

20 November 2009

Mr Elton Humphrey  
Committee Secretary  
Senate Community Affairs References Committee  
PO Box 6100  
Parliament House  
Canberra ACT 2600

Dear Mr Humphrey,

**RE: Australian Senate Inquiry into Suicide in Australia**

The Transcultural Mental Health Centre (TMHC) wish to thank the Senate Community Affairs References Committee, for the opportunity to present a written submission for the Committee's consideration, as part of the Senate Inquiry into Suicide in Australia.

The TMHC is a unit of Sydney West Area Health Service within NSW Health. The TMHC is a statewide service that was established to improve mental health outcomes for and promote access to mental health services for people of culturally and linguistically diverse backgrounds.

The Centre is comprised of services and programs that provide leadership and excellence in the provision of culturally and linguistically specific clinical services, transcultural mental health promotion, prevention and early intervention, resource development, cross cultural training education, policy development and planning and research.

The 2006 Census identified that almost 44% of Australia's population were born overseas or had at least one parent born overseas. Of those born overseas, 62.1% were born in a non-main English speaking country. The Census also identified that 15.8% of the population speak a language other than English at home. NSW is one of the most culturally diverse states in Australia. Within NSW, 23.8% of the population were born overseas, with 16.8% of the population born in non-main English speaking countries, a 7.9% increase between the 2001 to 2006 Census. NSW is also the largest settlement location in Australia, receiving approximately 41% of arrivals since 2002. In 2006, Sydney was the capital city with the highest proportion of its population born overseas – almost one third.

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

Previous research conducted by the TMHC in NSW in 1997, indicated that 25 per cent of suicide deaths were people born overseas, 60 per cent of whom were from a non-English speaking background. Previous findings also indicated a great diversity of rates of suicide amongst immigrant groups, with rates amongst some groups being higher than Australian born, especially amongst females and older immigrants. This research was undertaken over ten years ago and was based on data which is now nearly 20 years old. This is of great concern considering the growing and changing diversity of the Australian community.

TMHC strongly supports the need for up to date research to inform suicide prevention programmes and initiatives that are appropriate and considerate of CALD community needs (both established and new and

emerging). This research should include epidemiological studies into the current rates and trends of suicidal behaviour, and investigations into risk and protective factors, which may be associated with suicidal behaviour.

Specific comments with reference to the Terms of Reference have been provided (Tab A) to highlight evidence based issues, as they pertain to members of CALD communities. TMHC has also offered recommendations on how the identified issues, may be addressed. As a state-wide organisation focusing on the mental health and wellbeing of people from diverse communities, TMHC urges the Committee to be considerate of the unique, varied and changing needs of CALD communities when reviewing legislation, programs and services related to suicide in Australia and suicide prevention.

The TMHC would be pleased to be involved with any further initiatives targeting CALD communities that the Committee may wish to develop as a result of the Inquiry. If you would like to discuss any aspects of this response further, please do not hesitate to contact me via email: [Maria.Cassaniti@swahs.health.nsw.gov.au](mailto:Maria.Cassaniti@swahs.health.nsw.gov.au) or on (02) 9840 3757.

Yours sincerely,

A handwritten signature in black ink that reads "m. Cassaniti". The signature is written in a cursive, lowercase style.

Ms Maria Cassaniti  
Centre Coordinator  
Transcultural Mental Health Centre (NSW)

## NSW Transcultural Mental Health Centre response to the Australian Senate Inquiry into Suicide in Australia

Comments are provided against the content of the document with reference to each term of reference.

### **Background Information:**

- Research indicates that people who are separated from their country and culture of origin are vulnerable to various stresses, mental health problems, loneliness and suicidal behaviour (International Association of Suicide Prevention)
- Findings from a number of studies suggest that immigrant status could be considered a risk factor for suicide (Ferrada-Noli et al., 2007).
- Earlier research undertaken by McDonald & Steel (1997) investigated suicide mortality rates in NSW between 1970 to 1992 and found that out of 13 580 suicide deaths 26.5% involved people who were overseas born, with 56.9% born in non-English speaking countries. McDonald & Steel (1997) also found a great diversity in the rates of suicide of people from different countries of birth, with suicide trends amongst immigrants mirroring trends of their country of origin, and particular high suicide rates prevalent among older immigrants.
- In addition, research undertaken in Sweden suggests that second generation immigrants are at a higher risk of suicide death than their parents (Hjern & Allebeck, 2002).
- Morrell et al. (1999), found that male migrants within NSW non metropolitan areas, were at a higher risk of suicide, and overall, female migrants had a significantly higher risk than Australian-born females.
- Some of the risk factors identified in previous research pertaining to suicide in immigrant populations include (Dusevic, Baume & Malak, 2001):
  - Traumatic experience or prolonged stress prior to, or during, immigration
  - Acculturative stress, social isolation and lack of support
  - Breakdown of traditional and family support structures and possible intercultural conflict
  - Low levels of English language learning and proficiency
  - Accessibility and appropriateness of support services
  - Decrease in socio-economic status, non recognition of overseas qualifications.
- A recent review of research priorities in suicide prevention in Australia (Robinson et al., 2008) indicates that during the period 1996-2006 out of 209 Australian published journal articles and 26 funded grants on suicide prevention identified nil targeted people from CALD communities.

### **a) the personal, social and financial costs of suicide in Australia;**

- Suicidal thoughts and behaviour are recognised worldwide as a significant public health problem (Johnston et al., 2009) and associated with high levels of distress and costs at an individual, community and societal level.
- Suicide has long been a taboo subject and many people have difficulties discussing suicidal behaviour, this is further exacerbated in CALD communities where there are high levels of stigma surrounding mental health issues.
- It is often stated that in addition to the direct loss of life, there is the long lasting psychological trauma for friends and family, and on average a single suicide affects at least six close family members/friends. However anecdotally, within CALD communities this figure is underestimated. The cost, not only to the family affected but to the CALD community as a whole, is immeasurable. Research, also suggests that a person's death has a great impact on 'professionals' who may have been involved in assisting the person (Gitlin, 2008) and that there may be cultural differences in the responses of professionals (Thomyangkoon & Leenaars, 2008)

### **Recommendations:**

- To continue capacity building initiatives focused on stigma reduction campaigns aimed at demystifying mental health issues amongst CALD communities, particularly in new and emerging communities.
- Supporting capacity building initiatives for service providers working with people from CALD communities at risk of suicide.
- That further cross-cultural research be implemented into the impact of suicidal behaviour on friends and family, and also on professionals from services who may be assisting people at risk of suicide.
- To develop and adopt a Charter of Rights of Suicide Survivors, such as that developed by WHO in 2005.

**b) the accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides (and the consequences of any under-reporting on understanding risk factors and providing services to those at risk);**

- Suicidal behaviour in CALD communities is largely unknown, due to the paucity of contemporary research into the topic and the limited number of demographic variables currently collected. This is of concern considering the diversity of the Australian community.
- It is contended that suicide figures published in ABS mortality data largely underestimate true suicide rates (AIHW, 2009) because of: coding issues, criteria used to determine intent, and length of time taken to classify a death as suicide. This issue further impacts on the collection of data specifically related to CALD communities.
- Coronial data, which is stored and disseminated via the NCIS, and available for possible analyses (i.e. age, sex, place of usual residence and country of birth) offers very little information regarding people from CALD communities and as a result suicides may be under-reported.
- The ABS in its *Causes of Death* (cat. No. 3303.0), collects information from the Registrars in each State or Territory, this is supplemented with information from NCIS, which includes the following migrant specific characteristics: age, country of birth, sex, place of usual residence and duration of residence in Australia, if born overseas. However, sometimes even these limited number of variables are not collected.
- Data may only be available at an aggregated level e.g. Regions of Birth as outlined in the ABS *Standard Australian Classification of Countries (2008)* (cat.no. 1269.0).
- Stigma that exists within some communities may also lead to an unwillingness amongst some coroners and families to report deaths as suicides and thus a number of suicide deaths may be categorized as unintentional or accidental (Walker et al., 2008).
- Inconsistent data collection impacts tremendously on the nature and scope of research which can be conducted, and consequently to inform policy and practice, which may potentially identify high risk groups such as second generation and older members of CALD communities. An article written by Luckett et al., (2005) in the NSW Public Health Bulletin, highlights the importance of collecting information to facilitate the exploration of interactions between cultural and socio-economic-demographic factors and their influence on health and well being.
- Luckett et al., (2005) identified that in 1999, the Council of Ministers of Immigration and Multicultural Affairs recognised the need for a variety of variables to be collected to explore cultural and language diversity. The set of variables contained within the recommended *Standards for Statistics on Cultural and Language Diversity* were developed in consultation with various organisations and consist of the following:

*Minimum Core Set:*

- Country of birth of person
- Main language other than English spoken at home
- Proficiency in spoken English
- Indigenous status

*The Minimum Core Set is drawn from a Standard Set which also includes:*

- Ancestry
  - Country of birth of mother
  - Country of birth of father
  - First language spoken
  - Languages spoken at home
  - Main language spoken at home
  - Religious affiliation
  - Year of arrival in Australia
- Previous research such as that undertaken by McDonald and Steel in NSW (1997), found a great diversity in the rates of suicide of people from different regions of birth, and that these rates were similar in rank order to those in their country of origin, with particular high rates of suicide among older immigrants.
  - McDonald and Steel's (1997) study investigated suicide mortality rates in NSW during the period 1970 – 1992 and found that out of 13,580 suicide deaths; 26.6% were females and 73.4% were males. 26.5% of people were overseas born, with 43.1% being born in mainly English speaking countries and 56.9% in non-English speaking countries.
  - Colucci (2006) cites research which indicates diversity in the rates and trends of suicidal behaviour between and within Asian and Western countries.  
*"For instance, the age distribution and male to female ratio are different ... In the former [Western] the male to female ratio is greater at 3 (or more):1 whereas in the latter [Asia] the ratio is smaller at*

2:1, with some countries like India showing a very similar ratio (1.4:1) and China showing higher suicide in women” (Colucci, 2006, p.3)

- McDonald and Steel (1997) also suggest that attempted suicide is important to study as it is a strong predictor of suicide.
- In line with extending the exploration of suicidality to include suicide, suicide attempts, suicidal ideation and deliberate self harm, Johnston et al. (2009) explored suicidal thoughts and behaviours among Australian adults. They investigated the findings from the 2007 National Survey of Mental Health and Wellbeing, however, a major limitation with this survey was that it relied on the respondent being sufficiently proficient in English to complete it and the researchers also stated that a “significant number of those experiencing suicidality did not receive treatment”.
- From their findings, Johnston et al (2009) suggest that suicide prevention frameworks and initiatives should target those at high risk and interventions should be both clinically and population based and at the interface to encourage people to seek assistance.
- The consequences of the limitations of the existing data collection practices highlighted above, may mean that existing suicide prevention initiatives, may not be addressing the specific needs of CALD communities living in Australia. For example, group figures are unable to explore the effect of factors such as: age, first and second generation, gender (Stewart, 2005) in addition to a person’s visa category, as a potential difference between forced and voluntary migration may be apparent in a person’s pre-migration experience.

### **Recommendations:**

- That a rigorous system of data collection be implemented in addition to conducting epidemiological studies, to develop a base of knowledge and understanding of suicidal behaviours within CALD communities. The exploration and understanding of existing and previous trends may assist in developing initiatives for established, new and emerging CALD communities and subsequent generational initiatives.
- Actively support proposals which advocate the implementation of a rigorous system of extensive data collection and data linkage initiatives federally (NCRIS, 2006) and within State and Territories.
- In line with the study undertaken by Lockett et al., (2005) consideration be given to auspice a study amongst major data collecting agencies (such as the ABS, NCIS, State and Territory Registries of Births Deaths Marriages, and Hospital Data collection systems), to identify what *Statistics on Cultural and Linguistic Diversity* are reported on and collected.
- In line with the study conducted by Johnston et al (2009), to conduct a survey amongst members of CALD communities who may have been excluded from the National Survey of Mental Health and Wellbeing because of their English language fluency levels to inform the development of suicide prevention initiatives.

### **c) *the appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide;***

- The ability to work across cultures competently involves a capacity to interact with, and be accepted by, individuals from culturally diverse groups. This provides a setting for the correct assessment and diagnosis of mental health problems.
- Previous research has indicated that people from CALD communities have lower rates of accessing community mental health services (McDonald & Steel, 1997) compared with Australian born.
- There are a variety of service barriers and psychosocial factors which may affect the level of utilization and also the diversity in service utilization between communities (Stolk et al., 2008) including a person’s visa category (Murray & Skull, 2005).
- In TMHCs experience, in an emergency situation, for example, when a person is acutely suicidal, it is important to be aware of the barriers to appropriate assessment of people from CALD communities, such as:
  - Difficulties in communication may occur due to limited English language skills.
  - Fluency is often lost in the presence of depression, psychosis or stressful situations.
  - Vocabulary for emotional states and words used to describe distress varies greatly across cultures.
  - Fluency may be difficult to assess.
  - Some religious or cultural beliefs may be interpreted as delusional when they are not (e.g. Nyagua & Harris, 2008).
  - Stigma attached to mental illness may lead to delays in seeking help and non disclosure of symptoms, by the person and/or family.

- Methods of suicide amongst CALD communities may differ from methods among the Australian born and when assessing availability of means of suicide it may be necessary to consider methods common within the particular community.
- Fry (2000) suggests that practical clinical issues could include:
  - Training for health professionals and other emergency personnel which addresses cultural and gender differences pertaining to suicide risk
  - Targeted interventions and education initiatives, which should be delivered by people from the same cultural group
  - Information on health and legal services should be offered.

**Recommendations:**

- That culturally sensitive practice training be rolled out for legal, health and mental health practitioners, in metropolitan, rural and regional Australia.
- Targeted recruitment of bilingual/bicultural staff, with knowledge and skills in culturally sensitive practice to work across the range of agencies mentioned above.
- That suicide prevention training be relevant to the roles played by agencies (e.g. primary, secondary and/or tertiary prevention) with the aim of increasing effectiveness between agencies.
- That standards are introduced in the use of interpreters in crisis situations and when assessing/supporting people at risk of suicide.
- That training be provided in suicide prevention for workers in the multicultural health and community sector.

**d) *the effectiveness, to date, of public awareness programmes and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide;***

- The Living is For Everyone (LIFE) Framework has produced 24 Fact Sheets. One of these Fact Sheets examines suicide prevention in CALD communities, and emphasizes the importance of culture in shaping the way that people view and interpret suicide.
- The Living is For Everyone (LIFE) Framework has developed the *Helping Someone at Risk of Suicide* leaflet. In liaison with Multicultural Mental Health Australia (in association with the Australian Department of Health and Ageing), they are available in 23 languages and aim to assist those who suspect that someone close to them may be considering suicide.
- The TMHC has found that using different mediums of communication particularly multicultural radio (e.g. SBS radio) and print (e.g. translated resources) have been particularly useful in reducing stigma within CALD communities in a culturally relevant way.

**Recommendations:**

- To support the development of targeted, culturally appropriate suicide prevention models to: improve community strength, resilience and capacity, inform and educate the public, decrease stigma and encourage help seeking. This may include: stigma reduction training, support and resources for carers and families, use of translated resources and information on accessing services.
- To support the ongoing facilitation of cultural awareness training, distribution of translated resources and clinical services which are identified as meeting the needs of specific targeted groups particularly new and emerging communities and service providers working with CALD communities.

**e) *the efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk;***

The NSW Health *Framework for Suicide Risk Assessment and Management* is a useful resource for service providers to identify risk and protective factors for suicidal behavior. Whilst the Framework has identified a limited number of risk and protective factors for CALD populations, it would be significantly enhanced by further research which explores the risk and protective factors for current and emerging CALD communities.

**Recommendations:**

- That suicide prevention programs/training be designed to address the complexities and multiple barriers that CALD communities face.
- To support research into the risk and protective factors for current and emerging CALD communities.

**f) the role of targeted programmes and services that address the particular circumstances of high-risk groups;**

- There are large gaps in research on suicidal behaviour amongst young people from CALD communities and in particular second generation immigrants (Dusevic et al., 2001b).
- A study by Morrell, Taylor, Slaytor and Ford (1999) concluded that female migrants overall (with diversity in regions of birth) had a significantly higher risk of suicide than Australian-born females suicide, and amongst migrant males, those living in non-metropolitan areas account for most of the excess of male suicide in rural NSW.
- Risk and protective factors may not be the same for different suicidal behaviours, For example, Fry (2000) conducted a study in Blacktown, NSW which indicated that 50-80% of those expressing self-harming behaviour did not attend hospital. Also, there appears to be a vulnerability amongst young migrant women and second generation migrants in relation to attempted suicide.
- Fry (2000) suggests that there may be a paradox of hypothesized protective factors, which when taken to the extreme may become risk factors for certain members of our community. For example, family and intergenerational conflict may be associated with increased risk of self-harming behaviours. For example, young people may face intra and inter cultural conflict (Kennedy et al., 2005).
- McCallum (2005), states that the prevalence of chronic nervous and mental disorders amongst CALD communities is estimated to rise from 14% at ages 60-64, to 26% of people aged 75 years and over, compared to about a rate of 16% for Australian born older people. By 2011 it is projected that 23% of older Australians (65 and over) will be from CALD communities and that past migration patterns will significantly affect the mix of older people's countries of birth (AIHW, 2004).
- Recent studies also show an association between problem gambling and high rates of both suicidal ideation and suicide attempt (Zangeneh, 2005). Suicidal ideation of problem gamblers from CALD communities is unknown.
- Adaptation of existing training and resources may be appropriate e.g . by the cultural adaptation of training courses and manuals and translation of material. Training programmes could be conducted in a targeted community's language (Minas, Colucci and Jorm, 2009) where cultural validity and evidence based research exists.

**Recommendations:**

- In line with the *NSW Multicultural Mental Health Plan 2008-2012* TMHC recommends targeted and collaborative suicide prevention activities which include improving the use of interpreters and translators, stigma reduction campaigns, developing mental health literacy and resources particularly for new and emerging communities.
- Campaigns need to consider the complex relationships that exist between ethnicity, culture, socioeconomic factors, pre-migration experiences, acculturation and more recent studies which show a link between gambling and suicide.
- There is a need to work collaboratively with communities and individuals, to assist explorations of what communities identify as risk and protective factors for suicidal behaviour (e.g. migrant status, age, stage of life, economic status, availability of social supports and this may vary between different generations of immigrants) to ascertain whether these factors are unique and / or generalisable across cultures.
- To ensure models of suicide prevention and early intervention are relevant to the cultural and linguistic needs of the targeted community/population.
- To conduct research which explores the ethnocultural aspects of suicidal behaviour and how these may differ between and within CALD communities, for example, young people and older people.
- That the complexities of suicidal behaviour in young migrant women be researched to explore personal experiences along with quantitative analysis.

**g) the adequacy of the current programme of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy;**

- A recent review of research priorities in suicide prevention in Australia (Robinson et al., 2008) indicates that during the period 1996 – 2006, out of 209 Australian published journal articles and 26 funded grants on suicide prevention identified, nil targeted people from CALD communities.
- Notwithstanding the dearth of contemporary research conducted, previous research undertaken has indicated that there is great diversity in suicide rates between people from different regions / countries of birth (Steel and McDonald, 2000).
- Previous suicide studies have largely focused on country of birth and not explored risk and protective factors in suicidal behaviour (Minas et al., 2007) and investigated whether risk and

protective factors in the general population are the same for the immigrant population e.g. mental ill-health, alcohol and substance abuse, social disadvantage (Dusevic, Baume & Malak, 2001).

- There is also an absence of contemporary research regarding whether risk and protective factors are similar for first and second generation immigrants, between genders, motivations for migrating and possible age effects.

#### **Recommendations:**

- To support the collection of both quantitative and qualitative information on patterns of suicide for CALD communities within an evidenced-based suicide prevention framework.
- To implement research studies / pilot projects, which identify appropriate models of prevention and early intervention for current and emerging CALD communities and to explore risk and protective factors within the cultural milieu of the 'at risk groups'.

#### ***h) the effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress***

- The LIFE framework specifically refers to suicide and people from CALD background and suicide in refugee communities.
- The LIFE webpage gives information on two initiatives being supported and Factsheet 20, identifies the need to consider CALD community needs.

#### **Recommendations:**

- In addition, to the Australian Suicide Prevention Advisory Council to establish a working group which could facilitate, monitor and evaluate proactive and targeted support for high risk groups identified in the LIFE (2007) Framework such as people from CALD communities including established, refugee and new and emerging communities.
- To develop initiatives which target people from CALD communities (established, new and emerging, first and second generation migrants), in addition to suicide prevention programmes targeting refugee communities.
- That suicide prevention activities use multiple sources to guide the development of initiatives and programmes, such as obtaining the views of key stakeholders, relevant literature reviews and an exploration of existing initiatives.
- To facilitate the integration of suicide prevention activities into other policies and frameworks such as the National Mental Health Plan.
- To prioritise the development of suicide risk assessment research which identifies differences in suicidal behaviour amongst CALD populations, the assessment of risk to self, and which assesses the risk of harm to self by others (e.g. victims of domestic violence) and by self to others (Stewart, 2005).



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