental health information developed over the years becomes an uncertainty or redundant.

Recommendations

Mental Health funding to CALD agencies and for CALD community needs in Australia is meagre in proportion to the size and need of the CALD population. The disparities in funding for and within ethnic community based agencies are quite evident and needed urgent attention.

We strongly recommend that appropriate funding to community ethnic communities be allocated to develop grassroots mental health support and independent advocacy. Mainstream mental health services as indicated earlier have not been very effective in reaching CaLD people with mental illness who are in need of mental health support.

There needs to be accurate measurement of the mental health status of Culturally and Linguistically Diverse (CaLD) communities. It is fundamental to the provision of quality mental health services for CaLD communities. Data collection should include country of birth, ancestry or ethnic origin, languages spoken. The provision of funding for professional interpreting is crucial.

This data should be collected by **all** mental health services across the state. It also needs to be analysed and reported on regularly for the following areas:

- The demographics of CaLD mental health service users;
- The prevalence rates of mental health problems in CaLD populations;
- The utilisation rates of mental health services by the CaLD population;
- How the needs and concerns of CaLD consumers are being addressed in relation to quality service provision.

We recommend that research on mental health in CaLD communities be a priority. As this makes it extremely difficult to obtain funding by CaLD communities as all governments require evidence to justify funding allocations.

There is state-wide commitment towards a person centred approach and support in mental health service. We believe that this approach should take into account of cultural beliefs and practice and not be standardised for all communities. We recommended that this approach be modified for the CaLD communities but further research to determine their perspectives and understanding of that concept and practice including training with mental health providers to enhance their understanding of the cultural perspectives.