The State of Play

Key Mental Health Policy Implications for CALD Communities in Australia – Findings from MMHA Consultations

multicultural
MENTAL HEALTH AUSTRALIA

Multicultural Mental Health Australia

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

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

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

MMHA JOINT OFFICERS GROUP

Implementation of MMHA's priority areas is assisted through the Joint Officers Group (JOG). The Group is convened by MMHA and consists of State and Territory Mental Health Directorates, the Commonwealth Department of Health and Ageing (DoHA), the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), the Federation of Ethnic Communities Councils of Australia (FECCA), and consumer and carer representatives.

The Group is a forum to facilitate the implementation of MMHA's priority areas, including assisting with the implementation of projects with national applicability, and with prioritising multicultural mental health policy issues.

MMHA CONTACT

Multicultural Mental health Australia
Locked Bag 7118, Parramatta CBD BC, NSW 2124
P: 61 2 9840 3333 F: 61 2 9840 3388
W: www.mmha.org.au
E: admin@mmha.org.au

CONTENTS

ACKNOWLEDGEMENTS

Multicultural Mental Health Australia would like to acknowledge and thank the following agencies, government departments and individuals for their contribution and assistance to MMHA in conducting the various consultations:

ACT	ACT Department of Health – Mental Health Branch ACT Transcultural Mental Health Network CALD Consumers and Carers Carers ACT Companion House Mental Illness Education ACT Migrant and Refugee Settlement Services of the ACT Schizophrenia Fellowship of NSW
NT	CALD Consumers and Carers Melaleuca Refugee Centre Multicultural Council of NT NT Department of Health and Families – Mental Health Branch NT General Practice Education Queensland Transcultural Mental Health Centre Top End Mental Health Service
SA	CALD Consumers and Carers Federation of Ethnic Communities Council of Australia Migrant Health Service SA Migrant Resource Centre SA Multicultural Communities Council of SA SA Department of Health – Mental Health Branch Survivors of Torture and Trauma Assistance and Rehabilitation Service University of Hawaii University of SA
TAS	Carers TAS CALD Consumers and Carers Ethnic Communities Council of Tasmania Federation of Ethnic Communities Council of Australia Horizon MRC Hobart Multicultural Tasmania Polish Welfare TAS Department of Health and Human Services – Mental Health Branch University of TAS
WA	Association for Services to Torture and Trauma Survivors CALD Consumers and Carers Ethnic Communities Council of WA Fremantle Multicultural Centre Government of WA - Minister for Water and Mental Heath Multicultural Services Centre WA Transcultural Mental Health Services WA University of WA WA Department of Health – Mental health Branch

EXECUTIVE SUMMARY

Introduction

This report, ***The State of Play***, brings together the findings from MMHA's consultations conducted, between July 2007 and June 2010, in the smaller states and territories across Australia where multicultural mental health services, networks and infrastructure were under-developed or fledgling (i.e. Australian Capital Territory (ACT), Northern Territory (NT), South Australia (SA), Tasmania (TAS) and Western Australia (WA)). This report also brings together the findings from a consultation of national multicultural and ethno-specific peak agencies.

The findings of the various consultations have previously been released as individual reports (MMHA, 2007, 2008a, 2008b, 2009, 2010a). However, this report presents a discussion of key common themes and specific issues across the consultations with a review of relevant research and policy documents to ascertain the knowledge base on the identified issues and their policy status.

The consultation forums form a core part of MMHA's funding obligations with the Commonwealth Department of Health and Ageing and were a key strategy to engaging stakeholders across Australia to identify issues that affect the mental health outcomes for Australia's culturally and linguistically diverse (CALD) communities.

A key context for the consultations is that research shows that mental health disparities exist for Australians from CALD backgrounds. Therefore, the consultations were an initial step towards bringing communities and key stakeholders together in smaller states and territories to start the process of addressing those disparities.

Structure of the Report

1. A Context for the Consultations

Section 1 provides an introduction to the report. It also provides a context and rationale for the consultations including background research on Australia's diversity and patterns of access to mental health services.

2. Consultation Strategy

Section 2 provides a detailed report on MMHA's consultation objectives, the framework used to conduct the consultations; the role of MMHA's Joint Officers Group; the timelines of the consultations; analysis of participant data and feedback on consultation evaluations.

3. Findings and Policy Implications

Section 3 provides the aggregated findings of the consultations conducted by MMHA. Key themes across consultations are identified and associated policy implications are presented. This chapter also refers to relevant literature and policy documents that address the key themes identified.

4. Conclusion

Section 4 provides a short conclusion and identifies some preliminary steps that could be taken to eliminate the identified disparities for CALD communities.

Summary of Consultation Themes and Policy Implications

MMHA's consultation forums found that key stakeholders perceived that significant gaps still existed with regards to the mental health outcomes for CALD communities.

The aggregated analysis of the data highlights key policy implications that need to be addressed. These themes and policy implications are summarised in the table below.

Summary - Consultation Themes and Policy Implications	
Consultation Themes	**Policy Implication**
Stigma & Mental Health Literacy	1. A clear vision, planning and resources are needed for reducing stigma and improving mental health literacy amongst Australia's CALD communities.
Culturally Competent Mental Health Services	2. There is a need for uptake and implementation of national cultural competency standards and training amongst mental health services across Australia.
CALD Data, Targets & Research	3. There is a need for: ▪ improved and consistent collection, analysis and reporting of CALD data of mental health service user demographics and outcome measures across Australia; ▪ targeted CALD performance benchmarks for publicly-funded mental health services; ▪ a funded national CALD mental health research agenda, including targeted research to analyse prevalence rates of mental health conditions amongst CALD populations across Australia.
Interpreter Use	4. There is a need for: ▪ mapping and coordination of the range of interpreter options and funding available for mental health services across Australia; ▪ training of mental health staff in the use of interpreters; ▪ training of existing interpreters (in all states and territories) to work in mental health settings; ▪ further increasing the pool of available interpreters for use in mental health settings.
Partnerships & Pathways ▪ The Role of Multicultural & Ethno-specific Services & Models ▪ The Role of Transcultural Mental Health Networks & Services	5. There is need for: ▪ funding Transcultural Mental Health Centres and Networks in each state and territory; and ▪ increasing the capacity of existing transcultural mental health networks to address the existing mental health gaps for CALD communities.
CALD Consumer and Carer Participation and Advocacy	6. There is need for: ▪ prioritising CALD consumer and carer participation at the state and territory level and fund initiatives that increase participation; and ▪ prioritising CALD consumer and carer representation at the national level via the National Mental Health Consumer and Carer Forum.
Population specific issues (men, women, rural and remote communities, youth, aged, refuges and emerging communities, etc)	7. Planning to meet the mental health needs of CALD populations also need to consider targeted initiatives according to population groups such as men, women, youth, aged, refugee and newly emerging communities, and people with co-occurring disabilities.
Suicide and CALD communities	8. There is a need for: ▪ improved data collection, reporting and analysis of suicide in CALD communities; and ▪ targeted suicide prevention programs for CALD communities.
Role for MMHA	9. There is a need to consider the stakeholder feedback about potential roles and priorities for MMHA (see next table).

Role for MMHA

The consultations also aimed to seek input into MMHA's activities as well as gain stakeholder feedback about issues important to them. Within this context a number of roles and priorities were suggested for MMHA in further actioning the feedback from the consultations. The various roles and examples were analysed for similar themes and are categorised in the table below.

Suggested Roles for MMHA	
Potential role	**Ways to enact the role**
Advocate & support	▪ Advocate for and support systemic change with relevant state, territory and commonwealth departments, networks and planning structures
Plan	▪ Develop strategic national multicultural mental health plans
Resource development	▪ Develop resources for CALD communities (e.g. fact sheets & multimedia resources) ▪ Develop resources for the mental health sector to improve their capacity to address the mental health needs of CALD communities
Facilitate	▪ Bring together key stakeholders and facilitate communication and planning ▪ Facilitate information exchange (e.g. best practice in working with CALD communities)
Educate	▪ Educate the mental health sector to work cross-culturally ▪ Educate peak mental health bodies about CALD consumer and carer issues ▪ Educate CALD communities about stigma, mental illness and pathways to support
Inform & Promote	▪ Provide and distribute information to CALD communities ▪ Work with ethnic and mainstream media to reduce stigma
Capacity Building	▪ Build the capacity of CALD communities, community leaders, multicultural and ethno-specific services to address mental health issues amongst CALD communities ▪ Build the capacity of CALD consumers and carers to participate in mental health service planning, delivery and evaluation
Research	▪ Identify research gaps and develop a multicultural mental health research agenda

CONCLUSION

There is clearly a need for systematised and thorough evidence for policy and practice. However the consultations revealed that stakeholders are concerned about the significant information gaps with regards to the collection, reporting and analysis of CALD mental health data that hinder effective evidence-based mental health policy development.

At the national level, the Commonwealth of Australia has committed to addressing multicultural mental health issues through Multicultural Mental Health Australia. At the State and Territory level, some governments have also begun to realise their commitment through providing initial funding to set up transcultural mental health networks. Importantly, transcultural mental health networks need to be further developed and resourced so that the key issues identified within this report can begin to be addressed. Further, Transcultural Mental Health Centres need to be funded in smaller states and territories as they can provide a practical structure with which to begin the work of addressing the mental health disparities for CALD communities in the smaller states and territories.

1. A CONTEXT FOR THE CONSULTATIONS

1.1 Introduction

Mental health problems can affect all Australians, regardless of one's cultural or linguistic background. Mental health problems do not discriminate who they impact on. Despite this, getting help for mental health problems is difficult for many Australians, particularly those from culturally and linguistically diverse (CALD) backgrounds. This chapter briefly explores issues around Australia's diversity and access to mental health services because these issues provide an important context and rationale for the various consultation forums that have taken place.

1.2 Australia's Diversity

Table 1.1 below shows that Australia's population is significantly diverse. Analysis of the 2006 Census by the Victorian Multicultural Commission (VMC, 2006) identified that almost 40.4% of Australia's population were born overseas or had at least one parent born overseas. Of those born overseas, 63.2% 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. Even within the smaller states and territories there is considerable diversity in the population with the proportion of the population born overseas (OSB) ranging between 10.6% and 27.4%. The percentage of people who speak a language other than English (LOTE) range between 3.5% to 23.2% of the population (this includes indigenous languages within the NT).

Table 1.1 – Cultural Diversity – Australia and All States and Territories Compared (Adapted from VMC, 2006)

	Australia	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
Total population	19,855,290	6,549,177	4,932,422	3,904,534	1,514,337	1,959,087	476,479	192,900	324,037
% of pop who are OSB	22.2	23.8	23.8	17.9	20.3	27.4	10.6	13.8	21.7
Born in a NMESC[1] as a % of the pop	14.1	17.1	17.6	8.1	10.9	12.4	4.4	7.9	14.3
Born in a NMESC as a % of OSB[2]	63.2	71.9	73.8	45.1	53.8	45.8	41.5	57.6	65.9
% of Australian born with one or more OSB parent/s	18.2	18.3	19.7	15.2	18.6	21.9	11	13.6	20.2
LOTE[3] speakers as a % of the pop	15.8	20.1	20.4	7.8	12.2	11.6	3.5	23.2[4]	14.6

Notes:
1.NMESC (Non Main English Speaking Country) 2.OSB (Overseas Born)
3.LOTE (Language Other Than English) 4.Includes Indigenous languages

Despite this diversity, not all Australians have equal access to culturally appropriate mental health treatment and care when they need it. There is a small, but growing body of evidence that shows that CALD communities in Australia tend to fare worse than many when it comes to timely and culturally appropriate access to mental health services (DOHA 2004).

1.3 Patterns of Access to Mental Health Services

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

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

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

1.4 Barriers to getting help when it is needed

Australian and international research on the perceptions of consumers and carers from CALD backgrounds, CALD communities, and mental health staff[1] tend to attribute the persistence of the previously outlined disparities to the following categories of factors:

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

1.5 The Role of the Consultation forums

Within the context outlined previously, Australian and State and Territory Governments, the mental health sector, the community sector (including mainstream, multicultural and ethno-specific) and Australians from culturally and linguistically diverse communities need to come together to develop strategies to address the gaps and inequities in mental health outcomes for Australia's diverse communities. The consultation forums by MMHA is one step towards bringing communities and key stakeholders together in smaller states and territories to start the process of addressing the previously outlined inequities. The next chapter outlines the consultation strategy used by MMHA to conduct the various consultations including detailing the objectives of the consultation forums.

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

2. CONSULTATION STRATEGY

2.1 Objectives

The MMHA consultation program was designed to gather the views of key stakeholders engaged with multicultural mental health issues in states and territories where multicultural mental health services, networks and infrastructure were under-developed or fledgling (ACT, NT, SA, TAS, WA). Outcomes of the consultation forums were then reported to the respective state or territory governments for consideration and feedback before finalising a recommended action plan which was then released to attendees and the general public. The reports were also submitted to the Commonwealth Department of Health and Ageing for review and consideration. The consultations were further used as a mechanism for key stakeholders to provide input into MMHA's activities and actions so that MMHA's work remained meaningful, practical and relevant to their needs.

Specific objectives were to:

- identify the mental health needs and issues of consumers and carers from CALD backgrounds within each of the states and territories being consulted;
- identify how the mental health needs of CALD communities could be addressed by state, territory and commonwealth governments and how MMHA could assist to this end;
- identify multicultural mental health promotion needs within each of the states and territories being consulted;
- identify primary care provider and clinical mental health service issues with regards to the provision of services to CALD consumers, carers and communities within each of the states and territories being consulted;
- identify key issues that impact on the mental health and wellbeing of refugee and emerging communities within each of the states and territories being consulted; and
- bring key stakeholders at the state and territory level together to showcase local services, learn from interstate strategies and build on existing, or develop new, transcultural mental health networks and linkages.

2.2 Consultation Framework

MMHA's consultations involve a 4 stage process (Scoping; Planning; Conducting the Consultation; and Reporting and Feedback - see figure 2.1) with each stage involving input and feedback from the relevant state or territory mental health department.

Figure 2.1 – MMHA Consultation Framework - Summary

In organising each consultation, MMHA also sought to partner with key stakeholders within each state and territory (such as the respective state or territory mental health directorate, the statewide Ethnic Communities Council or other multicultural health and/or mental health services) to help promote the consultation and

to help identify and recruit potential participants and speakers for the consultations. MMHA then sent invitations to the identified stakeholders. More details on the consultation stages are provided in Table 2.1 below.

Table 2.1 – MMHA Consultation Framework

Stage	Activities	Outcomes
Stage 1: *Scoping*	MMHA begins liaison with relevant JOG member and mental health branch and existing multicultural networks and partners to identify suitable timeframe and potential stakeholders.	▪ Suitable timeframe identified ▪ Potential stakeholders identified
Stage 2: *Planning*	MMHA liaises with relevant JOG member and mental health branch and existing multicultural networks and partners to plan for consultation.	▪ Consultation timeframe confirmed ▪ Key stakeholders invited ▪ Key speakers identified ▪ Local facilitators identified
Stage 3: *Conduct Consultation*	MMHA conducts consultation in partnership with key local stakeholders, including relevant mental health branch. Local and, in some cases, interstate and international guest speakers present on key issues and services. Participants then select discussion groups according to the following key issues: i. CALD consumer & carer issues ii. Multicultural mental health promotion needs iii. Primary care providers and clinical issues in mental health iv. issues for refugees and emerging communities Scribes and facilitators are allocated to each group and provide written reports back to MMHA.	▪ Consultation objectives addressed ▪ Key issues and recommendations identified ▪ Potential follow-up actions for MMHA identified ▪ Consultation evaluated
Stage 4: *Reporting and Feedback*	MMHA develops a report with key issues and recommendations from the consultation forum and circulates the report to relevant government departments for consideration. Feedback was then used to generate a recommended action plan before being released to attendees and the public. MMHA also reports on key findings at MMHA's JOG meetings and reviews recommendations with JOG and DoHA. MMHA also liaises with JOG and DoHA to negotiate further actions for MMHA following the consultation	▪ Final consultation report circulated ▪ MMHA, JOG, & DoHA negotiate further actions for MMHA

2.3 The role of the MMHA Joint Officers Group

Apart from key local partners, another key strategy to ensure appropriate governance of the various consultations has been the MMHA Joint Officers Group (JOG) (see page 3 for a description of JOG). Since its inception in 2006, MMHA sought information and feedback from JOG members in developing, coordinating, conducting and evaluating each of the consultations. MMHA also provided regular reports to JOG regarding the outcomes and recommendations of the various consultations.

2.4 Timelines

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

MMHA planned the timing of the consultations to co-occur with other forums to maximise attendance rates, reduce costs and with consideration of existing project workloads. Table 3 below outlines the various state and territory consultations timelines and attendance numbers.

Table 2.2 – MMHA Consultation Timelines & Attendance Numbers

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

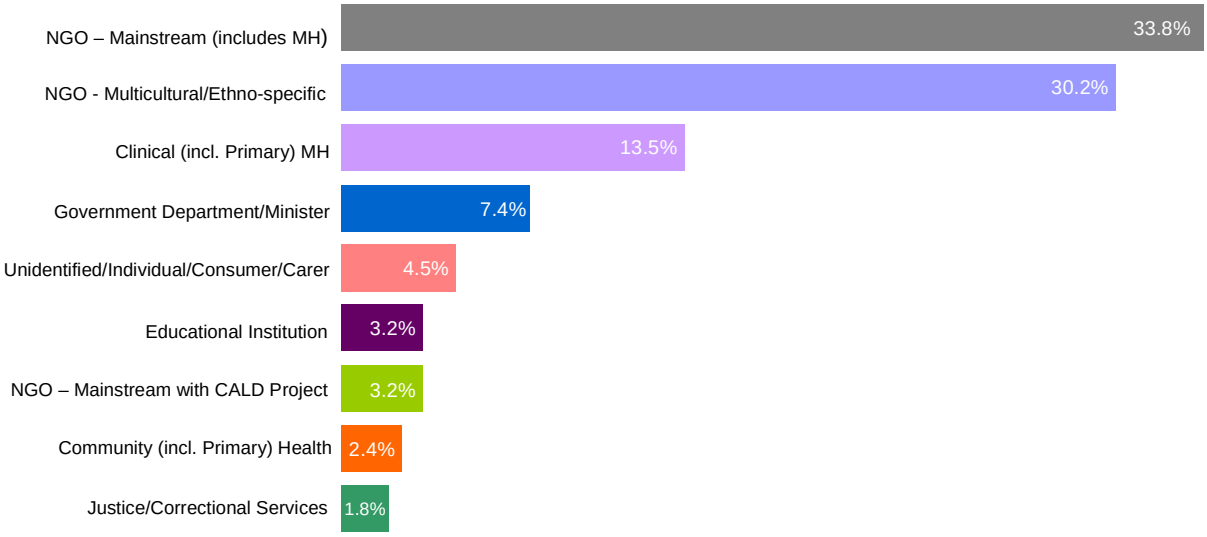
2.5 Participant Data

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

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

In total, 379 individuals attended the various consultations (see Table 2.2 above for a distribution of numbers according to consultation). Most were representatives of various agencies, while some (4.5%) did not identify as being a representative of any particular agency (these include interested individuals and consumers and carers). Figure 2.2 overleaf gives the aggregated distribution of the types of participants who attended the various consultations.

Figure 2.2 – Distribution of Participants by Agency Type/Role



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

2.6 CALD Consumer and Carer Participation

MMHA sourced consumer and carer guest speakers for the consultations through existing state and territory networks, the MMHA National CALD Consumer and Carer Reference Groups, and MMHA Speakers Bureau to provide personal perspectives. MMHA also worked with state and territory CALD consumer and carer networks (where they existed) to promote the consultations to consumers and carers from CALD backgrounds. Each of the state and territory consultations also included a specific discussion group for CALD consumer and carer issues.

MMHA anticipated that the consultation forums were unlikely to draw large numbers of consumers and carers from CALD backgrounds due to existing high levels of stigma within CALD communities (i.e. those who attend may not be willing to identify their status as a consumer or carer of someone with a mental illness or those who may not attend for fear of being identified as someone with mental illness within a small community); due to the lack of culturally-specific consultation methods and due to lack of existing support networks that support CALD consumer and carer participation (this issue is also highlighted by consultation participants as an issue that needs further action).

Culturally-specific consultation methods require time-consuming community development principles to engage and target CALD communities. Trained bilingual facilitators and/or interpreters would also have been necessary to facilitate clear and accurate communication. Theses strategies were outside the timeframes and current funding arrangements within MMHA. MMHA was also reliant on the existing networks within each state and territory and their capacity to identify and support CALD consumers, carers and communities to participate. In many instances those networks

did not exist or were under resourced and consisted of a voluntary network of interested agencies and/or government departments with limited capacity to engage with CALD communities. MMHA aimed to engage service providers working, or concerned, with the mental health issues of CALD populations as an option to gathering data about those issues and concerns.

Where some participants were known within the sector as consumer and carer advocates and/or consultants, they were asked to be guest presenters. Those known consumers and carers were counted as part of those who did not identify as being part of any particular agency (4.5%). As MMHA did not require attendees to self-identify as a consumer or carer (to mitigate the potential effects of stigma), it is not possible to accurately identify the number of consumers and carers from CALD backgrounds who have attended the various consultation forums.

2.7 Consultation Evaluations

Each of the state and territory consultations provided participants an opportunity to provide feedback on the consultations through questionnaires. The questionnaire sought participant feedback about the consultation process, content (including relevance) of presentations and discussion groups, and other practical logistical issues such as catering and venue. This feedback was gained through a combination of rating scales and open-ended questions.

The results of each of the evaluations were summarised and provided as part of the final report for each of the consultations. For example, analysis of the consultations conducted in WA (March 2009) and ACT (June 2010) revealed that 80.5% and 90% (respectively) of respondents agreed or strongly agreed that the discussion groups, topics and questions were relevant. Other examples of responses include:

"The number of participants indicated that the Darwin community intended to input in this important issue. A very good sign to have it. We heard the challenges; the next step is for each of us to think about ways to contribute to the recovery of consumers' – NT Consult

"Excellent. "Great that a Sydney-based service is coming to the ACT to bring everyone together – thank you…"– ACT Consult

" MMHA to be congratulated for coming to Western Australia and getting us together to finally look at this population group and do something about the topic" – WA Consult

In summary, the evaluations showed that the consultations were a useful forum to bring together important and interested stakeholders within each of the smaller states and territories to build on or further develop fledgling networks to address multicultural mental health issues within those states.

The next section discusses the key common themes and issues raised at the various consultations and their corresponding policy implications and includes a review of relevant research and policy documents that address the issues raised.

3. FINDINGS AND POLICY IMPLICATIONS

3.1 Introduction

This chapter presents the aggregated findings of the various consultations conducted by MMHA. Key themes are presented along with a discussion of specific issues identified within those themes. Relevant research and policy documents were also reviewed to ascertain the knowledge base on the identified issues and their policy status. Table 3.1 below presents a snapshot of the key themes identified through the consultations.

Table 3.1 – Key Themes Identified
Stigma & Mental Health Literacy
Culturally Competent Mental Health Services
CALD Data, Targets & Research
Interpreter Use
Partnerships & Pathways ▪ The Role of Multicultural & Ethno-specific Services & Models ▪ The Role of Transcultural Mental Health Networks & Services
CALD Consumer & Carer Participation & Advocacy
Population specific issues (men, women, rural & remote communities, youth, aged, refuges & emerging communities, etc)
Suicide and CALD communities
Role for MMHA

3.2 Key Themes

The following section presents a more detailed analysis of the themes identified in the consultations.

3.2.1 Stigma and Mental Health Literacy

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

- There is a *"Lack of knowledge of availability of services, they don't know where to go"* - ACT Consult
- There is a *"Lack of information on service provision and mental health topics"* - TAS Consult
- *"Stigma was identified as an ongoing issue for CALD consumers and carers that needs to be targeted and addressed"* - WA Consult
- There is a need for the *"recognition of the cultural barriers/stigma"*- NT Consult

- There is a need for *"stigma reduction and education in mental health and wellbeing"*- SA Consult
- *"The stigma associated with mental illness in CALD communities and the low rates of presenting needs to be addressed…states and territory jurisdictions to fund the on-going implementation of the national MMHA project, Stepping Out of the Shadows Stigma Reduction."* – National CALD Peaks Consult

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

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

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

Policy implication 1:

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

3.2.2 Culturally Competent Mental Health Services

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

- *"Clinicians have difficulty communicating with people of CALD background and are reluctant to use interpreters. Communication needs are not properly understood"*- ACT Consult
- There is a need to *"educate mental health services"*- NT Consult
- There is a need *"to improve the leadership and coordination of cultural competency training"*- SA Consult

- *"The Department of Health and Human Services Tasmania and its Mental Health Services Branch need to provide regular education sessions to public hospital staff, GPs, health educators, etc, especially those who are the first point of contact for CALD consumers with a mental illness"*- TAS Consult
- *"Mainstream providers have difficulty in communicating with people from CALD backgrounds and understanding their needs…there is a need for culturally competent and appropriate mental health services for people from CALD backgrounds"*- WA Consult
- *"The National Cultural Competency Tool to be implemented by all mental health services with support from state and territory governments, including funding support."* – National CALD Peaks Consult

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

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

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

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

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

Policy implication 2:

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

3.2.3 CALD Data, Targets, and Research

(i) CALD data collection needs to be improved

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A more recent review of suicide prevention research by Robinson et al (2008) for the period between1999 and 2006 identified that, of 209 published journal articles and 26 funded grants, none targeted CALD populations. Only 2% of people who conduct suicide prevention research were identified as targeting CALD (see table 3.2).

Table 3.2 - Australian suicide prevention research targeting CALD, 1999 to 2006
(Source: Robinson et al., 2008)

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

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

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

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

Policy implication 3:

There is a need for:

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

3.2.4 Interpreters

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

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

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

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

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

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

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

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

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

MMHA has begun preliminary scoping (via JOG) of the range interpreter services available and the gaps across states and territories. This preliminary scoping has highlighted that a range of interpreter policies exist with some under review. A range of noteworthy interpreter training projects have also been initiated in some states and territories (e.g.VTPU (Milteic et al, 2006) and QTMHC (The Collegial Model of Interpreting within Culture – QTMHC, 2010).

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

Policy implication 4:

There is a need for:

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

3.2.5 Partnerships and Pathways

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

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

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

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

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

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

(ii) The role of Transcultural Mental Health Services & Networks
Participants also commented on the role that Transcultural Mental Health Services had in other states and territories (such as QLD, VIC & NSW) in terms of assisting the mental health system to better meet the mental health needs of CALD population groups. Within the smaller states and territories it was acknowledged that transcultural mental health networks played an important initial role in bringing key stakeholders together to address the mental health gaps for CALD communities. However, participants commented on the need to fund transcultural mental health centres to begin the work required to address existing mental health gaps for CALD communities (such as research, cross-cultural training and development). This includes the need to upscale existing networks so that services are proportionate to what CALD communities in the bigger states receive with their transcultural mental health centres. There were also suggestions for transcultural mental health networks to be scaled up to facilitate better networking (e.g. through building and training networks of bilingual mental health staff). For example:

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

Since the various consultations began, some of the states and territories have begun to develop transcultural mental health networks and positions as a strategy to increase consultative mechanisms with CALD communities and key stakeholders and to begin mapping and identifying systemic issues with regards to addressing the mental health needs of CALD consumers and carers within their states and territories. Yet, as table 3.3 below shows, disparities in transcultural mental health services exist between states and territories.

Table 3.3 – Transcultural Mental Health Centres, Services, & Networks – Oct 2010

Service type	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Transcultural Mental Health Centre		✓		✓			✓	
Transcultural Mental Health Service (Under review)								✓
Transcultural Mental Health Network	✓					✓		
None existent			✓		✓			

Policy implication 5:

There is need for

- funding Transcultural Mental Health Centres & Networks in each state and territory; and
- increasing the capacity of existing transcultural mental health networks to address the existing mental health gaps for CALD communities.

3.2.6 CALD Consumer and Carer Participation and Advocacy

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

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

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

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

CALD consumer and carer participation has been a key priority for MMHA, with MMHA developing the first national CALD consumer and carer reference groups. This has included the development and training of a Speakers Bureau. MMHA has also been supporting the national reference group members to set up state and territory based

reference and peer support groups. Yet building the capacity of CALD consumers and carers to participate at the state and territory level has been difficult with lack of funding being a key barrier (see table 3.4 overleaf).

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

Table 3.4 – CALD Consumer & Carer Participation in Reference Groups – Oct 2010

Jurisdiction	Status
ACT	▪ No CALD Consumer and Carer Reference groups
NT	▪ No CALD Consumer and Carer Reference groups
NSW	▪ No CALD Consumer and Carer Reference groups
QLD	▪ CALD Consumer and Carer Reference set up as part of QTMHC
SA	▪ CALD Consumer and Carer Reference Groups set up ▪ Unfunded
TAS	▪ CALD Consumer and Carer Reference Groups currently being set up ▪ Unfunded
VIC	▪ CALD Consumer only Reference Group set up by VTPU ▪ Funded until Dec 2010 through VMIAC
WA	▪ CALD Consumer and Carer Reference Groups currently being set up with MSCWA ▪ Unfunded
National	▪ No MMHA CALD consumer or carer representation on the National Mental Health Consumer and Carer Forum

Policy implication 6:

There is need for:

- prioritising CALD consumer and carer participation at the state and territory level and fund initiatives that increase participation; and
- prioritising CALD consumer and carer representation at the national level via the National Mental Health Consumer and Carer Forum.

3.2.7 Population Specific Issues

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

(i) Age-based issues

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

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

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

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

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

A recent report into CALD dementia[2] research (Cheng et al, 2009) also noted the following:

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

As the Mental Health Council of Australia has noted:

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

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

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

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

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

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

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

(ii) Refugee and emerging communities

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

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

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

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

(iv) Regional (rural & remote) issues

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

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

(v) Other issues for consideration

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

(a) CALD women and mental health issues

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

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

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

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

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

Policy implication 7:

Planning to meet the mental health needs of CALD populations also need to consider targeted initiatives according to population groups such as men, women, youth, aged, refugee and newly emerging communities, and people with co-occurring disabilities.

3.2.8 Suicide and CALD communities

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

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

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

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

Understanding the true scale of the problem is difficult because some cultures may not report deaths as suicides due to stigma, resulting in some suicides reported as unintentional or accidental deaths (Walker et al, 2008). However, recent research by De Leo et al (2010) into rates of suicide amongst first-generation Australian immigrants has indicated:

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

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

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

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

The Commonwealth Department of Health and Ageing also articulates that:

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

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

Policy implication 8:

There is a need for:

- improved data collection, reporting and analysis of suicide in CALD communities; and
- targeted suicide prevention programs for CALD communities.

3.2.9 Role for MMHA

As previously stated in Chapter 2 (Consultation Strategy), the consultations aimed to seek input into MMHA's activities as well gain stakeholder feedback about issues important to them. Within this context a number of roles and activities were suggested for MMHA in further actioning the feedback from the consultations. For example, the consultation participants suggested that MMHA should:

- *"Advocate to Territory and Commonwealth governments that they and their funded services have specific, measurable CALD performance targets. Service delivery must demonstrably meet CALD needs. "* – ACT consult
- *"Help with financial, lobby/advice, resources. Advice with what not to do, provide expertise and how to sustain"* – SA consult
- *"Provide information and appropriate strategies to the Department of Health and Human Services Tasmania on methods used by other states.."* – TAS consult
- Facilitate *"conference; exchange of information.."* – NT consult
- *"Encourage the Commonwealth and WA governments to improve the mental health and wellbeing of CALD communities and provide funds for the development of promotional strategies specifically targeting CALD communities."* – WA consult

The various roles and examples were analysed for similar themes and are categorised in table 3.5 below.

Table 3.5 – Suggested Roles for MMHA

Potential role	Ways to enact the role
Advocate & support	▪ Advocate for and support systemic change with relevant state, territory and commonwealth departments, networks and planning structures
Plan	▪ Develop strategic national multicultural mental health plans
Resource development	▪ Develop resources for CALD communities (e.g. fact sheets & multimedia resources) ▪ Develop resources for the mental health sector to improve their capacity to address the mental health needs of CALD communities
Facilitate	▪ Bring together key stakeholders and facilitate communication and planning ▪ Facilitate information exchange (e.g. best practice in working with CALD communities)
Educate	▪ Educate the mental health sector to work cross-culturally ▪ Educate peak mental health bodies about CALD consumer and carer issues ▪ Educate CALD communities about stigma, mental illness and pathways to support
Inform & Promote	▪ Provide and distribute information to CALD communities ▪ Work with ethnic and mainstream media to reduce stigma
Capacity Building	▪ Build the capacity of CALD communities, community leaders, multicultural and ethno-specific services to address mental health issues amongst CALD communities ▪ Build the capacity of CALD consumers and carers to participate in mental health service planning, delivery and evaluation
Research	▪ Identify research gaps and develop a multicultural mental health research agenda

Policy implication 9:

There is a need to consider the stakeholder feedback about potential roles and priorities for MMHA (see table 3.5).

4. CONCLUSION

MMHA's consultation forums in the smaller states and territories found that key stakeholders perceived that significant gaps still existed with regards to the mental health outcomes for CALD communities. These perceptions are supported by the literature reviewed including the *Framework for the implementation of the national mental health plan 2003-2008 in multicultural Australia* (DoHA, 2004).

The aggregated analysis of the consultation forum themes and issues highlighted key policy implications that need to be addressed by a partnership between the Australian government, State and Territory governments, Australia's mental health sector, Australia's multicultural sector and Multicultural Mental Health Australia.

There is clearly a need for systematised and thorough evidence for policy and practice. However, it is clear that stakeholders are concerned about the significant information gaps with regards to the collection, reporting and analysis of CALD mental health data that hinder effective evidence-based mental health policy development.

At the national level, the Commonwealth of Australia has committed to addressing multicultural mental health issues through Multicultural Mental Health Australia. At the State and Territory level, some governments have also begun to realise their commitment through providing initial funding to set up transcultural mental health networks. Importantly, transcultural mental health networks need to be further developed and resourced so that the key issues identified within this report can begin to be addressed. Further, Transcultural Mental Health Centres need to be funded in smaller states and territories as they can provide a practical structure with which to begin the work of addressing the mental health disparities for CALD communities in the smaller states and territories.

5. REFERENCES

Access Economics, 2006, *Dementia Prevalence and Incidence among Australians who do not speak English at Home,* report commissioned by Alzheimer's Australia.

Alvidrez, J., 1999, 'Ethnic variations in mental health attitudes and services for use among low-income Aferican American, Latina and European American young women', *Community Mental Health Journal,* Vol. 35, No. 6, pp. 515-530.

Atkin, N., 2008, 'Getting the message across: Professional interpreters in general practice', *Australian family Physician*, Vol. 37, No. 3, March 2008.

Australian Bureau of Statistics, 1999, *Standards for Statistics on Cultural and Language Diversity.* (ABS Cat. No. 1289.0). Canberra: ABS.

Australian Bureau of Statistics (ABS), 2006, "Cultural Diversity Overview" in *A Picture of the Nation: the Statistician's Report on the 2006 Census*, Catalogue No. 2070.0, ABS

Bird, S., 2008, 'Lost without translation', *Australian Family Physician*, Vol. 37, No. 12, December 2008

Blignault, I. & Haghshenas, A., 2005, 'Identification of Australians from culturally and linguistically diverse backgrounds in national health data collections', in *Australian Health Review, 29*(4), pp. 455-468.

Bower, M., 1998, *Transcultural Mental Health Service Delivery Models for Small and Dispersed Migrant Populations: A Tasmanian Study,* Australian Transcultural Mental Health Network, Department of Psychiatry, University of Melbourne.

Bruxner, G., burvill, P., Fazio, S., and Febbo, S., 'Aspects of psychiatric admissions of migrants to hospitals in Perth, Western Australia', *Australian and New Zealand Journal of Psychiatry,* Vol. 31, No. 4, pp. 532-542.

Carers Victoria, 2003, *For Love, For Faith, For Duty, For Deed: Beliefs and values About Caring in the Anglo-Celtic, Greek, Italian, Polish, Turkish and Vietnamese Communities in Victoria,* Research report prepared by R. Cole and T. Gucciardo-Masci, carers Victoria, Melbourne.

Center for Multicultural Youth (CMY) and ADEC, 2008, *Engaging Refugee and Migrant Young People Around Mental Health: Exploring Strategies that Work*. Report from the State-wide Multicultural Youth Issues Network Meeting, 16 October 2008, Melbourne. Available from ADEC at www.adec.org.au

Cheng, A., Cruysmans, B., Draper, B., Hayward-Wright, N., Jeon, Y-H., LoGuidice, D., Wu, H., and Zogalis, G., 2009, *Strategic Directions in CALD Dementia Research in Australia*, report commissioned by the Australian Government, Canberra.

Collins, J., Stolk, Y., Saunders, T., Garlick, R., Stankovska, M., & Lynagh, M., 2002, *I Feel so sad…It Breaks my Heart: Mid West Area Mental Health Service carers of Non-English Speaking Background research Project,* North Western Mental Health, Melbourne.

Commonwealth of Australia, 2009, *Fourth National mental health Plan: An Agenda for Collaborative Government Action in Mental health 2009 – 2014*, Commonwealth of Australia, Canberra.

Commonwealth of Australia, 2010, *National Standards for Mental Health Services 2010,* Commonwealth of Australia, Canberra.

Davidson, G., R., Murray, K., E., and Schweitzer, R., 2008, 'Review of refugee mental health and wellbeing: Australian perspectives', *Australian Psychologist*, Vol. 43, Is. 3, pp. 160-174.

De Leo, D., Kolves, K., Ide, N., "Sucide in first-generation migrants, Australia 1974-2006" – presentation at Diversity in Health Conference 2010, accessed on line on 11 November 2010 from www.ceh.org.au/dih/

Department of Health and Ageing (DoHA), 2004, *Framework for the implementation of the national mental health plan 2003-2008 in multicultural Australia*. Canberra: Health Priorities and Suicide Prevention Branch, Commonwealth Department of Health and Ageing.

Department of Health and Ageing (DoHA), 2005, *Mental Health Information Development: National Mental Health Information Priorities.*(2nd ed.). Canberra: Health Priorities and Suicide Prevention Branch, Commonwealth Department of Health and Ageing.

Department of Health and Ageing (DoHA), 2008, *Research and Evidence in Suicide Prevention,* LIFE Framework, Commonwealth Department of Health and Ageing, Canberra

Fan, C., 1999, 'A comparison of attitudes towards mental illness and knowledge of mental health services between Australian and Asian students', *Community Mental Health Journal*, Vol. 35, No. 1, pp. 47-56.

Francis, S., & Cornfoot, S., (Centre for Multicultural Youth), 2007, *Multicultural Youth in Australia: Settlement and Transition,* Report commissioned by Australian Research Alliance for Children and Youth, Australian Capital Territory

Griffiths, K. M., Jorm, A.F., Christensen, H., Medway, J., & Dear, K. B.G, 2002, 'Research priorities in mental health, Part 2: an evaluation of the current research effort against stakeholders' priorities', *Australian and New Zealand Journal of Psychiatry*, Vol. 36, Iss. 3, pp. 327–339.

Hjern, A., & Allebeck, P., 2002, 'Suicide in first and second generation immigrants in Sweden – A comparative study', *Social Psychiatry and Psychiatric Epidemiology*, Vol 37, No. 9.

Huang, Y.T, and Phillips, C., 2009, 'Telephone interpreters in general practice: Bridging the barriers to their use', *Australian Family Physician*, Vol. 38, No. 6, June 2009.

Julian, R., 2004, 'Migrant and refugee health', *Health in Australia*, 3rd ed., Edited by C. Gribch, Pearson Longman, New South Wales.

Khalidi, S., & Challneger, R., 1998, *The Need for Cultural Sensitivity: An Assessment of the Mental health Needs of People from Culturally and Linguistically Diverse backgrounds in the ACT*, Australian Transcultural Mental health Network, Department of Psychiatry, University of Melbourne, Melbourne.

Klimidis, S., Lewis, J., Miletic, T., McKenzie, S., Stolk, Y. & Minas, I.H., 1999, *Mental Health Service Use by Ethnic Communities in Victoria. Part 1: Descriptive Report*, Victorian Transcultural Psychiatry Unit, University of Melbourne, Melbourne.

Kokanovic, R., Petersen, A., Klimidis, S., 2006, 'Nobody can help me…I am living through it alone: Experiences of caring for people diagnosed with mental illness in ethno-cultural and linguistic minority communities', *Journal of Immigrant and Minority Health,* Vol. 8, No. 2, pp 125-135.

Luckett, T., Blignault, I., Eisenbruch, M., 2005, "Researching culture and health: Variables used to identify culturally diverse groups in New South Wales", in NSW Public Health Bulletin, Vol 16, No. 9-10. Accessed on line on 17 November 2009 at http://www.publish.csiro.au/nid/227/issue/4219.htm

Lurie, N., & Fremont, A., 2006, 'Looking Forward: Cross cutting issues in the collection and use of racial/ethnic data', *Health Services Research*, Vol.41(4, part1), Aug 2006, pp. 1519-1533.

Mc Donald, B., & Steel, Z., 1997, 'Immigrants and Mental Health', *Culture and Mental Health: Current Issues in Transcultural Mental Health*, NSW Transcultural Mental Health Centre, NSW.

Mc Donald, B., & Steel, Z., 2000, 'Suicide in immigrants born in non-English speaking countries', *Synergy*, Winter edition, Multicultural Mental Health Australia. accessed on line on 18 November 2009 at http://www.mmha.org.au/mmha-products/synergy/Winter2000/McDonaldSuicide/?searchterm=mcdonald

Mental Health Council of Australia (MHCA), 2009, *Submission to Senate Community Affairs Committee Inquiry into Suicide in Australia*, Mental Health Council of Australia, accessed on line on 28 October 2010 at http://www.mhca.org.au/submissions

Miletic, T., Minas, H., Stolk, Y., Gabb, D., Klimidis, S., Piu, M., and Stankovska, M., 2006, *Improving the Quality of Mental Health Interpreting in Victoria*, Victorian Transcultural Psychiatry Unit, Victoria.

Minas, I.H., Lambert, TJ.R., Kostov, S., Boranga, G., 1996, *Mental Health Services for NESB Immigrants,* Bureau of Immigration, Multicultural and Population Research, Department of Immigration and Ethnic Affairs, Commonwealth of Australia, Canberra.

Minas, I.H., Silove, D., & Kunst, J.P., 1993, *Mental Health for Multicultural Australia: A National Strategy*, Report of a consultancy to the Commonwealth Department of Human services and Health, Victorian Transcultural Psychiatry Unit, Melbourne.

Minas, I.H., Stuart, G.W., & Klimidis, S., 1994, 'Language, culture and psychiatric services: a survey of Victorian clinical staff', *Australian and New Zealand Journal of Psychiatry*, Vol. 28, pp. 250-258

Multicultural Mental Health Australia (MMHA), 2004, *Reality Check: Culturally Diverse Mental Health Consumers Speak Out,* Multicultural Mental Health Australia, available from the web at www.mmha.org.au

Multicultural Mental Health Australia (MMHA), 2007, *Mental Health Needs of CALD Communities in Tasmania – Consultation Report*, MMHA, available from the web at www.mmha.org.au

Multicultural Mental Health Australia (MMHA), 2008a, *The Mental Health Needs of Culturally and Linguistically Diverse Communities in South Australia – Consultation Report*, MMHA, available from the web at www.mmha.org.au.

Multicultural Mental Health Australia (MMHA), 2008b, *Mental Health Issues for People from Culturally and Linguistically Diverse backgrounds in the Northern Territory – Consultation Report*, MMHA, available from the web at www.mmha.org.au

Multicultural Mental Health Australia (MMHA), 2009, *The Mental Health Issues for People from Culturally and Linguistically Diverse Backgrounds in Western Australia – Consultation Report*, MMHA, available from the web at www.mmha.org.au

Multicultural Mental Health Australia (MMHA), 2010a, *Mental Health Issues for People from Culturally and Linguistically Diverse Backgrounds: National CALD Peaks Consultation – Consultation Report*, MMHA, available from the web at www.mmha.org.au

Multicultural Mental Health Australia (MMHA), 2010b *Stepping Out of the Shadows – Reducing Stigma in Multicultural Communities – June 2010 Project Report*, MMHA, available from the web at www.mmha.org.au

Multicultural Mental Health Australia (MMHA), 2010c, National Cultural Competency Tool (NCCT) for Mental Health Services, Multicultural Mental Health Australia, available from the web at www.mmha.org.au

Multicultural Mental Health Australia (MMHA), 2010d, Media Release – 20 April 2010 – *Where are CALD communities in mental health reforms?*, available from the web at www.mmha.org.au

National Coroners Information System (NCIS), 2009, web page: Data from Coronial Files, accessed on line on 17 September 2009 at http://www.ncis.org.au/web_pages/what_data_is_available.htm

National Ethnic Disability Alliance (NEDA), 2010, *What Does the Data Say? People from Non-English Speaking Backgrounds with a Disability in Australia*, NEDA, NSW.

Nagel, T., & Trauer, T., 2010, 'Outcome measurement with indigenous consumers', in T. Trauer (Ed.), *Outcome Measurement in Mental Health*. Cambridge: Cambridge University Press.

Pirkis, J., & Callaly, T., 2010, 'Mental health outcome measurement in Australia', in T. Trauer (Ed.), *Outcome Measurement in Mental Health*. Cambridge: Cambridge University Press.

Prasad-Ildes, R. & Wright, B.,2004, 'One size does not fit all: The case of standardised mental health outcome measures in multicultural Australia', *Synergy,1*, pp. 6-7.

Queensland Transcultural Mental Health Centre (QTMHC), 2005, *Translation and cultural contextualisation of the mental health inventory into 13 community languages*. Queensland: Queensland Health, Queensland Government.

Queensland Transcultural Mental Health Centre (QTMHC), 2010 http://www.health.qld.gov.au/pahospital/qtmhc/

Rao, D., V., Warburton, J., Bartlett, H., 'Health and social needs of older Australians from culturally and linguistically diverse backgrounds: issues and implications', *Australasian Journal on Ageing*, Vol. 25, No. 4, pp. 174-179.

Robinson, J., Pirkis, J., Krysinska, K., Niner, S., Jorm, A., Dudley, M., Schindler, E., De Leo, D., and Harrigan, S., 2008, 'Research priorities in suicide prevention in Australia: A comparison of current research efforts and stakeholder-identified priorities', Crisis, Vol. 29, No. 4, pp. 180-190.

Rooney, R., O'Neil, K., Bakshi, L., & Tan-Quigley, A., 1997, *Investigation of Stigma and Mental Illness Amingst Non-English Speaking Background Communities and Development of Approaches to its Reduction,* Australian Transcultural Mental Health Network, University of Melbourne, Melbourne.

Rooney, R., Wright, B., O'Neil, K., 2006, 'Issues faced by carers of people with a mental illness from culturally and linguistically diverse backgrounds: Carers' and Practitioners' perspectives', in *Australian e-Journal for the Advancement of Mental Health (AeJAMH),* Vol. 5, Iss. 2, accessed on line at www.auseinet.com/journal/vol5iss2/rooneypdf on 20 January 2009

Rural Health Education Foundation, 2007, *Dementia – A National Priority – Dementia, Mental Health and Neurological Co-morbidities: Facilitator's Guide,* produced on behalf of the Commonwealth Department of Health and Ageing, Canberra

Sainsbury Centre for Mental Health, 2002, *Breaking the Circles of Fear: A Review of the Relationship between Mental Health Services and African and Caribbean Communities,* The Sainsbury Centre for Mental Health, London, accessed on line at http://www.scmh.ork.uk/80256FBD004F6342/vWeb/pcPCHN6FMJWA on 23 January 2009.

Scheppers, E., Van Dongen, E., Dekker, J., Geertzen, J., and Dekker, J.,2006, 'Potential barriers to the use of health services among ethnic minorities: a review', *Family Practice,* Vol. 23, No. 3, pp. 325-348.

Senate Select Committee on Mental health, 2006, *A National Approach to Mental Health – From Crisis to Community,* First Report, Commonwealth of Australia, Canberra.

Sozomenou, A., Mitchell, P., Fitzgerald, M., Malak, A., & Silove, D., 2000, *Mental Health Consumer Participation in Culturally Diverse Society*, 2nd ed., Australian Transcultural Mental Health Network, Sydney.

Stolk, Y., Minas, I. H., Klimidis, 2008, *Access to Mental Health Services in Victoria: A Focus on Ethnic Communities*, Victorian Transcultural Psychiatry Unit, Melbourne.

Victorian Department of Health (Vic DoH - Previously Department of Human Services), 2006, *Culturally and linguistically diverse communities and outcome measurement: Guidelines for clinicians*. Melbourne: Mental Health Branch, Victorian Department of Health.

Victorian Multicultural Commission (VMC), 2006, *Population Diversity in Local Councils in Victoria: 2006 Census*, Victorian Multicultural Commission: Victorian Government, accessed on line on 28 October 2010 at http://www.multicultural.vic.gov.au/population-and-migration/victorias-diversity/population-diversity-in-local-councils

Walker, S., Chen, L., & Madded, R., 2008, 'Deaths due to suicide: the effects of certification of coding practices in Australia' in *Australian and New Zealand Journal of Public Health*, Vol. 32, pp. 126-130.

Wynaden, D., Chapman, R., Orb, A., McGowan, S., Zeeman, Z., and Yeak, S.h, 2005, 'Factors that influence Asian communities' access to mental health care', *International Journal of Mental health Nursing,* Vol., 14, No. 2, pp. 88-85.