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Transcultural
Mental Health Centre

15 April 2011

Ms Maria Vamvakinou MP
Federal Member for Caldwell
Chair
Joint Standing Committee on Migration
PO Box 6021
Parliament House
Canberra ACT 2600

Dear Ms Vamvakinou,

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RE: Inquiry into Multiculturalism

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The Transcultural Mental Health Centre (TMHC) wishes to thank the Joint Standing Committee on Migration for the opportunity to contribute to the Inquiry into Multiculturalism in Australia. This Inquiry recognises that globalisation and recent migration patterns have contributed to a world where countries are becoming increasingly multicultural. The UN estimates that there are 214 million migrants around the globe, an increase of about 37% in the previous two decades and this is expected to rise.

Ancient and precious Indigenous cultures have existed in Australia for over 40 000 years. In modern times Australia's history is also characterised by migration which has resulted in one of the largest proportions of immigrant populations worldwide. This population comprises migrant and refugee communities, including established, new and emerging populations, recently arrived, first, second, and subsequent generations.

In the 1970s immigration policy embraced the concept of multiculturalism which meant that regardless of culture or language all Australians should have equal access to services. However, in the last two decades and up until the release of *The People of Australia – Australia's Multicultural Policy*, there has been no explicit updated social policy on multiculturalism with vision and values which recognized and celebrated diversity.

The transcultural experience is at the heart of the Australian story: today over 300 languages are spoken in Australian homes by people who have over 200 ancestries and practice more than 100 religions. Therefore, the transcultural experience needs to be addressed, that is the phenomenon of merging and converging cultures, the position that migrants and refugees find themselves in when they move from one place to another, and the impact on their children and even grandchildren. The experience varies across the country, from person to person, community to community and is also influenced by the time of their migration.

Therefore, mental health services are increasingly confronted with a complex and multilayered matrix of meanings, beliefs and ideas around mental health and wellbeing. Addressing the transcultural experience is fundamental for health and wellbeing, mental health promotion and mental ill health prevention. We need to continually 'take the pulse' of the needs of individuals and communities in response to the transcultural mental health risk and protective factors, within our multicultural populations, which may influence and may or may not extend beyond first generation migrants/refugees to subsequent generations.

It is important that a social inclusion agenda recognises the experiences of individuals living with multiple identities and across and between diverse communities, including: individuals living with a disability, including a mental health condition, cultural and/or language diversity, sexual and gender diversity, living in rural and remote areas, and subsequent generational change.

New South Wales (NSW) has led the way in establishing a model for multiculturalism supported by a legislative framework. As one of the most culturally diverse states in Australia, NSW recognises that culturally and linguistically diverse (CALD) populations, contribute to the wealth, productivity and strength

of our society. However, with such a diverse population comes a range of experiences that may impact on an individual's physical and mental health. The experiences which immigrants and humanitarian entrants bring with them may also influence their approach to health and other human service agencies and the way that they connect and remain connected with these agencies.

This NSW model of governance has enabled services such as the TMHC to work in partnership with the mental health service sector, communities, consumers and carers to address issues of access and equity. This submission is focused on point three of the Joint Standing Committee's terms of reference: settlement and participation. The TMHC's contribution to this Inquiry highlights learning in the field to date and can inform consequent strategies to address multiculturalism and transcultural mental health within a social inclusion framework. Government and community ownership and collaboration is essential in leading targeted activities appropriate to the social and cultural needs of the groups or populations being served to enhance greater participation in the community.

Please find attached TMHC's submission. We also refer the Committee to recent TMHC submissions (Tab A) to other standing committees at a state and national level which will serve to complement our response to this public consultation. The TMHC would be pleased to be involved with any future initiatives that the Committee may wish to develop to achieve the strategic directions and intended outcomes of *The People of Australia – Australia's Multicultural Policy*.

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

Yours sincerely,

Maria Cassaniti
Centre Manager
Transcultural Mental Health Centre

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

NSW's unique transcultural mental health model is the first of its kind and in 18 years of operation has yielded important information to guide policy, planning and service development for culturally and linguistically diverse (CALD) populations locally, nationally and globally. This submission reflects the experiences and lessons learned by the Transcultural Mental Health Centre within the NSW context.

Identified Mental Health Needs

An analysis of the literature illustrates that mental health and comorbidity are an important health care issue among migrant and refugee populations. A summary of the issues faced by this population include:

- Issues of access to social and mental health services (community and hospital based)[1], under-utilisation of services and the later/critical stage of presentation to mental health services.[2]
- Limited availability of interpreter services with new and emerging communities (and skill shortage or lack of skill recognition in mental health work) or a lack of confidence or an unwillingness by certain members of the workforce to engage and use interpreters.
- Limited cross cultural skills in some sections of the mainstream mental health workforce. Mental health service providers may also lack the cultural competencies to correctly identify, diagnose and treat mental health issues within a cultural context.
- High levels of stigma in the community with mental health and comorbidity experiences and concerns with professional confidentiality, privacy, language barriers and knowledge of the health care system.
- A breakdown of traditional culture, generational conflict and language difficulties (especially with second generations) may impact on the mental health of individuals and families.
- Unique issues present in different populations: older family members may revert to their first language due to dementia or mental illness. Children and young people often act as mediators and may also experience difficulties in balancing their bicultural identity. A change in family dynamics and/or roles within the family unit may occur as a result of the migration experience.
- Further factors impacting on multicultural mental health are outlined in the *NSW Multicultural Mental Health Plan 2008-2012*.

Policy and Planning Context

A number of factors have enabled the TMHC to progress its work from planning through to systems and clinical and community capacity. The key enablers include:

- In NSW multiculturalism has had bipartisan support for over 30 years. The NSW Government framework and legislation via the Multicultural Policies and Service Program and annual reporting requirement by all public health services based on the *Community Relations Commission and Principles of Multiculturalism Act 2000.* Annual reporting provides a framework for planning for CALD communities in NSW and ensures accountability across all levels of service provision.
- A statewide mental health policy and service delivery framework, the *Multicultural Mental Health Plan 2008-2012,* replaced the previous *NSW Health Caring for Mental Health in a Multicultural Society 1998.* The current Plan has a Statewide Implementation Committee with representation from Local Health Networks and key service providers. Local implementation committees are able to identify their own priorities and adapt the strategies within a local context and target communities most in need.
- A commitment to working in partnership at all levels (national, state and local). The TMHC has had the opportunity to provide input into the development of policies and plans and provides expert advice to numerous working and advisory groups. This allows the opportunity for CALD issues to be embedded within a policy and plan from the initial stages, thus facilitating more effective implementation and outcomes.
- One of the principles of the *National Mental Health Plan 2003-2008* was that mental health care should be responsive to the continuing and differing needs of consumers: families and carers; CALD communities and other specific populations. This Plan was then supported by the *Framework for implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia* which provided a framework for implementation across the country.
- The *National Standards for Mental Health Services* includes Standard 4: Diversity Responsiveness. A National Cultural Competency Tool has been developed by Multicultural Mental Health Australia for the implementation of Standard 4.

Organisational Context

The Transcultural Mental Health Centre (TMHC) was established in 1993 as a statewide service to improve the mental health and wellbeing of people from CALD communities across the lifespan and at different stages of the migration, refugee and settlement experience.

As a service of NSW Health the TMHC provides leadership in transcultural mental health planning, policy development and implementation; and management of statewide programs to improve access and equity to services which are inclusive and responsive to the diverse and changing needs of both established and emerging CALD communities.

TMHC utilises multiple interrelated components to progress mental health outcomes for CALD populations. These include: specialist clinical service delivery, research and evaluation; organisational and workforce development; mental health promotion, prevention, and early intervention; community engagement and development (including culturally relevant multilingual multimedia resources and campaigns). These components ensure that the Centre remains responsive to consumer, carer, community and workforce needs.

The Centre's work is based on a foundation of collaborative partnerships with consumers, carers and their families, across mental health and related health services, NGOs and community sectors. The strength of the TMHC's partnership model is that it simultaneously combines a specialist clinical service which addresses issues at the individual and familial level with a capacity building approach focused on both CALD communities and the wider workforce. This model strives to be complementary, integrated, equitable, and inclusive within the wider health and community context.

Recent Key Partnership Initiatives

The following initiatives, funded by the Mental Health and Drug and Alcohol Office (MHDAO) at the NSW Department of Health (NSW DOH) are outlined to illustrate examples of the TMHC partnership-based model of action:

–   **Multicultural Mental Health Outcomes and Assessment Tools (MH-OAT) Project**

The TMHC undertook a review of the MH-OAT (standardised assessment protocols, processes, materials, and related staff education programs) and their accurate and meaningful use in an increasingly diverse NSW. The goal of this review was to produce addenda revisions, and practical recommendations for further development of MH-OAT to enhance its use with consumers from CALD communities. Following the completion of the Project, MHDAO also funded the TMHC to design, conduct, and evaluate a state-wide implementation program for public sector mental health services.

The Multicultural MH-OAT Management Committee was established and consisted of representatives from the MHDAO, NSW Health, InforMH (responsible for collecting, analysing and reporting information aboutmental health services in NSW), and the TMHC. A Multicultural MH-OAT Review Project Reference Group was established and consisted of members from mental health services across NSW representing both ambulatory and inpatient services across the lifespan in rural and metropolitan areas. Metropolitan and rural MH-OAT Coordinators, cross-cultural mental health researchers and clinicians, the academic sector, and senior clinical advisors to the Department of Health were invited to join the group.

The project had a number of objectives:
1. To develop and field test a decision guide to assist clinicians with providing culturally and linguistically appropriate service delivery for CALD consumers.
2. To conduct a review of the MH-OAT clinical documentation modules to evaluate their clinical utility for CALD consumers and provide recommendations for revisions and additions to the modules.
3. To explore perceptions around the use of MH-OAT standardised outcome measures with CALD populations.
4. To provide education packages to support all products developed by the project.
5. To ensure sustainability of the CALD appropriate aspects of MH-OAT through specific recommendations.

The project conducted 15 consultations with Healthcare Interpreter Services, Carer groups, and mental health clinicians providing care across the life span in inpatient and community services across the then eight Area Health Services, with 101 participants. In response to consultation findings, a Transcultural Referral Guide was developed, field tested with 60 clinicians and refined, to provide guidance on linking consumers with the most appropriate source of care or to enlist partner agencies in the treatment team.

A Transcultural Assessment Checklist was also designed, field tested with 60 clinicians and refined to provide guidance for inpatient and community clinicians in assessment, clinical review, care planning and discharge linkage. In response to the field trials, a Transcultural Assessment Module was designed, piloted with 113 clinicians and refined as an optional documentation tool for recording culturally relevant information in an easily-locatable form in the clinical record. A professional development package was devised and field tested to support the introduction and use of the project products. The project also canvassed clinician contributions regarding the use of the standardised measures with CALD consumers, leading to recommendations for improved uptake. Training was facilitated with 487 clinicians across 29 sites in of NSW on the use of the Multicultural MH-OAT (Transcultural Referral Guide, Assessment Checklist and Module) and a DVD of the training was produced for use in future training. The training and the tools assist clinicians in utilising locally- based resources and referral pathways as well as engaging with specialist mental health services as required.

- **The Transcultural Rural and Remote Outreach Project (TRROP)**

The Commonwealth and the NSW Governments have provided a strong impetus for addressing the mental health needs of CALD communities in rural areas through clear policy statements. TRROP is a partnership between the TMHC, the Centre for Rural and Remote Mental Health (CRRMH), Greater Southern Area Health Service (GSAHS), Greater Western Area Health Service (GWAHS), Hunter New England Area Health Service (HNEAHS) and North Coast Area Health Service (NCAHS). TRROP is an equity and access initiative intended to explore models of service delivery for CALD communities in rural areas. It is the first activity of this kind in rural NSW. Further, the innovative governance structure was designed to pilot a model of participation and decision-making that included stakeholders involved in the delivery of healthcare to rural and remote communities from the state level through to the local level.

NSW is also the largest settlement location in Australia, receiving approximately 41% of arrivals from overseas since 2002. The pattern of immigrant settlement is skewed towards capital cities, however federal and state policies in the last decade have contributed to a consistent flow of humanitarian entrants settling in rural and remote areas of NSW. Demographic data indicate that these areas already had appreciable numbers of immigrants of CALD backgrounds.

The TRROP governance structure included a Steering Committee with representation from MHDAO, TMHC, CRRMH and participating Area Health Services, a Project Advisory Group with Commonwealth, State, and NGO participation for advice and to advocate for the project in their respective vectors, and a consortium of local stakeholders convened in each project site. The consortia are a significant innovation of TRROP that have proven to be an effective model for future NSW Health projects, because they give project activities community input, ownership, support and local credibility.

Four key performance areas were adopted, with the intention that activities in each site should aim to address all of the targets. These aim to improve systems, service, workforce and community capacity.

Consultations with CALD community members and with service providers from the public and NGO sectors were conducted to scope the existing situation and provide accurate, contemporary data to inform decisions. This was the largest qualitative study of this nature undertaken in NSW and has created a database useful for both TRROP and other projects. One hundred and seven people representing 36 cultures and four migration streams contributed to the community consultations, conducted in Coffs Harbour, Griffith, Tamworth and Wagga Wagga. Contributing to the consultations were 123 service providers, from Coffs Harbour, Dubbo, Griffith, Lightning Ridge, Tamworth, and Wagga Wagga.

Guided by consultation findings, discussions with key stakeholders via the project's governance structure, and an analysis of the literature, TRROP designed activities that were both project-wide and site-specific. Activities were usually piloted in one site, revised, and then rolled-out for the other sites. During the project, 77 professional development programs delivering 155 hours of training were conducted for 1,440 mental health clinicians and other service providers to CALD consumers, including 108 video conference participants. A total of 14 Wellbeing Workshops were conducted for 127 members of eight language-specific communities and for mixed-participant groups across the sites.

Consultation outcomes reinforced the knowledge that religious leaders are often the first, or only, source of support for mental health concerns. This finding was translated into the Spiritual Leaders Information Sessions with 44 religious leaders participating across the four sites.

– **Older Persons from CALD Community Mental Health Project**

The Project scope was threefold, firstly to conduct a planning, policy and literature review to inform the *NSW Multicultural Mental Health Plan 2008-2012* (now released) and secondly to provide a transcultural mental health context for the NSW Health Specialist Mental Health Services for Older People (SMHSOP) Advisory Group. The Project's third focus was to build the capacity of CALD communities in NSW to improve both mental health literacy and access and equity to mental health services.

The Project found that the number of older people from CALD communities living in NSW is growing at a faster rate than the overall Australian ageing population and is becoming increasingly diverse. Data projections for 1996-2011 in NSW suggest that although the overall ageing population will increase by around 35%, the ageing population from CALD communities will increase close to 100%. These findings have a number of implications for older people from CALD communities accessing and utilising mental health services.[3]

The literature review indicates that there are particular stressors experienced by older people from CALD communities, which may vary according to their migration, refugee and re-settlement experience. These include:

- Many older people from CALD communities experience isolation and loneliness, and often do not have extended families to support them.
- Grief, loss, shame and stigma may be experienced as part of the migration experience and psychological distress may take the form of depression.[4]
- Ageing in an unfamiliar cultural environment can be challenging.[5, 6]
- Frequently, mental health issues may not be recognised, may be incorrectly assessed, or not assessed at all. This may result in older people from CALD communities not being referred to an appropriate service and/or treatment.
- Cultural and linguistic issues can become more salient in older people as both English language and first language skills may be diminished or lost, especially with the onset of dementia.
- Some older people from CALD communities arrived in Australia as displaced persons and experienced previous trauma and/or torture. In later years, these experiences may present and require specialist intervention and treatment.
- There are higher rates of suicide at old age, among some immigrant groups (when compared to Australian-born older people population).[2]

Following the analysis of the demographics and literature review, the Project coordinated 138 consultations across NSW to identify service provider awareness of the mental health needs of older people from CALD communities and the resources required to meet these needs. Service providers included multicultural and ethno-specific services, Aged Care Assessment Teams (ACAT), aged care services and geriatric mental health services.

The key findings from the consultations include:

- GPs and public health services are the main referrers of older people from diverse populations to SMHSOP.
- The extent to which a person speaks English may not be fully recognised. Language difficulties may be exacerbated when distressed.
- Alzheimer/dementia issues are the most prevalent presenting issues for CALD older people in multicultural organisations.
- Ethno-specific/multicultural agencies identified service issues around interpreters, language barriers and understanding a clients culture.
- Workforce development issues such as cultural competency, recognition of bilingual skills, access to interpreters, access to culturally relevant assessment tools and organisational development related to cultural inclusion.

The key findings are currently being responded to by the SMHSOP Advisory Group, via the CALD Older Persons Mental Health Working Group.

Enablers and Barriers to Moving Forward (with a focus on transcultural mental health)

– **Research and evaluation**

Valuable transcultural mental health research has been carried out by TMHC, the Psychiatry Research and Training Unit, the Victorian Transcultural Psychiatry Unit and others. However, a lack of attention to social policy on multiculturalism in the past two decades has resulted in limited research funding to investigate the varied and changing needs of multicultural populations across the country. Garrett et al[7] reviewed the coverage of multicultural health research in Australia and found that out of 4146 articles only 2.2% focussed on multicultural issues. Similarly, Robinson et al's [8] recent review of suicide prevention research between 1999-2006, found that of 209 Australian published journal articles and 26 funded grants, none focused on the needs of CALD communities.

The multiculturalism social policy void has also contributed to minimal data collection on CALD communities and what is available is inconsistently collected across agencies. Public health surveys are also key instruments for obtaining information on health indicators. However, it has been identified that members of CALD communities are often under represented in population based studies. For example, a study conducted by Johnston and colleagues[9], which explored the 2007 Australian National Survey of Mental Health and Wellbeing, highlighted that 13.3% of respondents had suicidal ideation during their lifetime, 4% had made a suicide plan and 3.2% had made a suicide attempt. However, the situation amongst people from CALD communities is unknown as 'due to the sensitive nature of the interview none was conducted with an interpreter' and 'the survey instrument … relied on the respondent being sufficiently proficient in English to complete it'.

There are limited models and/or associated methods that are accepted within the research arena on studying diverse populations. Despite this there has been strong commitment at a grassroots level and across agencies to share and foster a cross-fertilisation of skills, knowledge and experience. The TMHC's role within this period of minimal investment in CALD research has been to build the evidence base by coordinating regular conferences to ensure that the lessons learnt from small grants or pilot projects are shared in a public forum and that the work is continually moving forward through collaborations and partnership despite the paucity in appropriately funded research.

The voices of CALD communities need to be heard, understood and then actioned accordingly.

Mental Health Promotion, Prevention and Early Intervention

A key role of the TMHC is to develop and coordinate culturally-relevant mental health campaigns and resources that address the needs of culturally diverse populations. Although a NSW initiative, the resources have been used across the country and are accessed by an international audience. Resources include 23 publications (reports and journal articles) and 304 translated materials for communities and to assist clinicians in providing services to CALD consumers. The TMHC has found that professional translation is only one of a number of stages in the development and dissemination of information to CALD communities. Focus group testing, and checking by bilingual/bicultural clinicians, consumers and carers also ensure material is culturally relevant and reflects the transcultural experience of that community. TMHC has developed a multi-pronged approach to disseminating information such as multicultural radio and print to community and spiritual leaders and workplaces with high CALD demographics. The delivery of campaigns needs to be sympathetic to the varying needs of metropolitan and rural communities.

The challenge for mental health promotion, prevention and early intervention is in addressing the growing diversity within CALD communities. Mental health literacy (understanding of mental health and pathways to care) varies depending on factors such as time of migration and age at which individuals migrated. Some key issues include:

- Services need to review and adapt their approaches for new and emerging communities to prevent the onset of illness and to improve pathways to care.
- Adolescents and young people from CALD communities have different risk factors which impact on their mental health including: changes in family role/dynamics living between two cultures, mental health literacy, lack of understanding of mental health services, intergenerational conflicts, identity formation, family/society expectations, guilt about leaving families and sexual health.
- Older people from CALD communities represent a significant proportion of the older population living in NSW. It is widely recognised that the older population as a whole have potential stressors and mental health concerns. In addition to these, older people from CALD communities may experience problems such as loss of language, cultural identity, social isolation and limited access to services.

- Higher rates of suicide at old age in NSW, among some immigrant groups, when compared to Australian-born older people.[2]
- Targeted CALD carers and consumers support initiatives need to be culturally relevant, safe and empowerment based.

– **Workforce development, education and training**

TMHC continually reviews the practices related to providing care to CALD communities. To this end it works with educational programs at the undergraduate and postgraduate level (including offering student placements) and it also aims to continually build the existing workforce capacity through direct training and clinical supervision.

Although inroads have been made in working with the undergraduate level, greater emphasis is needed within course development and delivery to embed cross-cultural and transcultural mental health practice within courses. This would then place transcultural mental health skills at the core of practice rather than offering the skills as an elective or an option.

The high turn over of health workers within the public health system presents its own difficulties in planning, identifying gaps and providing opportunities for workforce development as the skills set remains quite basic. However, if there was support for the embedding of cross-cultural skills in the undergraduate level, the skills within the workforce could be developed in a more specialized level.

Key TMHC workforce development, education and training initiatives include:
- The TMHC Clinical Training and Supervision Program provides a responsive mechanism for developing understanding and knowledge of a range of mental health presentations across the lifespan. The Program aims to increase the capacity of the TMHC clinical mental health workforce to work effectively with CALD communities to create a potential for increased early intervention, compliance and improved outcomes. The TMHC has 15 clinical supervision groups (both generalist and specialist) held in various locations in the Sydney metropolitan area and in regional and rural areas, and attended by TMHC sessional workers, bilingual counsellors and mainstream mental health professionals.
- The GP Program runs a 15-topic, RACGP-accredited, unit of study *Cross cultural Mental Health Care in General Practice* in conjunction with the NSW Institute of Psychiatry for two semesters. In addition cross-cultural mental health workshops for GPs are facilitated at the Institute of Psychiatry, University of Sydney and the Divisions of General Practice.
- TMHC, in partnership with NSW Centre for the Advancement of Adolescent Health, developed the *GP resource Kit for Adolescent Health* which incorporated a cultural competence module. The tool has been evaluated and also adapted for use in New Zealand.
- The Transcultural Rural and Remote Outreach Project designed activities that were both project-wide and site-specific and included tailor-made professional development programs for mental health clinicians and other service providers. Delivery was both face-to-face and video conference-based.
- The Psychology Intern Program is the only psychology program in NSW to have as a primary focus the training of psychology interns to work effectively with consumers from CALD communities and become culturally-competent psychologists. The Program provides the supervision required by four-year psychology graduates (interns) before they can obtain full registration with the Psychology Board of Australia.

– **Clinical services**

The projected migration of people (both through the migration and humanitarian entrant programs) will impact on the availability of culturally-relevant mental health specialist skilled services being available and accessible. This will further be compounded by the variation of specialist skills in mainstream mental health services across the country.

Currently TMHC specialist clinical services provide a complementary 'value add' within the NSW mental health sector. The Clinical Service provides cross-cultural consultation/education/information on resources available; triage, allocation and case referral, transcultural and/or cross-cultural mental health assessment, management and care; and complex case oversight. Services may be provided over the phone, face-to-face, via outreach clinics, through interpreters or via tele-psychiatry. Since 2007 TMHC has expanded its brief to assist CALD communities with problems of comorbidity (Co-Exist NSW: Diversity Health Comorbidity Service with the aim of targeting hard-to-reach population groups).

The flexibility of the model allows for engagement of new clinicians when required to meet new and emerging community needs. It endeavours to provide a streamlined pathway to care for its consumers

(providing information on the mental health services that are available to access by them) and clinical consultation is available for service providers.

Continual evaluation of the services provided by the TMHC support the cost-effective facilitation of cultural concordant care. This efficient use of resources is particularly beneficial in the early intervention phase and is made possible by engaging from a pool of 160 clinicians (who between them cover over 60 cultural backgrounds).

Because of the geographical distance and diversity across each state and territory, the TMHC model for service delivery could be replicated to address the lack of critical mass and workforce shortage to provide services to the diverse populations which exist in other areas of Australia. Service gaps highlight the vast inequity which exists across the country and that could potentially be provided by existing services in an interstate service agreement.

This could allow for the sharing of knowledge, gained from almost two decades of service provision, and the sharing of scarce resources, e.g. bilingual practitioners with transcultural mental health training, clinic rooms or access to communities to build capacity of mental health literacy or to complete consultations/evaluations. This model could utilise existing infrastructure and meet the needs of the CALD communities in local community facilities.

When the Access to Allied Psychological Services (ATAPS) Projects and Better Access Initiative funded by the Commonwealth Government were rolled out across the country each Division of General Practice had a different model of service provision, with few considering CALD populations as a target group with unique needs. The current model that ATAPS uses is dependent on the importance of the skill set identified by the Divisions. Cultural formulation within the assessment of a mental health issue is a vital skill set in the Australian context and to date this is not embedded across the Program. Furthermore, while the ATAPS current model funds Divisions with variable interest and commitment to 'at risk' groups such as CALD communities, the model may be more effective if it worked on an evidence base of health population targets and not on the focus of the individual GPs.

TMHC and similar agencies work towards coordinating resources that address the needs of CALD populations. Neither ATAPS nor other clinical and training components of the Better Access Initiative provide coordinated and centralised opportunities to provide clients with cultural concordant care when required. There is difficulty within the current programs for coordinated cultural matching of client and clinician. Currently there are barriers in the process of allied health professionals being able to provide services across Divisional (ATAPS) or locality boundaries. Under the current ATAPS model private clinicians cannot access free telephone or face-to-face interpreters and the client is often unable to pay for an interpreter themselves.

Conclusion

The voices of CALD communities need to be heard, understood and actioned accordingly. Diversity is our strength and the development of a well informed multicultural social inclusion agenda will work towards building and harnessing community strength, resilience and capacity to maximize the positive effects of the economic, social and cultural impacts of migration in Australia.

The TMHC model has a proven track record in working with CALD communities with a focus on mental health and well being. The TMHC work's in partnership with the mental health service sector, communities, consumers and carers to address issues of access and equity. This integrative and collaborative approach supports the continual reciprocity of learning between service users and service providers. Government and community ownership and collaboration is essential in leading targeted activities appropriate to the social and cultural needs of the groups or populations being served. Longer term targeted investments in health, human and community services for migrant communities is essential if we want to build on Australia's long term productive capacity.

At this juncture Australia needs to embrace learning from previous investments in multicultural communities and continue to lead the way in making multiculturalism core business in a time of unprecedented diversity. Australia's dynamism and diversity offers unique opportunities for social inclusion programs that resonate with all communities across metropolitan, rural, regional and remote Australia.

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