

15 July 2011

Committee Secretary  
Senate Standing Committees on Community Affairs  
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Dear Sir/Madam,

I would like to thank the Senate Standing Committees on Community Affairs for seeking this long overdue Inquiry into the Government's funding and administration of mental health services in Australia.

My submission is based on point 6: ***The adequacy of mental health funding and services for culturally and linguistically diverse (CALD) communities.***

I was the Chair of the Multicultural Mental Health Australia (MMHA) program funded by the Department of Health and Ageing and auspiced by the Sydney West Area Health Service since 2000, and the Director of the Diversity In Health institute which consists of the largest multicultural health hub in Australia and includes the largest Transcultural Mental Health Centre in Australia. I am the chair of the newly established NGO Multicultural Mental Health Association of Australia.

Multicultural Mental Health Australia was and still is the *only* national multicultural mental health program and the *least* funded national mental health program Australia. Up until 2006, MMHA was funded very poorly and when the funds increased in 2006 to \$900,000 p/a for 3 years, it was still the least funded program compared to many other mainstream mental health programs and initiatives the Australian Government funds. The current distribution of mental health resources is not based on the size and needs of the CALD population in Australia and does not acknowledge that Australia is made up of more than 200 unique cultural groups and approximately 16 per cent of the population speak a language other than English at home. When it comes to mental health, the CALD community is a 'disadvantaged group' with particular needs.

During my tenure as the chair of MMHA, a number of very important issues were identified that needed intervention by Government through the equitable distribution of funds to support suitable mental health programs and services for the Australian CALD population. However despite MMHA's efforts in bringing these issues to the attention of the state and federal governments, some important issues remain unsolved and due to the lack of understating and commitment by the main funding bodies including the departments of Health and Ageing and Families Community Services, Housing and Indigenous Affairs who are the main federal mental health funders in Australia.

My submission outlines the main issues and offers solutions on how to remedy the existing mental health disparities between the mainstream and CALD communities in Australia.

I am looking forward to significant improvements to be made in the funding and administration of multicultural mental health services in Australia as a result of this inquiry, and for the enhancement of mental health outcomes to people with mental illness from CALD backgrounds.

I am contactable on mob: 041 748 9066 or email: [amalak@bigpond.net.au](mailto:amalak@bigpond.net.au)

Yours sincerely,

**Prof Abd Malak**

Chair  
Multicultural Mental Health Association of Australia

# SUBMISSION

TO

**THE INQUIRY INTO THE GOVERNMENT'S FUNDING AND  
ADMINISTRATION OF MENTAL HEALTH SERVICES IN AUSTRALIA**

**THE SENATE STANDING COMMITTEES ON COMMUNITY AFFAIRS**

BY  
**PROF. ABD MALAK**  
**July 2011**

## LIST OF APPENDICES

**Appendix 1:**

Snapshot of MMHA's Achievements

**Appendix 2:**

Min Butlers Media Release on boost to PASST program of 23.06.2011

**Appendix 3:**

Min Butler's Media Release on \$2.2 M for New Translation and Interpreting Service for Aged Care Residents – 08.07.2011

**Appendix 4:**

MMHA report on Implementation of Stigma Reduction Project

**Appendix 5:**

List of Distribution of National Mental Health Funding as Dec 2011

**Appendix 6:**

MMHA's *State of Play* Report

**Appendix 7:**

MMHA's Publications Catalogue

**Appendix 8:**

Min Butlers Media Release On Free Mobile Calls to Lifeline of 29.06.2011

## BACKGROUND

*Multicultural Mental Health Australia* was in operation since 2000 when the Department of Health and Ageing decided to change the provider last month. While a lot of work was completed and expertise gathered by the MMHA program over the years, and MMHA achieved many milestones and more than it was funded by DOHA, Minister Butler announced on 17 June 2011 that the grant was given to the Mental Health Branch of QLD Health, thus destroying the work and expertise gathered over the years by MMHA.

Despite the existence of the MMHA program, disparities continue to exist because the specific mental health needs of CALD communities have not been made a priority, and political and financial support has not been equal to the task by governments, leaving the many mental health needs of CALD consumers and carers unmet and not on par with those from English-speaking backgrounds.

There is a small but growing body of evidence which suggests CALD communities in Australia tend to fare worse than many when it comes to timely and culturally appropriate access to mental health services (Dept Health and Ageing 2004). Recent research in Victoria examined access data in the state's clinical mental health services between 1995/96 and 2004/05. It showed the gap between CALD groups had worsened, leading the authors to state:

*"Clearly disparities in access for ethnic communities have not only persisted but have increased."*  
(Stolk, Minas & Klimidis, 2008, p.14)

And this is in Victoria, a state with a high number and proportion of people born in NES countries. One can only infer the level of services in states and territories without any TMH centres, such as TAS, SA, NT and ACT.

Up until 2006, Multicultural Mental Health Australia was funded very sparingly, restricting its ability to address the needs of people from CALD backgrounds with a mental illness, from basic information needs to the development of projects of national applicability. Before 2006, policy and communication were the main priority areas funded. This only changed after the DOHA funded Multicultural Mental Health Australia to examine and address gaps in the following priority areas:

- consumers and carers
- community capacity building
- workforce development
- communications, information and promotion and
- policy advice and development.

Multicultural Mental Health Australia was the only national program for multicultural mental health and has made significant progress during the short time it was funded more adequately ( 2006). (See Appendix 1: Snapshot of MMHA's Achievements)

To demonstrate the disparities that still exist and the developments made so far, an outline of the multicultural mental health landscape is provided below:

### ISSUE 1: TRANSCULTURAL MENTAL HEALTH CENTYRES, SERVICES & PROGRAMS

There are considerable funding disparities between states and territories in Australia. For example, half of our nation does not have a Transcultural Mental Health Centre/Service (TMHC). While we have a centre/service for the Survivors of Torture and Trauma in every state and territory –and we should – there is also a need for a TMHC to be funded and available in each state and territory as a bare minimum.

The Program of Assistance for Survivors of Torture and Trauma (PASST) administered by DOHA was given a burst in funding on 23 June 2011 of \$55M over four years, and another \$300,000 to the Forum of Australian Services for Survivors of Torture and Trauma for information and training resources, while only 4 Transcultural Mental Health Centres/Services exist in Australia, with no funding for growth in this program witnessed in the past 10 years. The TMHCs rely on the ability and goodwill of the state governments to be funded and supported while the PASST

services are funded by the Australian Government which enables equity in the provision of PASST services in *every* state and territory. This is also needed for transcultural mental health services. (See Appendix 2: Min Butler's Media Release on \$55M Boost to PASST Program - 23.06.11)

There are far more people from CALD backgrounds with mental illness than there are survivors of torture and trauma in Australia, yet this is not reflected in the distribution of funds and the availability of relevant services and programs, and this considerable discrepancy must be remedied. How the Australian government and DOHA rationalised this discrepancy in the administration of mental health funds is difficult to understand.

While TMHCs exist in NSW, VIC, WA & QLD, the service mix and scope provided by the centres varies from state to state. Some TMHCs provide clinical services, community education and advocacy, others only workforce training etc. Their funding also varies considerably and is not based on the size and need of the CALD population. Transcultural mental health centres, services and programs need to be resourced and established in **all** states and territories and for them to provide the same type of service mix and scope and include all: clinical, advocacy, promotion and education services as a minimum.

In addition, the one and only multicultural mental health program responsible for a larger proportion of the CALD population continues to receive only \$2.7 Million over 3 years. The same amount that it received in 2008, with no CPI increases considered in the recent refunding of the program to the new provider: QLD Health. Neither did DOHA consider the continuation of funding of the expert MMHA program, and be more visionary and transparent by dividing the responsibilities between the 2 providers in order to maintain the history and expertise of the 11 y.o MMHA program. This solution would have greatly assisted the CALD community in the expansion and provision of relevant projects and services across the nation and enable the continuation of past gains.

1. Proportion of NES (LOTE) Pop'n / Total Population	2. Total Number of NES COB	3. Proportion of NES COB Pop'n / Total Population
1. NT 23 %	1. NSW 1,099,210	1. WA 19.4 %
2. VIC 20.4 %	2. VIC 879,896	2. VIC 17.8 %
3. NSW 20 %	3. QLD 406,458	3. NSW 17 %
4. ACT 14.5 %	4. WA 378,878	4. SA 17 %
5. SA 12 %	5. SA 256,384	5. ACT 15.6 %
6. WA 11.5 %	6. ACT 51,062	6. QLD 10.4 %
7. QLD 7.7 %	7. TAS 38,003	7. NT 8.3 %
8. TAS 3.5 %	8. NT 6,015	(Incl. Indigenous Com'ty IC)
		8. TAS 8 %
<b>NATIONAL 15.8 %</b>	<b>NATIONAL 3,126,436</b>	<b>NATIONAL 16 %</b>

The tables above demonstrate that resources are not distributed equally across the nation to reflect the proportion of CALD residents and their needs. A good example of this is the fact that DOHA took the MMHA grant from NSW and gave it to QLD, a state with only 7.7% of the its population speaking a language other than English at home (1) and a state that has only 1/3 of NSW's number of those born in a NES country of birth (2).

## ISSUE 2: DATA COLLECTION

The accurate measurement of the mental health status of CALD communities is fundamental to the provision of quality mental health services for CALD communities (MMHA *Framework for the Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia*).

Unfortunately, there are limited data collections systems available to observe and measure:

- The demographics of CALD mental health service users;
- The prevalence rates of mental health problems in CALD populations, and
- The utilisation rates of mental health services by CALD populations.

- (i) *There is a lack of baseline CALD data because consistent CALD data is not collected across service systems and jurisdictions and therefore we can not analyse data between states and territories and between service systems.*
- (ii) *The complex & variable data collection systems across states and territories make it difficult to collate and compare data nationally.*
- (iii) *The lack of generational CALD data collection makes it difficult to identify patterns of mental illness between generations.*

Multicultural Mental Health Australia has been advocating for a minimum CALD data set to be collected by public mental health services since 2004. The set of COB, LOTE, English proficiency and Interpreter need as recommended by the ABS should be used by all the public mental health systems (as a minimum) across all the national and state and territory jurisdictions.

The last correspondence MMHA received from the national Mental Health Information Systems Sub-committee (MHISS) in Sept 2009 and signed by the convenor, who is the Mental Health Director for QLD Health and is now the auspicing body of the MMHA program, advised:

- *The additional data collection burden that would be incurred by the jurisdictions to collect this information (ie LOTE and proficiency in English) outweighs any advantages that may be realised*
- *The existing COB data element that is being collected can be used to deduce information on Main Language Spoken at Home*

This lack of understanding of the basic the relationship of language and country of birth came from the same Mental Health Director who received the MMHA grant recently!

### **ISSUE 3: INTERPRETER SERVICES FOR MENTAL HEALTH**

The lack of availability and knowledge about the use of and access to interpreter services in mental health settings presents a major barrier in the utilisation of mental health services. This knowledge gap has a direct impact on the quality and safety of mental health service provision to CALD communities.

A survey conducted by MMHA with the states and territories, found that there was no consistency in the access, use and availability of interpreters by mental health services across jurisdictions. In addition consultations held by MMHA in various states and territories since 2007 indicated lack of interpreter access, use, availability and training of interpreters in mental health issues and terminology are major issues requiring immediate government intervention and resourcing.

Despite this evidence, Minister Butler recently announced \$2.2M for the availability of Telephone Interpreting Services (TIS) to residential facilities for the aged and cultural awareness training to aged care staff. The same needs to occur to mental health services regardless of whether they are state or federally funded. If resources can be provided to private-for-profit residential facilities they can also be provided to public and private mental health providers given the importance of language in the assessment, diagnosis and treatment of mental illness. (See appendix 3: Min Butler's Media Release on \$2.2 M for New Translation and Interpreting Service for Aged Care Residents – 08.07.2011)

### **ISSUE 4: ACCESS, PATHWAYS & SUITABILITY OF PRIMARY MENTAL HEALTH SERVICES FOR CALD CONSUMERS**

Suitable *primary* mental health pathways are lacking or remain unclear for CALD consumers. These pathways also differ between the state and territory jurisdictions. This has an impact on access rates to mental health services. Access rates to mental health services are not the same between English-speaking and non-English speaking consumers and carers. This results in the continuation of our population accessing health services through

emergency departments and at a crisis stage. It places an even greater burden on CALD community members to deal with the mental illness themselves and seriously jeopardises their recovery prospects.

Most Australian literature identifies the following mental health service access patterns across CALD communities (Sozomenou, Mitchell, Fitzgerald, Malak & Silove, 2000; DOHA, 2004; Minas, Lambert, Kostov, & Boranga, 1996; Klimidis et al, 1999a; Stolk, Minas, & Klimidis, 2008; Minas, Silove, Kunst, 1993)

- There are higher rates of involuntary and lower rates of voluntary admissions by CALD consumers;
- There are lower rates of access to community and inpatient services compared with people born in Australia;
- Consumers from CALD backgrounds tend to be hospitalised for longer periods; and They are more likely to present for treatment at the acute, crisis stage

Adding to this confusion is the fact that there are 8 different Mental Health Acts in Australia. For people from CALD communities this only makes it even more difficult for them to understand the mental health system/s, the availability and how to access mental health services as well as their rights when they need help with mental health problems.

## ISSUE 5: STIGMA

Physical Illness is seen as an assault on the sufferer, mental illness is seen as a character flaw in many societies. While stigma affects all Australians living with a mental illness, in CALD communities it's usually more pronounced in CALD communities due to difficulties in accessing information and services, as well as limited knowledge about mental illness. Stigma. Stigma can undermine a person's confidence and make them feel isolated and ashamed, impacting upon their employment opportunities and social participation, while also contributing to family breakdown.

In order to address stigma in CALD communities, community education is required, including specific programs which take into account the strengths, traditions and beliefs of various cultures, as well as the various explanatory models used to explain mental illness.

In 2008, MMHA started to address the issue of stigma following the provision of more adequate and targeted funding to produce relevant information and tools. Then in 2009, MMHA launched the first ever national Stigma Reduction Community Education program, across a number of states and territories. The project explored how individuals and communities can deal appropriately with stigma. It is highly relevant to CALD communities as it builds on the strengths, traditions and beliefs which exist in our communities.

While an independent evaluation of the project in 2009-10 showed many positive outcomes for CALD communities, the ongoing implementation across the nation was hindered by the lack of state support and funding, forcing MMHA to become a program implementer and coordinator in some states and territories, and had to rely on the good will of the multicultural community agencies and expected CALD communities to volunteer their services and time to deliver the sessions. This is not expected for the mainstream community based education programs, generally these are funded.

(See Appendix 4: MMHA's report on the Implementation of the National Stigma Reduction project)

Despite the success of the program and the recommendations from the independent evaluation After a year, the project had to be shelved as there was no buy-in from the states and territories and the funding body (DOHA) refused to assist by either by encouraging the states and territories to participate or DOHA funding the program to be implemented nationally on an ongoing basis. This resulted in a waste of tax payer funds for its development and a loss of opportunity to increase mental health literacy and stigma in CALD communities. Despite evidence that shows that stigma associated with some forms of psychiatric morbidity (notably depression) has waned in the English-speaking community over the last decade, primarily due to substantial resources invested in national programs such as

*beyondblue*. The success of these national initiatives suggests a strong link between sizeable and significant health promotion activities and a change in community perception. Unfortunately, there is yet to be a comparable investment into CALD specific, ongoing mental health educational and promotional activities.

## **ISSUE 6: SUICIDE IS A SIGNIFICANT ISSUE FOR CALD COMMUNITIES**

While suicide rates for both males and females have decreased in the past 10 years, it remains a health, social and economic concern, between 1997 and 2005, there were more than 2,000 suicide deaths each year in Australia (AIHW, 2009). However the suicidal behaviour in CALD communities is limited because of the lack of ongoing research on the topic and limited data collection. For example, the National Coroners Information System currently only collects one CALD-specific data variable: Country of Birth (NCIS, 2009).

Religion, cultural traditions, social status, personal experiences and genetic factors of the country of birth all play a complex role in suicide risk and protective factors<sup>1</sup>. Risk factors include:

- Prolonged periods of stress during migration
- Social isolation and lack of support
- Breakdown of traditional and family support structures
- Limited English language skills
- A decrease in socio-economic status, compared to country of birth<sup>2</sup>

In 2008 the Commonwealth released the national LIFE framework on suicide, which clearly states that suicide prevention in CALD communities needs special consideration because rates among immigrants to Western countries appear to be higher than rates within their countries of birth. Despite the rhetoric, the practice is very different due to the lack of available resources.

Suicide was specifically identified as a key issue of concern at the various state, territory and national consultations conducted by MMHA. Consultation 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 targeting CALD communities.

Some comments and advice included:

- "There are no culturally and linguistically appropriate suicide prevention programs in WA" – WA Consultation, March 2009
- There is a need to "develop projects on mental health taboos, beliefs, explanations (of suicide)...." – ACT Consultation, June 2010
- "Culturally-appropriate suicide projects to be funded in every jurisdiction to help reduce the suicide rates in CALD communities" – National CALD Peaks Consultation, June 2010
- "DoHA needs to mandate the systemic collection of data relating to suicide and suicide attempts by all relevant jurisdictions" – National CALD Peaks Consultation, June 2010

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<sup>3</sup>. However, recent research<sup>4</sup> 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 country 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.

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<sup>1</sup> De Leo D, Kolves K, Ide N (2010)

<sup>2</sup> Dusvic N, Baume P, Malak A (2001)

<sup>3</sup> Walker S, Chen L, Madded R (2008)

<sup>4</sup> De Leo D, Kolves K, Ide N (2010)

- Certain age groups are also more vulnerable than others, with research indicating high suicide rates amongst older immigrants<sup>5</sup>. International research also suggests second generation immigrants have a higher risk of suicide death than their parents<sup>6</sup>.

## ISSUE 7: RESEARCH

Research on mental health in CALD communities has not been a priority, although all governments require evidence to substantiate funding allocations.

A review of research priorities in mental health conducted for DoHA in 2002, revealed there was a lack of mental health research dealing with non-English speaking population groups, accounting for only 2.2% of published articles and attracting only 1.5% of research grant funding (Jorm, Griffiths, Christensen, & Medway, 2002, p. 70).

A more recent review of suicide prevention research by Robinson et al (2008) for the period 1999 to 2006, it was identified that of 209 published journal articles and 26 funding grants, none targeted CALD populations.

Only 2% of people who conduct suicide prevention research were identified as targeting CALD populations (table 1).

Table 1. Australian suicide prevention research targeting CALD, 1999-2006 (Source: Robinson et al., 2008)		
	Total #	% Targeting CALD
Published journal articles	209	0 %
Funded grants	26	0 %
People who conduct suicide prevention research	45	2%

In January 2011, the National Health & Medical Research Council reported that it made the following funding allocations for research projects on CALD populations:

1. Ethnographic, treatment, and policy responses to patients presenting for care with chronic medically unexplained symptoms in *Viet Nam*: A randomised control trial of cognitive behaviour therapy, structured care and treatment (\$471,278) = *NOT in/for Australia*
2. Enhancing knowledge about the role of human factors, enforcement practices, and legislation in Australia and *China* to inform the development of culturally-specific speed management strategies to reduce road trauma (\$367,834) = *NOT Mental Health & NOT in Australia*
3. Understanding ethnic differences in the relationships between *cardiovascular* risk factors and cardiovascular disease in high risk populations \$145,016 = *NOT Mental Health*  
(See Appendix 5: List of Distribution of National Mental Health Funding)

The provision by the NHMRC of \$471,278 to a CALD-specific mental health project overseas ie Viet Nam represents only 3.7% of the total Commonwealth investment, whereas 16% of Australia's population speaks a language other than English at home (based on the 2006 Census). When the \$471,278 is subtracted, the picture is more alarming in that no funds were provided for research projects to investigate the mental health needs prevalence of conditions, suitable treatment options or mental health service use etc of the CALD community in Australia.

The lack of funding for CALD research means CALD mental health issues slip off the agenda and adequate mental health services and systems are not planned to be funded for all Australians.

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<sup>5</sup> McDonald R, Steel Z (1997)

<sup>6</sup> Hjern A, Allebeck P (2002)

## **ISSUE 8: CALD CONSUMER AND CARER PARTICIPATION**

The current revised National Standards for Mental Health Services highlights the importance of consumer and carer participation at all levels of service planning, design, delivery and evaluation.

It was only through Multicultural Mental Health Australia that consumers and carers from CALD backgrounds were given a real voice on a national scale. MMHA was funded as late as 2008 to develop a platform for CALD consumers and carers to participate at the national level. This included:

- National CALD Consumer and Carer Reference Groups;
- An Australian-wide CALD Consumer and Carer Speakers Bureau; and
- State-based language and topic-specific peer support groups.

National and state-based mainstream Consumer Advocacy Groups, Forums, Coalitions, ARAFMIS, MH Councils, Carers organisations and support groups etc, have been funded and operating for a number of years for the mainstream consumers and carers.

During the state-based consultations held by MMHA since 2007, CALD consumers, carers and workers systemically advised that participation rates in the management and decision-making structures of mainstream Mental Health services by CALD C&C were very low, even non-existent.

For example, MMHA had been advocating for CALD representation on the National Mental Health Carer & Consumer Forum since February 2009 only for a favourable decision to accept them coming in June 2011 ie two years of advocacy and after many rejections. Whilst every state and territory has a consumer and a carer representative, and every national mainstream mental health peak agency has a representative on this important and only national forum, there weren't any CALD consumers or carers represented nor was Multicultural Mental Health Australia permitted to be represented, even though it was the only national multicultural mental health program funded in Australia. In the end, MMHA had to offer and paid for the CALD consumer and carer representation, while all the other consumer and carer representatives are paid for by the federal and state and territory jurisdictions. All jurisdictions refused to subsidise the CALD representations. This level of exclusion borders on overt racial discrimination as it deliberately ensured that the voices of CALD communities were silenced, despite the representation of disadvantaged groups such as CALD and indigenous being on the terms of reference of this very forum, in practice it was a different story!

## **ISSUE 9: CALD NEED IDENTIFICATION- ARE THE MH NEEDS OF CALD POPULATIONS ON PAR WITH MAINSTREAM COMMUNITY?**

In 2007, MMHA commenced consultation forums with the smaller states and territories and those without – or with very limited - transcultural mental health services eg TAS, SA, NT, ACT and WA and a national one with the CALD peak agencies.

Responses from these forums indicated that the mental health needs of CALD communities are far greater than those of the mainstream. The consultation forum participants further advised that it was the first time CALD consumers and carers were asked about their needs in a systemic way, and they were grateful to MMHA for the opportunity given to relevant stakeholders to meet, discuss and record the mental health situation / landscape of the CALD population in their state. (See Appendix 6: MMHA's The State of Play report).

Some of the common comments received were:

*"I enjoyed the whole day enormously. We've never had such a consultation forum on this topic and group before. We needed it very much. I hope we continue to meet and change the situation for people from CALD backgrounds with mental illness"*

*"Everything was good, Multicultural Mental Health Australia to be congratulated for coming to Western Australia and getting us together to finally look at this population group and do something."*

As a result of these consultation forums, MMHA was instrumental in helping:

- Establish a Transcultural Mental Health Network in TAS with a paid P/T Project Officer position
- Establish a Transcultural Mental Health Network in SA
- A Multicultural Mental Health Plan developed in SA
- The consultation findings being included in the development of the Strategic Plan on Mental Health by the WA Mental Health Commission.

Without having a TMH centre, service, program, position etc, in each state and territory it was difficult for MMHA Mental Health Australia to have its national projects implemented. While MMHA was funded to improve a number of neglected areas of mental health for CALD communities, it was unable to operate effectively and equitably across states and territories due to the lack of infrastructures and support systems on the ground.

#### **ISSUE 10: IMPROVE THE MENTAL HEALTH WORKFORCE'S COMPETENCY**

There is a growing recognition that Australia's mental health workforce must become 'culturally competent' in order to cater for and respond to the mental health needs of CALD consumers and carers. It is also a common fact that the Australian mental health workforce has a long way to go before it can respond and address the unique and special needs of CALD consumers and carers.

'Cultural competency' can be defined as a set of behaviours, attitudes and skills, policies and procedures that help staff across all levels of the health sector to work effectively and efficiently in a multicultural society. It is underpinned by a number of access and equity principles and a responsibility to meet legislative requirements and provide accessible services.

There are a number of barriers to providing competent cross-cultural care to CALD consumers, and improvements are required including:

- Limited availability of bilingual and bicultural mental health professionals
- Cultural differences between clients and clinicians, which results in misunderstanding and communication problems
- Poor access to and availability of interpreters
- Lack of training to assist mental health professionals use interpreters effectively
- A limited availability of interpreters trained in mental health issues and terminology
- Limited acceptance and practice of explanatory rather than Western therapy/treatment models
- Limited cultural awareness within organisations, which is also reflected in staff attitudes and behaviours
- Limited recognition of cultural safety and/or limited understanding of cultural accessibility of mental health services, even in areas with a high proportion of CALD Australians
- Limited uptake of training tools and processes which facilitate cultural competency

In 2008 MMHA was funded to develop a National Cultural Competence Tool with Guidelines to be used by all mental health sectors ie the public, private and the community mental health sectors nationally. The tool was aligned to the Diversity Standard of the revised National Standards for Mental Health Services, released in September 2010. To be effective however, the tool's implementation must be funded, mandated and monitored so that mental health services become culturally competent.

Thanks to a progressive National MH Standards Implementation Committee, MMHA was permitted to assist with the development of the Diversity Std 4. MMHA's requests however to DOHA to assist by funding the printing and distribution of the National Cultural Competence Tool with the national standards in order to give the Tool legitimacy, increase its use and compliance by the mental health workforce, and improve the cultural competency of the workforce significantly, were regrettably ignored by DOHA.

MMHA's submission to DOHA of a national promotion strategy on the National Mental Health Standards, Tool and Guides to CALD communities was also ignored, as was MMHA's recommendations for state and federal endorsed training of the Tool in order to assist in its effective implementation nationally and to maximise the tool's

effectiveness. Just like the MMHA's national Stigma Reduction project, the National Cultural Competence Tool was also shelved via lack of commitment and support by DOHA and by the state and territory jurisdictions!

### ISSUE 11: INCREASE MENTAL HEALTH LITERACY IN CALD COMMUNITIES

The literacy levels of people from CALD backgrounds on mental health, illness and wellbeing is well below that of their mainstream cohorts. In 2007, MMHA was provided with extra funds to produce a range of mental health resources and implement strategies directed at the CALD communities.

DoHA funded the production of 15 mental health topics in 21 languages, and in 5 formats: brochures, CDs, daisys, tapes, Braille, and large print with hundreds of orders being completed and distributed across Australia. However when the new provider was announced the DOHA representatives refused MMHA's advise to leave the resources with the Diversity in Health Institute and instead suggested the discarding the resources. When this was denounced by MMHA, DOHA preferred to spend thousands of dollars in their packing and transferring to a Distribution Centre in the ACT rather than leaving them with the Diversity Health Institute to enable their smooth continued distribution and not confused the CALD communities with a foreign distribution centre. (See Appendix 7: MMHA's publications catalogue)

In 2008, funding was finally given to MMHA to employ multiple communication strategies to promote positive mental health messages to CALD communities; and not just multilingual brochures. MMHA made good use of the media to educate the CALD population using a number of formats and partnerships, eg SBS radio, Community Broadcasting Association, ethnic and local print media.

Just as these relationships were built up and progress made, DOHA decided to stop it by giving the grant to a new provider in 2011 thus ignoring the fact that such partnership require time to build up trust and cooperation and the processes must be consistent and ongoing, in order to chip away and gradually desensitise our communities of their fears and prejudices on mental illness.

Increasing knowledge about mental health via the media and partnerships across other areas besides mental health has reduced stigma in the mainstream community during the last 5-10 years eg depression with *beyondblue* program, and media with the MindFrame project. However, for the CALD population, the same resources were not provided as they were for the mainstream community. For example people from CALD backgrounds do not see huge multilingual billboards promoting the importance of good mental health and who to contact if they need help, as is often seen in English for SANE Australia and *beyondblue*.

### ISSUE 12: DISPARITIES IN FUNDING ALLOCATION

Given that this Senate Inquiry is looking at the **funding** and **administration** of Mental Health in Australia it would be remiss of me not to bring to the attention of Senate Standing Committees on Community Affairs the abysmal distribution of mental health funds to CALD communities by both federal and state governments:

In December 2010, MMHA conducted an internet search on Funding For National Mental Health Projects/Initiatives/Services by the Australian Government, and found information on 36 programs funded by:

1. Dept. Education, Employment & Workplace Relations - DEEWR;
2. Dept. of Families, Housing, Community Services and Indigenous Affairs – FAHCSIA;
3. Dept. of Health & Ageing - DoHA;
4. National Health & Medical Research Council;
5. Dept. Veterans' Affairs -DVA and
6. Medicare Australia

Of the 36 programs, only two national programs were funded for the CALD community ie:

1. Program of Assistance for Survivors of Torture and Trauma and
2. Multicultural Mental Health Australia

(See Appendix 5: Distribution of National Mental Health Funding)

This search demonstrated what MMHA had suspected through its experience and observations from attending mental health forums, conferences, discussions, community feed-back etc, and that was that Mental Health funding to CALD agencies and for CALD community needs in Australia is pitiful and not in proportion to the size and need of the CALD population. At every forum attended, MMHA was the sole voice advocating for the mental health needs of the CALD population out of hundreds of mainstream mental health providers. If MMHA wasn't present at these, CALD issues would not have been raised or considered.

This search also confirmed that as a national program, MMHA was not funded on par with other national mental health peak agencies and programs, yet it was expected to address the range and size of needs of the *whole* CALD population (1/4 of Australia's population) *all* ethnic and *all* population groups within, *all* mental health topics and issues across the *whole* nation while most of the mainstream peak agencies and programs were only required to deal with one topic or one issue eg *beyondblue* and depression, *MindFrame* and media etc.

The \$2.7M over 3 yrs now provided to QLD Health for the previous Multicultural Mental Health program only constitutes 1% of the \$2.2B boost in mental health funding promised at the last budget by the Australian Government. Yet the CALD community is significantly larger than this and because of the backlog of needs due to previous neglects in adequate investment for suitable mental health programs and services for CALD communities, and to ensure equity, at least 10% or \$22M of the \$2.2B must be allocated specifically for multicultural mental health programs in Australia.

In addition, the funding of a number of national providers (not just one) is needed to ensure the availability of a variety of options, models and expertise. There are many mainstream national mental health providers and the same level of commitment must be made by government to ensure equity and funding distribution and access to suitable mental health services and programs. Only a serious investment and transparent accountability in the funding of Mental Health programs, services and initiatives by DOHA, FAHCSIA, NHMRC, DEERW and state-based departments will bring the mental health needs of CALD communities on par with their mainstream cohorts.

Other funding and administrative disparities that exist and need to be addressed include:

1. The lack of access to specialized or alternate mental health services by people from CALD backgrounds. For example, all **help-lines** for various topics and population groups eg kids line, lifeline, suicide line etc are provided in English only. None are available to people who can not speak English. The government recently promoted the fact that mobile phone calls to Lifeline will be free, with no consideration given to those who can not access Lifeline due to language difficulties. (See Appendix 8: Min Butler's Media Release on Free Mobile Calls to Lifeline- 29 June 2011)
2. Multicultural mental health policies and plans at state and territory levels do not exist: So far only NSW has a multicultural mental health plan and this was released as late as 2009.
3. With the new 4<sup>th</sup> National Mental Health Plan 2009-2014 there is an opportunity to reduce many of the disparities I have outlined. However for this to occur, S&T Mental Health Implementation Plans must be monitored closely and required to demonstrate quantitatively and qualitatively on how they include CALD appropriate strategies to address the needs of their CALD constituents. The absence of monitoring will result in poor compliance and the mental health needs of CALD communities will remain unmet.

### Recommended critical success factors for effective mental health services for CALD clients

Since the introduction of the National Mental Health Strategy and the release of the First National Mental Health Plan (covering the period 1993-1998), it is evident that there are a number of persisting issues of concern which are applicable to CALD clients and communities, as well as the wider population:

1. Delivering quality mental health services geared to consumer recovery
2. Improving community attitudes to mental health and illness
3. Increasing community engagement and education on mental health 'literacy'
4. Improving integrated care and the care of complex cases
5. Adequacy of data collection and research.

Although success factors for CALD communities may broadly shadow those of the general community, they usually need to be addressed differently to meet the unique needs of CALD communities. Additionally, some success factors deviate from mainstream approaches and need to be specifically and variously addressed.

MMHA had identified the following critical success factors for effective mental health services for CALD clients and communities:

- i. Improving the safety and quality of mental health services for Australia's CALD communities.
- ii. Supporting a range of culturally responsive mental health service options.
- iii. Implementing targeted CALD mental health promotion, prevention and early intervention strategies.
- iv. Undertaking targeted and culturally inclusive research, and relevant CALD data collection, to improve our understanding of the impact of mental health problems and their associated risk and protective factors for CALD communities.

These four critical success factors are consistent with the underpinning principles and priority Action Areas identified in the *Framework for the Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia*. Likewise the feedback which MMHA had received through its consultations with State and Territory mental health and multicultural services, and with the National CALD Consumer and Carer Reference Groups

#### **i. Improving the safety and quality of mental health services for Australia's CALD populations**

Designing services to be responsive to the needs of their whole customer base and, inter alia, to those from CALD communities, via the implementation of access and equity strategies and practices in the organisation's management processes, and in the assessment, diagnosis, treatment and management by mental health services, including the examples below:

- a. Understanding and respecting the individual and their cultural and linguistic background, and their individual needs, beliefs and expectations.
- b. Responding with understanding and sensitivity to the individual's beliefs and customs, and being able to recognise critical cues.
- c. Employment of bilingual staff.
- d. Forming partnerships and working relationships with specialist multicultural and ethno-specific agencies and, where they exist, Transcultural Mental Health Centres, units and networks.
- e. Increasing CALD consumer and carer participation and engagement.
- f. Presenting the CALD perspective in policy submissions and helping to reform the sector.
- g. Funding and supporting language services.
- h. Training of mental health clinicians and para-medical staff
- i. Developing the mental health workforce's capacity to work cross-culturally:
  - Equitable services for mental health consumers
  - Evidence based development
  - Engagement of community sector
  - Alignment with government standards and policies
  - Partnership approach
  - Flexible service delivery
  - Integration of workforce cultural competency into routine organisation processes
  - Risk management approach
  - Applicability across sectors
  - Training support and evaluation
  - Accessibility.

**ii. Supporting a range of culturally responsive mental health service options**

Provision of a range of mental health service options which include services specifically designed for culturally diverse communities, such as multicultural services, ethno-specific services and Transcultural Mental Health Centres, units and networks. For example, the existence of specialist mental health services - Transcultural Mental Health Centres in every state and territory.

**iii. Implementing targeted CALD mental health promotion, prevention and early intervention strategies**

The wise use of resources - using appropriate formats and distribution methods, the target groups, and how the resources can be used in education, prevention and early intervention initiatives that are culturally and linguistically sensitive.

- a) Community education - demystifying mental illness and addressing stigma.
- b) Evidence-based project development.
- c) Participant-centred learning.
- d) Cross-jurisdictional and cross-sector partnership approach, via MMHA's Stigma Reduction Project.
- e) Engagement of the multicultural and ethno-specific sector.
- f) Adequate resourcing for successful project implementation.
- g) Sound project governance and advisory structures.
- h) Relevant information and resource development and dissemination.
- i) The use of a variety of communication, promotion and information strategies.
- j) The use of a variety of consultation and engagement strategies.

**iv. Undertaking targeted and culturally inclusive research, and relevant CALD data collection, to improve our understanding of the impact of mental health problems and their associated risk and protective factors for CALD communities**

CALD data collection and mental health outcome measurement, along with culturally inclusive research, are needed to inform service design and delivery to ensure that people most in need, including service users from CALD backgrounds, have equitable access to mental health services.

- a) The enhanced and accurate measurement of the mental health status of culturally diverse communities is fundamental to the provision of quality mental health services for diverse communities.
- b) Broadening the mental health sector's understanding of routine mental health outcome measurement.

**CONCLUSION:**

Following the outline of what exists and what doesn't in the multicultural mental health landscape, it is not difficult to conclude that:

1. There are considerable funding disparities between states and territories in terms of service coverage and equitable resource allocation for multicultural mental health services and programs to meet the wide range and size of the mental health needs of the Australian population from CALD backgrounds
2. We need to design, fund, deliver and implement MCMH programs and strategies across the whole nation not just a fraction of it.
3. The mental health needs of CALD consumers and carers are far greater than the mainstream community's.
4. Consumer and carer participation in the development, delivery and evaluation of mental health programmes continues to lag behind for CALD communities relative to the 'mainstream' and this needs to even out.
5. Research on mental illness in CALD communities must be funded to give us the knowledge on the prevalence of mental illnesses in particular ethnic, gender and population groups and assist Governments design and deliver suitable and effective programs and services nationally

6. Suitable and effective mental health programs and services must be funded to be used by people from CALD backgrounds with a mental illness when they need them and at the same rates as their English speaking counterparts.
7. The mental health workforce must be assisted to become culturally competent to better meet the unique need of people with mental illness from CALD backgrounds and the immediate funding of the national implementation of MMHA's developed National Cultural Competency Tool
8. We must eliminate the emergency service use of people from CALD backgrounds with a mental illness at a crisis stage, resulting in forensic and acute presentations and stop them from jeopardising and delaying their recovery prospects.
9. The issue of CALD data collection, analysis and reporting must be resolved as a matter of priority and funded to commence with the Commonwealth Government-funded MH programs in the immediate future with progressions made by the state and territory jurisdictions.
10. Funding to be provided to set up multilingual mental health counselling help-lines and national mental health interpreting services for people who cannot speak English.
11. The MMHA program to be reinstated to continue its ground-breaking work, there is room and need for more than one MMHA: the SWAHS-aided MMHA program can continue with resource development and distribution (ie Synergy magazine and E-Bulletin, Clearing House) multilingual communication, community promotion and education thru Stigma Reduction Project, the Speakers Bureau and CALD Consumer & Carer Reference Groups.
12. A reflective proportion of the new \$2.2B promised for Mental Health to be distributed more equitably in order to realistically address the mental health needs of the CALD community and:
  - Bridge existing mental health disparities between CALD and mainstream communities
  - Provide basic infrastructures across the nation not just some the states and territories ie TMHCs and positions
  - Fund CALD agencies to help bridge gaps and to work in partnership with mainstream agencies to align /design services to meet the whole population in need
  - Implement monitoring and mandatory mechanisms built into the funding contracts to enable the above eg FAHCSIA's PHAMS program
  - Fund and implement alternate service and promotion models based on community engagement and outreach strategies suitable to CALD communities in order to increase mental health literacy in CALD communities, reduce stigma and increase service uptake. For example, immediate national use of MMHA's Stigma Reduction community education project and target social avenues eg social, sporting and faith-based facilities and meeting points for best uptake.
  - Fund and implement the MMHA-developed National Cultural Competency Tool nationally

Ending on a philosophical note however, the reality is that \$2.7 Million over 3 years allocated to the MMHA program to cater for 1/5 of Australia's population is not enough to address the backlog of unmet mental health needs of the CALD community in Australia. These token and scarce resources create unhealthy competition and factions that the community in need of mental health services and programs does not require.

To bridge the gaps identified above, at least 10% of the \$2.2B mental health funds (ie **\$22M**) must be allocated to fund national mental health programs, projects and services suitable to the cultural and linguistic needs of CALD communities with another **\$20M** to set up Transcultural Mental Health Services in every state and territory similar to the PASST program for the survivors of torture and trauma and the mainstream mental health services.

The CALD community needs at least another 10 years of real investment, action and commitment to balance the disparities outlined above. It is now time to equitably address the mental health needs of CALD communities across the nation.

**END**