SUBMISSION

from the

VICTORIAN TRANSCULTURAL PSYCHIATRY UNIT

to the

SENATE SELECT COMMITTEE ON MENTAL HEALTH

on its

INQUIRY INTO THE PROVISION OF MENTAL HEALTH SERVICES IN AUSTRALIA

May 2005

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Abbreviations

AMHS	Area Mental Health Service(s)
BCM	Bilingual Case Management
CALD	culturally and linguistically diverse
CAMHS	Child and Adolescent Mental Health Service (Victoria)
CATTs	Crisis Assessment and Treatment Teams
MHS	Mental Health Service(s)
NESB	Non-English Speaking Background
PDRSS	Psychiatric Disability Rehabilitation and Support Service(s)
VTPU	Victorian Transcultural Psychiatry Unit

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1 INTRODUCTION

1.1 Victorian Transcultural Psychiatry Unit

This submission has been prepared by the Victorian Transcultural Psychiatry Unit (VTPU). The VTPU is one of seven State or Territory-based transcultural mental health units or networks in Australia[1]. It was established in 1989 in order to facilitate the improvement of mental health services for members of culturally and linguistically diverse (CALD) communities in Victoria. The VTPU is a statewide service within the Victorian mental health system (see Annex C – Victorian Mental Health framework). It has evolved from a small clinical service to a service that supports Area Mental Health Services (AMHS) and Psychiatric Disability Rehabilitation and Support Services (PDRSS) in working with CALD communities throughout Victoria. The VTPU is funded through a service agreement with the Mental Health Branch in the Department of Human Services, State Government of Victoria, and is administered by St Vincent's Health (Melbourne).

1.2 Focus of the submission

This submission will address those parts of the Inquiry's Terms of Reference (see Annex D) in which the VTPU has experience and expertise. With the exception of a summary of some findings from a recent VTPU study evaluating the Better Outcomes initiative and which pertain to the role of primary care in mental health service provision in general, discussion will be confined to the provision of mental health services to CALD communities (excluding refugees and Aboriginal and Torres Strait Islander people) in Victoria. Comments and recommendations are made in relation to points (a) – (d); (f) – (i); (l); and (n) – (p) of the Inquiry's Terms of Reference. It should also be noted that while most of the observations are supported by research, some are based on anecdotal evidence communicated informally to VTPU staff members in the course of their work with Victorian mental health services.

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[1] NSW Transcultural Mental Health Centre, Queensland Transcultural Mental Health Centre, WA Transcultural Mental Health Centre, Tasmanian Transcultural Mental Health Network, ACT Transcultural Mental Health Network, and the Multicultural Mental Health Access Program (McMHAP) in South Australia.

2 GENERAL COMMENTS

2.1 Cultural and linguistic diversity in Australia and Victoria

Australian society is culturally and linguistically diverse, with 21.9 per cent of Australians reporting in the 2001 Census as having been born overseas, and 13.3 per cent born in non-English speaking countries. This is also the case in Victoria, where the equivalent 2001 Census figures are 23.4 per cent and 16.7 per cent respectively. In addition, 20.1 per cent of Victorians have at least one parent born overseas, and there are over 180 different languages spoken in Victorian homes (Victorian Office of Multicultural Affairs). For several decades it has been widely recognised at all levels of government that members of CALD communities have special needs and that government policies and service delivery are obliged to take these into account in order to maximise the opportunities members of CALD communities to fully participate in social and public life.

> *"Our diversity is an important consideration in the formulation of Government policies, programs and in the delivery of services. It must be supported and respected to realise the potential benefits. We are committed to reducing inequality and ensuring that government policies and strategies are responsive to all Victorians. … As such, we encourage Government departments, agencies and community organisations to develop specific multicultural programs applicable to their own services and client groups."*
>
> **HON STEVE BRACKS MP**
> **Premier of Victoria and Minister for Multicultural Affairs**[2]

2.2 Mental health and CALD communities: policy, programs and research

Motivated in part by research and advocacy, and in part by a general desire to factor in the needs of special groups, National and State/Territory mental health policies in Australia have made commendable efforts to incorporate consideration of CALD communities. Table 1 {Klimidis, 2003 #82} grades the variety of policies, both Commonwealth and State/Territory, developed under the National Mental Health Strategy for their inclusion of references to CALD communities. Clearly it is rare for a policy not to mention CALD communities.

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[2] From "2001 Census Statistics No. 1-1 (First reprint) Victoria: Local Government Areas Top 30 Birthplace Groups (Overseas-born)", Victorian Office of Multicultural Affairs, Department for Victorian Communities, June 2003

Table 1: List of Commonwealth and State/Territory Mental Health Policies and level of inclusion of statements related to CALD communities (to November 2003)

MENTAL HEALTH POLICY TITLE AND YEAR OF RELEASE		CONTENT RATING[1]
Commonwealth	1.National Mental Health Policy (Australian Health Ministers, 1992)	MH2
	2. Mental Health Statement of Rights and Responsibilities (Australian Health Ministers, 1997)	MH2
	3. National Standards for Mental Health Services, 1996	MH3
	4. Second National Mental Health Plan, 1998	MH2, MH4
	5. Mental Health Promotion and Prevention National Action Plan Under the Second National Mental Health Plan: 1998-2003, 1999	MH3
	6. National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000	MH6
	7. Youth suicide in Australia: the national youth suicide prevention strategy, 1997	MH1
	8. National Action Plan for Depression, 2000	D2
	9. Life – A framework for prevention of suicide and self-harm in Australia, 2000	MH5
Australian Capital Territory	1. The future of Mental Health Services in the Australian Capital Territory – Moving Towards 2000 and Beyond – A Whole of Territory Strategic Plan 1998-2001, 1998	MH5
New South Wales	1. Caring for Mental Health – A Framework for Mental Health Care in NSW, 1998	MH6*
	2. Caring for Older People's Mental Health – A Strategy for the Delivery of Mental Health Care for Older People in NSW, 1998	MH5
	3. Caring for Mental Health in a Multicultural Society – A Strategy for the Mental Health Care of People from Culturally and Linguistically Diverse Backgrounds, 1999	TMH
	4. Getting in Early – A Framework for Early Intervention and Prevention in Mental Health for Young People in NSW, 2001	MH2
Tasmania	1. A Plan for Now and the Future – Strategic Plan for 1999-2002, 1999	MH5
	2. Tasmanian Multicultural Policy, 2001	GM
	3. Rural Mental Health Plan	MH2
Western Australia	1. Making a Commitment – The Mental Health Plan for WA, 1996	MH3
	2. Transculturally Oriented Mental Health Services, 2001	TMH
Queensland	1. Queensland Health non-English speaking background mental health policy statement, 1995	TMH
	2. Ten year mental health strategy of Queensland, 1996	MH3
	3. Queensland Health Multicultural Policy Statement, 2000	GM
South Australia	1. A New Millennium – A new beginning, 2000-2005 - Mental Health in South Australia, 2000	MH2
Victoria	1. New Directions for Victoria's Mental Health Services: The next five years, 2002	MH6
	2. Victoria's Mental Health Services: Framework for service delivery, 1996	MH3
	3. Improving services for people from a non-English speaking background, 1996	TMH

[1] MH1 = Mental Health or Suicide Prevention Policy – no reference to ethnic minority groups
MH2 = Mental Health or Suicide Prevention Policy – with reference to ethnic minority groups
MH3 = Mental Health or Suicide Prevention Policy – with special section on ethnic minority groups
MH4 = Mental Health or Suicide Prevention Policy – with reference to depression/suicide
MH5 = Mental Health or Suicide Prevention Policy – with reference to depression/suicide and reference to ethnic minority groups
MH6 = Mental Health or Suicide Prevention Policy – with reference to depression and special section on ethnic minority groups
D1 = Depression specific policy – no reference to ethnic minority groups
D2 = Depression specific policy – with reference to ethnic minority groups
TMH = Transcultural Mental Health Policy
GM = Multicultural General Health or General Multicultural Policy

At the national level, the most significant recent development is the Framework for the Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia (Commonwealth of Australia, 2004). This document applies a multicultural lens to the third National Mental Health Plan 2003 – 2008 (Commonwealth of Australia, 2003). It provides a comprehensive summary of the difficulties CALD communities face in relation to mental health problems and accessing effective services, and also the quality of services delivered, and makes a range of policy recommendations aimed at addressing these. In addition to the Framework, the suite of documents that make up the National Mental Health Strategy (the three National Health Plans, the National Standards for Services (see Annex A), the Mental Health Statements of Rights and Responsibilities, and the National Practice Standards for the Mental Health Workforce) contain numerous references to the need to improve the mental health of and access to effective services for CALD communities. In particular, National Mental Health Standard 7 – Cultural Awareness requires that the MHS provide 'non-discriminatory treatment and support which is sensitive to the social and cultural values of the consumer and the consumer's family and community'.

In Victoria, the key policy document is New Directions for Victoria's Mental Health Services: The Next Five Years (Victorian Government, 2002). New Directions identifies the need to further develop service capacity for CALD communities and describes several immediate and future actions to be undertaken towards this. A range of supporting policy documents such as the Standards for Psychiatric Disability Rehabilitation and Support Services (Victorian Government, 2004) and the Chief Psychiatrist's Guideline, Working Together with Families and Carers (Victorian Government, 2005b) also refer to CALD communities as a sub-group of the population that needs to be taken into consideration. The 1996 policy document, Victoria's Mental Health Services: Improving Services for People from a Non-English Speaking Background ('the 1996 Policy'), has provided a wide range of directions in the provision of public mental health services to members of CALD communities. Furthermore, an updated policy is under development with the consultation paper, Towards a Cultural and Linguistic Diversity for the Specialist Mental Health Sector, 2005-08 currently being circulated (Victorian Government, 2005a).

A range of programs and initiatives have also been developed, aimed at improving the accessibility of mental health services to CALD communities, cultural awareness and knowledge in the mental health workforce, and mental health literacy of CALD community members. Examples of Victorian initiatives (explained in more detail below) include State Government-funded Ethnic Mental Health Consultants who work with each of the area mental health services[3] (AMHS), the Bilingual Case Management Program operating in the Western Metropolitan Region since 1997, the application of a weighted formula for accommodating interpreter needs within AMHS, the inclusion of CALD communities in incentive funding for MHS, and a range of smaller projects in areas such as community education, training for primary care workers, etc. However, these smaller projects have usually been piecemeal in nature – short-term or of limited coverage across different CALD communities, and rarely supported by core funding.

CALD-oriented policy in Victoria (and in most other states) has not, in the main, been guided by research, and especially work on the particular conditions of CALD communities in Australia. This is due to the lack of a sufficient body of research in the area of CALD community mental health – research that is relevant to the development of policy, the development of service programs, and to a contribution to curricula in professional training and workforce competence development, as we indicate below.

Much yet needs to be done before the provision of mental health services in Victoria can be judged to be adequately addressing CALD community needs. While policies have been comprehensive and innovative (such as the 1996 Policy) there remains a significant problem in their implementation and in the priority given to the issues of CALD communities.

2.3 Summary of CALD community mental health issues

In Victoria, there is a lack of information on the need for mental health services in different CALD communities and sub-groups within these, due to the shortage of community-based research noted above. However, findings from what studies are available indicate that there is great variation in prevalence of mental disorders across CALD communities, and higher rates of mental disorder in some, including several of the more established resident communities. Research also suggests that CALD communities have greater difficulties in gaining access to specialist mental

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[3] There are 21 AMHS in Victoria, established in 1994-1995.

health services (both inpatient and community services) compared with the Australian-born. They continue to have higher rates of involuntary admissions to inpatient facilities and evidence suggests that they may access services at a late stage when the clinical state is more severe. Representation in community mental health services is lower than in inpatient facilities and representation in any form of mental health services is particularly low for those with lower English language facility. Stigma associated with mental illness – both among CALD communities (consumers, carers and families) and health professionals – remains a major problem. Competence in conducting clinical work across language and cultural barriers remains low among many mental health clinicians and workforce turnover, difficulties in releasing staff for training, are among the most significant challenges to improving cultural awareness and competencies. Further, there are systemic rigidities and resource deficits that limit the deployment of bilingual/bicultural mental health clinicians, despite Victorian-based research to show that ethnic matching of clinicians and consumers is an effective means of providing equitable services to CALD communities. In addition, interpreter availability in the provision of mental health services to CALD consumers and carers remains problematic. This is due to funding shortages, as well as limited professional development for interpreters in the area mental health, and for mental health staff on effective ways of working with interpreters. There is also insufficient funding for interpreting related to the work of PDRSS and general practice – particularly in relation to the new emphasis on orienting general practice towards dealing with common mental disorders, for which there is no provision for funded interpreting.

Important directions such as community development (towards reducing unmet need for services and implementing early intervention) have been difficult to establish given the structure and funding priorities of mental health services. Similarly, partnerships with (mostly) willing ethno-specific community organizations have not often been attempted (despite the 1996 Policy). Where they have been tried, they have been infused with difficulties in the definition of roles, boundaries of responsibility, and issues of mental health competency. Consumer and carer participation in the development and delivery of mental health programmes continues to lag behind for CALD communities relative to the mainstream. Providing an appropriate mental health system response in relation to higher prevalence disorders in CALD communities can be expected to be sub-optimal given the limited mechanisms established (e.g. Primary Mental Health and Early Intervention Teams, PMHTs) together with the meagre support provided to these mechanisms to address issues of cultural and linguistic community diversity. At the point of primary care itself, as already noted this system is currently being encouraged to better address community mental health. Within this development there is a need to ensure that CALD issues are addressed, particularly in localities where there are large CALD populations. Finally, there remains a national problem of lack of research into the mental health of CALD communities, from essential epidemiological work or alternatively local needs analyses, to studies of mental health literacy and pathways to care, to studies in the quality of care currently provided, and to studies of effectiveness and outcome of current and newly developed innovative approaches. Lack of such work implies that policies are poorly informed (based largely on opinion and advocacy processes), service design is poorly informed and clinical service delivery may not be as effective or as efficient as it ought to be.

3 SPECIFIC COMMENTS

a. To what extent has the National Mental Health Strategy, the resources committed to it, and the division of responsibility for policy and funding between all levels of government achieved the aims and objectives of the Strategy, and what are the barriers to progress?

The broad aims of the National Mental Health Strategy are to:

- Promote the mental health of the Australian community;
- Prevent the development of mental disorder;
- Reduce the impact of mental disorder on individuals, families and the community; and,
- Assure the rights of people with mental disorder.

These aims have a broad population health focus and emphasise the importance of mental health promotion, illness prevention and early intervention, timely access to mental health services for consumers and their carers (including continuity of care where appropriate), a focus on recovery, and consumer rights. As already noted, the various policy documents that constitute the strategy recognise that special attention must be paid to ensuring these goals are pursued with equal vigour, if not with greater assertiveness, for CALD communities.

It is at the level of resources, however, that the Strategy falls short when it comes to people from CALD backgrounds. Put simply, funding is insufficient to ensure that priority is given to CALD issues at the critical point of service delivery. In Victoria, there is currently limited means of providing CALD community-specific activities in a systemic, state-wide manner. This is particularly the case in relation to community development and community mental health education, service access, the development of a culturally competent mental health workforce, and language services. As well, implementation of the Strategy in relation to CALD communities would be better served by a geographically representative Multicultural Mental Health Australia.

(i) Community development and community education

Cultural factors significantly influence mental health literacy, pathways to care, attitudes towards mental illness, responses to illness, and illness-related communication, among other things. Community development and education regarding mental illness is a primary approach to dealing with such issues. AMHS would need to undertake concerted community development and community education initiatives in order to meet Commonwealth and State Government policy requirements in relation CALD communities in order to address mental health issues in such communities. For example, Standard 4 of the National Standards for Mental Health places responsibility on services to contribute to community acceptance and the reduction of stigma of people with mental illness. However, AMHS are inadequately resourced and structured to respond to anything beyond their statutory obligations and their work is focussed on treating the most seriously mentally ill. They are not funded or supported to undertake broader community education or community development initiatives that we see to be relevant, if not crucial, to the issue of access to care by CALD communities. Similarly, AMHS have little capacity to work with high prevalence disorders such as depression and anxiety except through the PMHTs. There is effectively a disjunction between the policy intention on the responsibility of MHS to undertake these activities and their actual, resourced role which is to deal with the most seriously mentally ill. In order for mental health promotion/illness prevention activities to be undertaken, responsibility needs to be held in the service sector for such activities. There is currently no funding stream which prioritises these areas of work and subsequently, there is no sustainable means of engaging in these types of activities.

Box 1: The Multicultural Education on Depression (MED) Project

In 2002 the VTPU in collaboration with the Australian Greek Welfare Society developed and conducted a community education programme on depression, called Multicultural Education on Depression. The program, run over a year and conducted in Greek, involved four one-day information delivery and participant discussions across the Melbourne metropolitan area. The program attracted the direct involvement of 270 members of the Greek community, however the estimated reach of the information would be closer to 500 community members. The aim of the sessions was to reduce ‘unmet need’ by providing sufficient information on depression to aid self-diagnosis, information on treatments and self-management, de-stigmatising the condition and giving information on locally available services. Where available AMHS bilingual clinicians provided information about locally available public mental health services. The project attracted the interest of community radio and several sessions were delivered through this medium. Community responses included a number of contacts with Australian Greek Welfare Society and radio stations seeking assistance, requests for additional one-day sessions and positive feedback from community participants.

Based on the success of the MED program, various attempts have been made by the VTPU in partnership with other CALD community organizations as well as the Depression Awareness Research Project of the Victorian Mental Health Institute to extend the program through improved models. Unfortunately funding has not yet been forthcoming. The larger point is that attempting to incorporate such models within the regular activity of the mental health sector for wider and sustained community reach is likely to remain problematic even if projects can be shown to be effective by evaluation. Despite prevention and early intervention policy, such community development approaches are not a funding or programming priority for any of the mental health services. On the other hand ethno-specific community organizations, as shown by the MED process, are ready to invest time, money and enthusiasm to such work.

Recommendation: That mental health promotion, illness prevention and early intervention activities for CALD communities are prioritised at the State government level for the funding of collaborative activities by mental health, welfare and community services.

(ii) Utilisation of mental health services

Low rates of access to MHS by members of CALD communities is a long-standing problem, highlighted in Victoria in the early {Minas, 1990 #83} and mid-1990s (Klimidis, et al., 1998) and again more recently (see below). Analyses of MHS utilization by CALD communities in NSW and WA support the Victorian observations (McDonald and Steel, 1997; Bruxner, Febbo and Burvill) and suggest that under-representation of CALD communities in mental health services may be a national problem. Unpublished data from the VTPU on MHS access by ethnic communities in Victoria in 2001-02 provide an illustration of the issue. Table 2 and Figure 1 below show that in this period, with the exception of the Turkish-born community, all CALD communities in Victoria accessed mental health services at a significantly lower rate per 10,000 persons than did the Australian-born community. Of particular note are the access rates of the Hong Kong and Malaysian communities, which are one-quarter of the Australian-born rates.

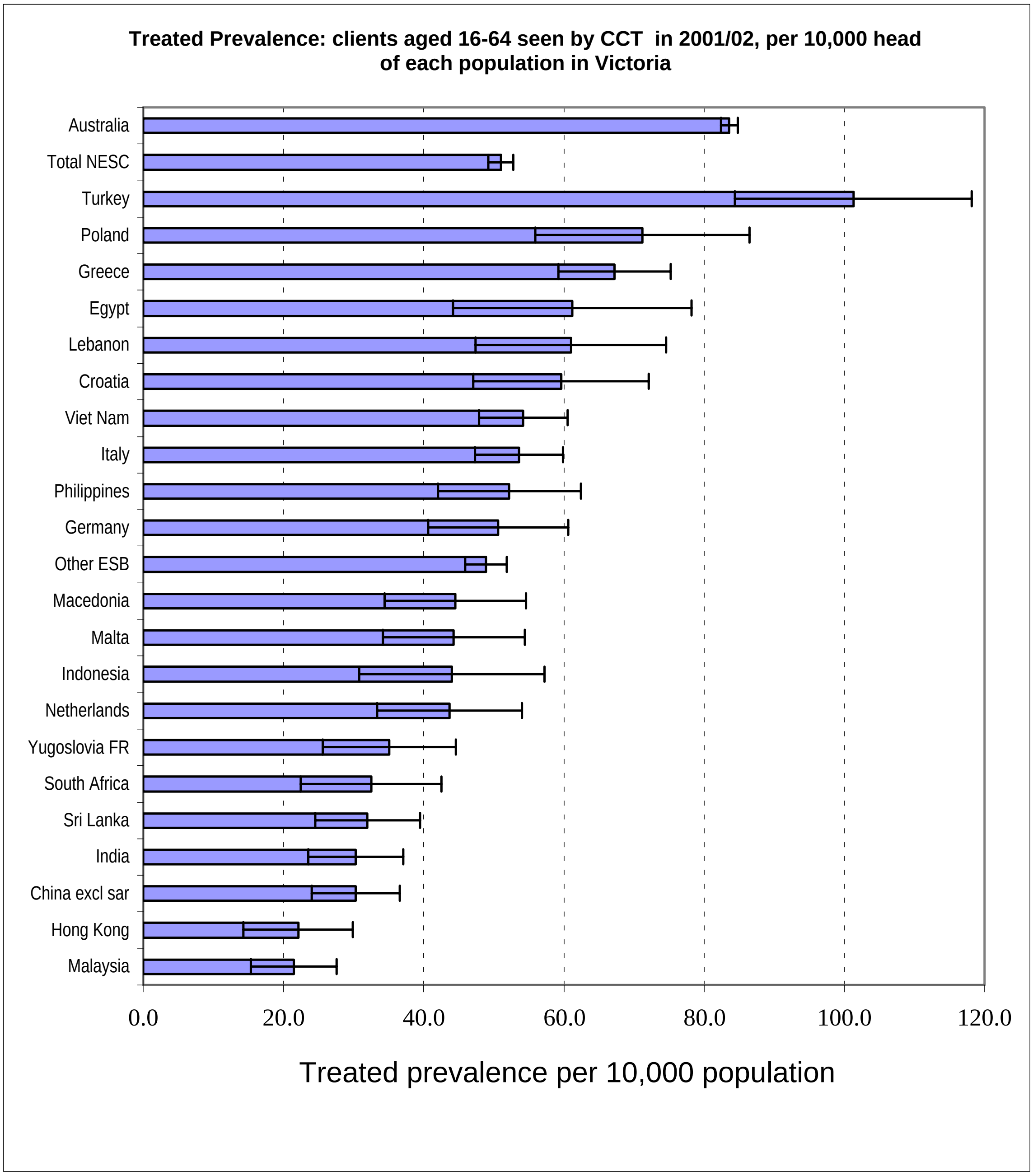
Table 2: Access Rates by Victoria's Ethnic Communities to Continuing Care Teams of Adult Mental Health Services per 10,000 head of each population, in 2001/02 (sorted by prevalence)

Birthplace	**Population aged 15-64 in 2001**	**Clients 16-64 seen in 01/02**	**Prevalence per 10,000 pop'n**	**95% confidence Intervals[1]**
Turkey	13,618	138	101.3	84.4 - 118.2
Australia	2,119,156	17,726	83.6	82.4 - 84.9
Poland	11,805	84	71.2	55.9 - 86.4
Greece	40,311	271	67.2	59.2 - 75.2
Egypt	8,173	50	61.2	44.2 - 78.1
Lebanon	12,617	77	61.0	47.4 - 74.7
Croatia	14,599	87	59.6	47.1 - 72.1
Viet Nam	51,430	279	54.2	47.9 - 60.6
Italy	52,806	283	53.6	47.3 - 59.8
Philippines	19,343	101	52.2	42.0 - 62.4
Germany	19,570	99	50.6	40.6 - 60.6
Other ESB	216,591	1,059	48.9	45.9 - 51.8
Macedonia	16,619	74	44.5	34.4 - 54.7
Malta	16,949	75	44.3	34.2 - 54.3
Indonesia	9,783	43	44.0	30.8 - 57.1
Netherlands	15,801	69	43.7	33.4 - 54.0
Yugoslavia FR	15,107	53	35.1	25.6 - 44.5
South Africa	12,619	41	32.5	22.5 - 42.4
Sri Lanka	21,904	70	32.0	24.5 - 39.4
China excl SAR[2]	29,393	89	30.3	24.0 - 36.6
India	25,113	76	30.3	23.5 - 37.1
Hong Kong	14,039	31	22.1	14.3 - 29.9
Malaysia	22,287	48	21.5	15.4 - 27.6
Total NESC[3]	**609,727**	**3,112**	51.0	49.2 - 52.8
Missing	137,331	552		
Total	**3,082,805**	**22,449**		

[1] Where the confidence interval of a birthplace does not overlap with the Australian prevalence of 83.6, the prevalence for that community is significantly different to the prevalence for the Australian-born.
[2] Special Administrative Region
[3] Non-English Speaking Country: country where English is not the first language.

Data Sources: Australian Bureau of Statistics, 2001 Census; Mental Health Branch, Department of Human Services, Victoria.

Figure 1: Representation of CALD communities in mental health services.



Low access rates by ethnic communities in Victoria have been attributed in the transcultural mental health literature to a range of factors such as the language barrier, lack of knowledge of services, differing explanatory models of illness, extended family care, preference for traditional treatment, reluctance to seek treatment due to stigma or shame, failure of case recognition or reluctance to refer by GPs, and lack of ethnically-matched mental health staff (Cheung & Spears, 1995; Collins *et al.*, 2002; Commander *et al.*, 1999; Commander *et al.*, 1997; Eisenbruch, 1990; Fan, 1999; Guarnaccia & Parra, 1996; Lam & Kavanagh, 1996; Li *et al.*, 1999; Lin *et al.*, 1978; B. McDonald & Steel, 1997; Mesier & Gurr, 1996; I.H. Minas *et al.*, 1996; Rooney *et al.*, 1998; Sang, 1996; Snowden & Cheung, 1990; Stolk, 1996; G.W. Stuart *et al.*, 1998; Takeuchi *et al.*, 1988; S. Ziguras *et al.*, 2003). Results from an unpublished Australian study (Klimidis *et al.*, under review) suggest that the exceptionally low access of treatment by Chinese and perhaps Southeast Asian communities may be the result of factors other than low mental health literacy (which was found to exceed that of the Australian-born community), such as tolerance for mental disorders, reliance on self-management or family-management, 'stoicism', or stigma. Whatever the underlying reasons, low rates of MHS access are likely to contribute to undue suffering and isolation by individuals with a mental illness, and families may be bearing undue burdens that might otherwise be alleviated with the support of mental health services (Collins et al., 2002).

In addition to low overall access, there is a high proportion of people of CALD background among involuntary admissions, which is a consistent Australian finding (Klimidis *et al.*, 1999; B. McDonald & Steel, 1997; Stolk, 1996, 2005). Severe mental disorders have been found to occur at similar rates across cultures (Jablensky *et al.*, 1992) and therefore mentally ill persons from communities with low MHS access rates are likely to require mental health service intervention at some stage (Andrews *et al.*, 2001; Jablensky *et al.*, 2000), particularly when families become unable to cope due to the disruptiveness of severe disorders (Cochrane & Bal, 1987). That members from CALD communities do not seek mental health services until they are severely disturbed is consistent with the high proportions of involuntary admissions of CALD patients relative to Australian-born patients. Evidence that CALD patients constitute a greater proportion of inpatients than of community clients (Klimidis et al., 1999; Stolk, 2005) lends support to this argument. Failure to address low access rates, therefore, has implications not only for the mentally ill person and their family, but also for mental health services, which may be required to intervene at a late stage of a disorder when the client may be in crisis and severely disturbed.

Recommendation: Given the inadequacy of existing epidemiological data and pathways to care information on CALD communities, further research into low utilisation of MHS by CALD communities should be funded.

(iii) Cultural competence of the mental health workforce

According to Criteria 7.3 of National Mental Health Standard 7, the MHS should employ staff who are bilingual or who have relevant experience in the provision of treatment and support to the specific social and cultural groups represented in the defined community. However, Victoria's Bilingual Case Management (BCM) Program, which is addressed to Standard 7, and which has been extremely successful has not been expanded beyond the Western Metropolitan Region of Melbourne. A further constraint in wider dissemination of the program is that attracting people of CALD background to work in the mental health sector has been problematic.

The BCM Program was introduced in 1997 in the four AMHS of the Western Metropolitan Region of Melbourne, and has shown remarkable success in improving access to mental health services and equity in treatment for clients who are culturally and linguistically matched with a Bilingual Case Manager (S. Ziguras et al., 2003; S. Ziguras *et al.*, 2000). Despite its demonstrated success, and despite sustained active promotion of the BCM program by the VTPU, other mental health services in Victoria have not adopted the program. This is especially troublesome in areas where population cultural and language diversity is clearly evident in the catchment of the AMHS. The lack of uptake of the program appears in part to be due to the community development and education function that is integral to the success of the BCM role. These community development activities are designed to reduce stigma and increase access, and require BCMs to carry a 25 per cent lower caseload than other case managers, thus reducing the overall effective full-time direct case management of the service. In addition there have been tensions within the existing BCM program to equate caseloads across case managers and there is a continuing need to monitor activities so that the fidelity of the BCM model is not compromised.

A further factor impeding the functioning and expansion of the BCM program has been the difficulties in recruiting BCM staff. Reasons for this may include the stigma associated with mental illness in ethnic communities, which deters young people from considering a mental health career; the current absence of a career path for BCMs, a lack of resources to support a larger body of BCMs across Victoria; the lack of professional and financial recognition of the specialist cultural, linguistic and clinical knowledge required for effective performance of the role; and personal and family choices regarding career paths. One option for addressing the lack of CALD background mental health practitioners may be to focus promotion in psychiatric nursing. As a professional group, psychiatric nurses comprise approximately 60 per cent of the mental health workforce. More broadly, it may be possible to address the lack of cultural and linguistic diversity in the mental health workforce through more active recruitment and promotion via professional associations, registration boards and educational programs supplying graduates in the mental health professions.

Recommendation: In view of the under-utilisation of mental health services by CALD communities:

- ***Priority should be placed on extending the Bilingual Case Management Program into mental health services in Victoria***
- ***Mental health services should be encouraged to employ bilingual staff through the provision of funding to cover the case management effective full-time shortfall associated with BCM community development work;***
- ***Funding should be provided for coordination of state-wide BCM programs with the aim of liaising with mental health services to develop a career structure, as well as providing a forum for BCM program planning, supervision, mentoring, peer-support, and collaborative projects; and,***
- ***Recruitment projects (at schools and universities and utilising relevant professional groups) should be funded to foster entry into mental health service careers by CALD young people.***

A particular disadvantage for CALD aged people is the use of culturally insensitive mental health instruments to assess cognitive functioning. The Mini-Mental State Examination (MMSE) (Folstein *et al.*, 1975) is widely used in Aged Persons' Mental Health Services to screen for cognitive impairment, such as may be associated with Alzheimer's disease. Scoring on the MMSE is heavily reliant on education level and culture-specific knowledge, and norms have not been developed for Australian ethnic communities (Burnam *et al.*, 1987; Klimidis & Tokgoz, undated). Even if the MMSE is translated, difficulty level and meaning of items may be distorted (Bagulho & Chiu, 1997). A senior interpreter who manages an interpreter service has reported to VTPU staff that when the MMSE is administered to patients with low English proficiency through an interpreter by staff unfamiliar with the cultural bias of the MMSE, scores may underestimate the actual functioning of the patient. This may disadvantage patients with low English proficiency as those scoring below a particular cut-off score are not offered medication to delay the onset of Alzheimer’s disease. A more culturally fair alternative may be the Rowland Universal Dementia Assessment Scale (RUDAS) (Storey *et al.*, 2004).

Recommendation: That funding be provided for a project to educate aged mental health services staff about the known cultural bias of the MMSE; and to investigate the cross-cultural validity and reliability of the RUDAS and other approaches to culturally valid cognitive assessment.

(iv) Language services (interpreting and translated materials)

With respect to interpreter services for the MHS, the principal issues are: interpreter availability (particularly for newly arrived language groups); cost (especially in providing rural and after-hours services); perceived lack of legitimacy of spending money on interpreting services for routine clinical encounters (especially by nursing staff); lack of clarity regarding the necessity of engaging interpreters at the critical points in the patient care process (related to the lack of procedural protocols in service delivery or ignorance of available protocols); lack of clarity among mental health staff in relation to assessing language proficiency in clients; lack of training among mental health staff on working together with an interpreter; and lack of mental health training for interpreters.

An additional issue related to language and communication is the availability and use of translated information on mental illness and mental services and policy (e.g., Statement of Rights and Responsibilities). Often these materials are not available in services or are available but only for the larger language groups. Availability is often based on limited project funding for the development and dissemination of such information and there is no continuing item of expenditure to expand the range of materials and languages. Furthermore, across services there have reportedly been instances of unwillingness to share these limited resources. It is unclear to us (VTPU) to what extent services are accessing the pool of multilingual materials collected on various websites such as the VTPU and Multicultural Mental Health Australia websites.

Recommendation: Additional resources should be allocated towards language services in order to address issues of training for mental health staff, training

for interpreters and to enable translations of a wider range of materials in a greater range of languages.

(v) National-State/Territory coordination of multicultural mental health policy development

An important issue related to the division of responsibility for multicultural mental health policy between different levels of government and between the government and non-government sectors is the limited geographic representation of Multicultural Mental Health Australia (MMHA). MMHA is a Commonwealth-funded consortium of various State and Territory mental health specialists and services, advocacy groups and tertiary institutions[4] responsible for progressing the national agenda in mental health and suicide prevention for the multicultural community. However, a major constraint on the effectiveness of the MMHA's work in linking multicultural mental health services across Australia and providing national leadership is the fact that its executive membership is not nationally representative. The consortium does not include any multicultural mental health services from the NT, ACT, Tasmania and Victoria and is heavily biased towards representation from NSW.

The VTPU is only able to contribute to the work of MMHA by invitation and does not have a formal role in the decision processes affecting MMHA's national programs. This situation imposes unnecessary barriers on the flow of information about innovative developments in Victoria to the national mental health sector and excludes Victoria from developments that are occurring nationally. The VTPU has participated in processes of national significance (for example, a Queensland-based project on the development of research and clinician guidelines for the application of mental health outcome measures in members of CALD communities) but such projects have been through direct arrangements and not facilitated, as they should, by MMHA processes. Of importance too is the lack of participation of the Territories and Tasmania, which are under-resourced generally and which require significant input from the national level to foster developments in transcultural mental health policies and services.

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[4] The following nine organizations comprise the MMHA consortium: NSW Transcultural Mental Health Network, Queensland Transcultural Mental Health Network, WA Transcultural Mental Health Network, Australia Mental Health Consumer Network, National Ethnic Disability Alliance, Federation of Ethnic Communities' Councils of Australia (Canberra), STARTTS NSW, Australian Institute for Suicide Research and Prevention (Griffith University), and the Centre for International and Multicultural Health.

Recommendation: National bodies established to implement policy directives should include representation from, and communication with, key stakeholders from all States and Territories. The executive membership of MMHA should be reviewed with the aim of making it geographically representative.

b. Are the various modes of care for people with a mental illness adequate, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care?

(i) Prevention and early intervention

We have commented above on prevention and early intervention approaches relevant to CALD communities, particularly universal prevention and early intervention projects. Selective prevention activity is limited in Victoria and not part of the core activity of the mental health system in reference to CALD communities (with the exception of limited support groups for carers). A large investment by VicHealth in 2001 financed a series of eight projects on supporting mental wellbeing among recently arrived and refugee communities (akin to selective prevention on the basis that such groups are particularly vulnerable), however these are short-term investments. They stand mainly as demonstration projects, and are located outside of the mental health system.

The development of Primary Mental Health Teams (PMHTs) attached to AMHS in Victoria has enabled better linkages with the primary health sector as a means of facilitating early intervention. The responsiveness of PMHTs to their local community needs occurs via the development of local community plans. Inspection of several community plans by the VTPU in 2003 indicated a need to support such teams with such basic information as catchment population composition in relation to ethnic diversity and available local resources (e.g., bilingual allied health, ethno-specific community organizations, etc.).

One challenge related to PMHTs is the difficulty of replicating or ‘scaling up’ CALD-related projects in other areas where they may be useful. An example of this is a project undertaken by the VTPU with the Somali community in 2003, resulting from an initiative by the South West Primary Mental Health Team. The project consulted Somali men and youths as to their needs, identified unemployment and intergenerational conflict as key issues, and provided an information session.

Although unemployment and intergenerational conflict are issues confronting Somali men generally, the project and the information session were confined to the catchment area of the South West PMHT. To have it extended to other areas where Somalis reside would involve negotiations across a range of services and persuading them to prioritise and resource this or an equivalent project. Predictably, there is little consistency in response across regions. In order to effectively address such problems, an alternative (perhaps centralised) model needs to be developed through which the needs of CALD communities can be meet by PMHTs in a more coherent fashion.

(ii) Acute care

Within acute care services in Victoria anecdotal accounts continue to be heard by VTPU staff with respect to CALD consumers regarding a number of unsettling issues: unnecessarily prolonged seclusion; lack of provision of information regarding instances of seclusion; lack of interpreting during admission to inpatient facilities up to the point of the mental health review; and lack of engagement of interpreters, as already discussed, at critical points in the pathway through care, among other difficulties. Given the lack of research and the sensitivities involved in inquiring into such matters, there is no way of knowing how widespread such problems are in acute care facilities.

Members of the mental health review board have recently been engaged in transcultural training courses conducted by the VTPU and have commented on the need for ongoing cultural awareness training to be part of the mental health review process. This has been a fundamental and unforseen gap but it remains an important point of intervention to ensure the rights of consumers are met with respect to cultural diversity policy in relation to hospital admission.

Similarly, there has been a substantial attempt to incorporate transcultural mental health assessment in Crisis Assessment and Treatment Teams (CATTs), mainly in the Western and Inner East mental health services with demonstrations of improvements in knowledge and awareness of significant issues in assessment and diagnosis. However, it is not clear from the evaluation of this project whether clinical practices have actually been modified. CATTs play a significant role as the ‘gateway’ for accessing mental health care in Victoria. It remains a critical issue across such teams that they are appropriately informed and trained on the issues of culture and diagnosis, and there is a need to continue a program of training specialised in this area.

(iii) Community care

With respect to community care, evaluation of the BCM model indicated it was bilingual case management was superior to regular case management in terms of clinical care (S. Ziguras et al., 2000). Results suggesting improved service by client-clinician ethnic matching included: lower incidence of use of depot medication and higher rates of compliance with prescribed medication; greater contact and more time spent by clients with the Continuing Care Team (in treatment); lower rates of contact with CATTs; fewer hospital admissions; higher client satisfaction with the clinical service due to both language matching and accommodation of cultural, religious beliefs and specific migration history in the therapeutic relationship; and, some indication of improved social functioning. One interpretation of these outcomes is that they reflect a standard against which regular community care falls short; improvements in clinical care in community settings is possible in relation to consumers from CALD communities.

(iv) Child and Adolescent and Aged Services

While most of our comments in this section reflect the experience of ‘adult’ mental health services much work needs to be done in understanding similar processes in relation to Child and Adolescent Mental Health Services (CAMHSs) and the services dedicated to those aged 65 years and over. Issues of access to CAMHSs remain unclear (Luntz & Klimidis, 2000) and there is scant information on the quality of mental health care provided in such services to CALD communities, the difficulties faced by clinicians in conducting such work, and the clinical outcomes of services provided. While most of these issues are also unknown in relation to services for the aged CALD population, issues of access appear to be less problematic (Klimidis et al, 1998; (Hassett *et al.*, 1999) or are equally problematic across CALD groups and the Australian-born.

c. Are there opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care?

Due to the limited coverage of the BCM program in Victoria, CALD community members living outside the four AMHS of the Western Metropolitan region are currently unable to access bilingual case managers. While the program should be expanded it is difficult to recruit sufficient numbers of case managers to cover the wide variety of cultural and linguistic groups. The BCM program should be viewed as a limited resource and should be given special consideration with respect to cross-service arrangements (particularly funding agreements) so that the availability of language and culture appropriate clinicians is more widely spread across the services.

Recommendation: The BCM program in Victoria should have the flexibility of cross-service arrangements in order to share the availability of language and culture appropriate clinicians across the services.

d. What are the appropriate roles of the private and non-government sectors in the provision of mental health services in Australia?

i. Discrimination against CALD consumers in the private mental health system

There is anecdotal evidence in Victoria of CALD consumers with private health insurance being refused treatment in private inpatient facilities due to their limited ability to communicate in English. It is essential to remember that if someone is in an acute psychotic episode and lacks insight s/he will be likely to be muddled, confused and unable to communicate clearly in any language. It is also reportedly commonplace for CALD consumers who are admitted to a private mental health facility to be assessed without the use of interpreters or translated assessment tools. Part of the reason for this is said to be the prohibitive cost of interpreters, which private hospitals are not prepared to meet and which is not covered through private health insurance rebates. Compounding this is fact that staff in the private system are largely untrained in working with CALD communities and therefore may not be skilled at engaging clients in a culturally appropriate (and respectful) manner.

Recommendation: In order to ensure that the cultural and language needs of CALD consumers, families and carers are considered in public and private services, government policy should apply equally to both sectors and incentives developed for their implementation.

(ii) Non-government sector and interpreters

A key role played by the non-government sector in Victoria is the provision of psychiatric disability rehabilitation and support services (PDRSS). However, opportunities for improving the delivery of these services to people from immigrant backgrounds are severely limited. Despite requirements set out in the Mental Health Act (1986) (s5) and in the National Mental Health Standards (Standard 7) that PDRSS meet the cultural and linguistic requirements of consumers and carers from CALD backgrounds in their work, there have been few government initiatives to support these requirements and the onus has been on services to meet them.

As an example, the Victorian Government's Standards for Psychiatric Disability Rehabilitation and Support Services (Victorian Government, 2004) stipulates that it is the responsibility of services to provide appropriate language services. Obtaining funding to fund access to interpreter services remains a critical issue for PDRSS. A study undertaken by the advocacy group Action on Disability within Ethnic Communities (ADEC) in 1999 indicated that many PDRSS received no direct funding allocation towards the cost of working with interpreters. This situation remains unresolved. The possibility of providing a service of appropriate quality without the provision of effective communication is remote. The VTPU welcomes the Victorian Government's current review of the funding and provision of language services and has strongly advocated and continues to advocate the need for PDRSS to obtain access to direct funds for interpreters. It is hoped that this situation will be redressed in the near future.

Recommendation: That direct funding is provided to psychiatric disability rehabilitation and support services for the provision of language services to consumers and carers from CALD backgrounds.

(iii) Links between mental health services and ethno-specific NGOs

Although the potential for capacity building and service integration has been suggested in national policy, there are issues in engaging NGOs such as ethno-specific organisations in the delivery of mental health care, as highlighted by the VTPU study outlined in Box 2 below. Their willingness to participate in mental health care delivery needs to be supported by acceptance and clearer definition of that role, assistance with ways to link in with other mental health services, capacity-building to allow them to better respond to the mental health needs of their communities, and mental health training for their staff. Currently there is no legitimised role for ethnic organizations in mental health services, and resources to support such work are inadequate.

Box 2: Findings from VTPU study on depression and CALD communities

As part of a national ‘scoping’ project in relation to depression and CALD communities a 2002 VTPU survey of 422 organisations across Australia, including community and Government-based services, found that one in four nominated their program to be addressing CALD communities. Of these, only 46 programs focused on the issues of CALD communities and mental health or depression specifically, and just five reported cultural adaptations of the program to accommodate CALD groups.

Several issues emerged from examining responses relating to the links between mental health services with CALD communities and with ethno-specific non-government organizations in relation to mental health. Most mental health services had no specific programs or modifications of existing programs to accommodate CALD communities. Those that had tried experienced barriers in reaching into CALD communities or particular subgroups within such communities with their programs. Services expressed the view that CALD communities ‘did not trust’ them and their efforts to be more engaged with CALD communities (e.g., through participation in community events or by engaging volunteers). Explanation of access difficulties to mental health care focused on the lack of understanding in CALD communities of the mental health system and the lack of general literacy (e.g., ability to read information) in some communities.

Ethno-specific non-government organizations (NGOs) had strong access to the communities but relationships with mental health services were difficult. Ethno-specific NGOs stated that they provide care to those with mental illness (CALD community members with mental illness seek their support) but at the same time are not regarded by mental health services as having a legitimate role in this. There were also perceptions that mental health services were discriminatory, uncooperative and lacking commitment to the issues of CALD communities. There was a view that an ‘external’ process for developing productive partnerships is required, with particular tasks of establishing roles, boundaries of expertise, and cross-fertilization of expertise. Ethno-specific NGOs saw themselves as participating in direct ‘casework’, community development, and advocacy on behalf of CALD communities, working with media, and disseminating information in their communities. However they also reported high existing caseloads, limited general finances, limited or short-term project funding (when solutions required longer-term committed activity), and a need for education in mental health (ability to detect and respond effectively to mental disorder).

Recommendation: Promotion is needed of the work of ethno-specific NGOs and their scope to assist MHS in relation to mental health care delivery for CALD communities.

f. Does the provision of mental health services in Australia address the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated, and people with complex comorbid conditions and drug and alcohol dependence?

It is of concern that CALD communities have been omitted from this list of special needs groups. It is assumed that this is an oversight, given that, as discussed already, the National Mental Health Strategy documents and most State/Territory policies require specific attention to the needs of members of CALD communities. The special needs of CALD communities are, obviously, discussed throughout the rest of this submission.

g. What is the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness?

Carers from CALD backgrounds are in need of assistance in better supporting their mentally ill relatives, as well as assistance in protecting their own emotional wellbeing and social participation. The complexity of CALD carers experiences and needs are highlighted in two studies, one looking at a group living in Perth (Kokanvic *et al.*, under review), and the second focusing on NESB carers in Melbourne (Collins et al., 2002).

In the Perth study, carers reported psychological reactions such as resignation, resentment, frustration, exhaustion, incredulity, and feelings of victimisation as well as responsibility for caring for their ill family member. On a practical level there were major disruptions or limitations to their own work, leisure, and mobility, and a consequent reduction in living standards. For some, home became a place to escape from, in pursuit of freedom from the constant need for support from their relative and from ‘a gloomy and confusing environment’. Ability to engage in paid work for some was seen as a means of respite. In others, considerations of separation from their mentally ill spouse were mixed with felt responsibility to provide care as a culturally expected role. Shame and resultant isolation coexisted with a need to be able to ‘tell their story’ and for emotional relief and support. Stigma related to the mental illness affected the lives of other family members such as children who were confused about the meaning of mental illness in the family in relation to themselves and concerned about their social standing among peers. Carers thus felt additional responsibilities to safeguard their children and other members of the family from possible social and psychological harm.

Assumptions that extended family would support the nuclear family in cases of illness ‘because they are from an ethnic group’ were not supported by this study. Often extended family dissociated themselves from the problem and were ‘excused’ by carers for their need to protect their own lives from the disturbance caused by the mental illness. The study findings also question the assumption that outside support by formal services is unconditionally welcomed. Some carers felt that support services ‘invaded’ their homes and challenged their roles and position in relation to family members, the mentally ill member, and the physical environment of the home. This indicates a need for support services to assess the potential for disruptiveness and how different cultural groups may react to their well-intentioned supportive actions. At the same time there was a clear need among those surveyed for practical/material forms of support and information (regarding mental illness, treatment, etc.).

In Victoria, the Mid West Carers of NESB research project (Collins et al., 2002), a qualitative study involving 42 CALD families, highlights the many difficulties routinely experienced by carers in relation to the mental health system. In line with (Kokanvic et al., under review), (Collins et al., 2002) found that CALD carers who were family members tended not to seek help outside the nuclear family and that contrary to stereotype of family involvement, were sometimes disappointed that extended family members didn’t enquire about the ill family member. For some participants, the task of obtaining treatment from formal services was complicated by fears of the mental health system and of what was going to happen to their family member in hospital. Consequences feared included clients’ distrust of the carer or anger towards the carer, and the resultant pain or anger experienced by carer. Families reported being placed under extreme stress in situations where they were not informed about the family member’s discharge (Collins et al, 2002) and where their loved one was admitted, medicated and discharged without additional support. A family carer says "…I still blame the government for everything that has happened because there were never enough services and money for people like her…because in such situations she’s not the only person who suffers, but also the family members suffer" (Collins et al, 2002, p. 71). Furthermore, one third of participants in the study said that they had never been given information at admission.

The Victorian Chief Psychiatrist's Guideline 'Working together with families and carers' (Victorian Government, 2005b) outlines the need for primary carers to be respected and supported as partners in providing care to the consumer. These guidelines outline a five-fold rationale for working with families and carers in the areas of assessment, treatment, and in meeting the needs of families and carers. They further stipulate that there is research evidence confirming that working with families and carers bring benefits to consumers and to families and that the cost-effectiveness of working with families has been demonstrated in the literature.

In addition the key service principles outlined assert that:

- Families and carers should be recognised, respected and supported as partners in providing care to the consumer and these roles should be clearly defined
- Families and carers should be engaged as early as possible in treatment and care specifying clear communication and sharing of information between the parties regularly
- Services should ensure that cultural and language needs of families and carers are considered.

The success of the Bilingual Case Management (BCM) Program (S. Ziguras et al., 2000) as outlined above, may also be attributed to the fact that the model incorporates substantial work with carers. An important aspect includes working together with carers throughout the development and implementation of the treatment plan. Carers are therefore supported by BCMs. They are also provided, through this contact, with opportunities to attend community forums and access information about mental illness in their language of origin as these events arise.

Box 3: CALD Carers Day at 2005 Carers Conference in Melbourne

In response to the need for adequate support of primary carers in the treatment, recovery and support of people with a mental illness, the VTPU representative for CALD issues on the Network of Carers of People with a Mental Illness recently convened a CALD Carers Day as part of the 6th Carers Conference in Melbourne (April 8-9, 2005). The program included a presentation by the Chief Psychiatrist on the 'Working together with families and carers' guideline, as well as sessions developed to support immigrant background carers in dealing with the behaviour resulting from their relatives' illness, and a session called 'Ask the

Doctor' where psychiatrists from the same language groups participated in discussion with carers and took their questions in an informal setting.

Evaluation of this day showed that the primary carers who attended from Vietnamese, Turkish, Italian, Greek and Maltese backgrounds found it reassuring to know that agencies and people working to support carers exist; they found the information provided very helpful and in some cases reported this was the first opportunity they had had to talk openly about mental illness in their own language. Other highlights of the day reported by participants included the provision of practical coping hints for carers they could try in future with take home information in their language of origin.

It is important to note that were it not for considerable funding being granted from the Victorian Multicultural Commission for the translation of materials presented on the day and for professional interpreters, this support would not have been available to CALD carers.

Clearly more activity, the ability to sustain such work, and the ability to extend it across a wide range of communities is needed in the area of CALD carer support, through information provision and opportunities to share their issues in safe (non-stigmatising) settings.

Recommendation: Mental health services in Victoria should be required to report on their progress in applying the recommendations from the Chief Psychiatrist's Guideline on 'Working with Families and Carers'.

Recommendation: That funds are made available to ensure that all primary carers, regardless of English literacy skills or cultural background, receive adequate information to support them in their caring role.

h. Is primary health care playing an appropriate role in mental health promotion, prevention, early detection and chronic care management?

Primary health care can and should play a much larger role in mental health promotion, prevention, early detection and chronic care management than currently is the case in Australia, including in Victoria. This is particularly so for CALD communities.

(i) Mental health challenges facing CALD communities

In CALD communities, the prevalence of common mental disorders is no lesser and in some communities higher than the Australian-born (G.W. Stuart et al., 1998). Migration-related circumstances affecting stress levels, and social, economic and health status appear relevant to explaining differing levels of depression and anxiety between immigrant and Australian-born groups (Kiropoulos *et al.*, 2004). A third important point in relation to mental disorder in immigrant communities is that most of the advocacy, research and service focus has been directed towards recently-arrived and refugee communities with relative inattention to the mental health needs of longer-term established communities (post-war and economic migrants arriving up to the 1980s). However, suicide rates are several times higher among older immigrants than the Australian-born (Burvill, 1995, 1998; B. S. McDonald, Z., 1997; Morrell, 1999; Taylor). In addition, studies indicating higher rates of mental disorders in several of the CALD communities (Kiropoulos et al., 2004; G. W. Stuart *et al.*, 1996a) suggest there is a need to broaden the service response focus, including (G.W. Stuart *et al.*, 1996b) through strengthened primary care services. Furthermore the issue of physical/mental co-morbidity in CALD longer-term immigrants will become increasingly important over the next two decades as large numbers of people from these groups enter older age during which time there are heightened risks for chronic diseases (e.g., diabetes). This necessitates the development of primary care solutions now to meet the emerging mental health needs of older immigrants.

(ii) Benefits of early detection in primary health care and current capacity of Australian system

More broadly, there are significant benefits to the early detection of mental disorder in primary care, including increased consultation rates for the mental disorder (Johnstone & Goldberg, 1976), increased rate of patients receiving appropriate mental health interventions (Ormel *et al*, 1991), including medication (Zung et al., cited in Ormel *et al.*, 1990), shorter episode duration, and more rapid improvement of psychiatric status (Ormel *et al.*, 1991; Ormel et al., 1990; Simon *et al.*, 1999). In terms of co-morbidity of physical and mental illness, there are also the benefits in managing physical conditions by redressing complications arising from the presence of a mental disorder, particularly lower adherence to treatment regiments.

The primary care hospital and rehabilitation system in Australia is broadly inattentive to the mental health of patients and carers despite international evidence for mental health co-morbidity in acute illness and chronic disease states. The effort to raise competencies in detection of anxiety and depressive states in hospital and rehabilitation settings in Australia is only beginning. Hospital services typically attend to mental health issues where severe mental illness is present and influences medical management, through consultation-liaison psychiatry services. However, these services are not available in many hospital settings. Less severe mental disorders, such as anxiety and depression are rarely part of the routine management in hospital and aftercare services.

(iii) Victorian initiatives to improve primary care response

Work by PANORAMIC[5] in Victoria over the past year to train primary care workers in mental health has met with good response and acceptance but without any service-based funding from mainstream health authorities, such efforts remain piecemeal. Beyondblue and the Victorian Centre of Excellence in Depression and Related disorders is funding PANORAMIC to undertake a more systematic program of such training. Evaluation of changes in practices and their translation to patient benefits remains a vital need in such work. Extension of this work in relation to CALD issues will be undertaken when more stable financial arrangements for the program are achieved. In a similar direction the VTPU is involved in a pilot project to develop and evaluate protocols for the detection and GP referral of mental disorders among older patients attending the emergency department at St Vincent's Hospital (Melbourne). The budget of this pilot (again funded from competitive research funding rather than the mental health service) will allow only a limited extension of this work for CALD community patients given the multiplicity of languages presenting at the service.

Recommendation: Given the age-related risk for chronic diseases and the increasing age of many immigrant communities, greater attention to co-morbidity of physical illness with mental disorders needs to be given in primary care settings, including culturally competent assessment, treatment and appropriate referral.

Recommendation: Current primary care initiatives in hospital and rehabilitation settings in addressing detection, treatment and referral of mental disorders that are co-morbid with physical disease, while undergoing development, should be funded sufficiently to be able to incorporate services for CALD communities.

Recommendation: Given the state of development of such primary care initiatives, evaluation and dissemination of programme process and effectiveness in CALD patients and principal carers should be encouraged, particularly where programmes operate in localities where there is a moderate to high population density of members from CALD communities.

(iv) Better Outcomes in Mental Health Care Initiative

General practice in Australia is currently receiving renewed attention as a means of reducing and containing the burden of disease attributable to mental disorders (Mathers, 2000) through the Federal Government's Better Outcomes in Mental Health Care initiative. The program will be of particular value to addressing common mental disorders while the public mental health systems remains predominantly focused (as a result of resource constraints) on severe mental illness. Better Outcomes includes funding for conducting mental health consultations, provision of mental health training for GPs, strengthening linkages to allied health professionals, and development of psychiatric support models for GPs. To date there has been a demonstrated high rate of uptake of the program by Australian general practice (Hickie *et al.*, 2004) and the model appears to be addressing the fundamental need for supporting GPs in providing mental health services.

Capacity of General Practice to provide MH care to CALD communities: utlilisation of bilingual GPs

In relation to CALD communities, the capacity of general practice to provide a sufficient level and quality of mental health care is not yet clear. A potential resource in the Australian health system is the availability of a large workforce of bilingual GPs, particularly in the capital cities. In addition to locally trained doctors from a non-English speaking background there are many overseas trained doctors with estimates of Asian trained doctors of 28 percent and those trained in other countries outside of the UK, Ireland and New Zealand of 21 percent of the total general practice workforce (Australian Institute of Health and Welfare, 2000). A study within the South-west and South-east Divisions of General Practice in Sydney indicated that as many as 54 percent of general practitioners in their sample used a language other than English in their consultations (Harris *et al*, year?). Furthermore, from the perspective of the community, there appears to be a significant preference by

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[5] a consortium involving, among others, the University of Melbourne (Departments of Psychiatry and Psychology, Centre for International Mental Health), National Heart Foundation, Diabetes Australia-Victoria, Melbourne Health, the VTPU, and the

members of ethnic minority groups in Australia to attend general practices where languages other than English are available. Knox and Britt (2002) examining data from the Bettering the Evaluation and Care of Health (BEACH) study showed that 39.5 percent non-English speaking background patients consultations were with general practices where the doctor consulted mostly in a language other than English. This compared with 7.8 percent of English-speaking background patient consultations with such doctors. Even among patients with fluent English from ethnic minority communities, 20 percent of them attend bilingual doctors, with this figure rising to 78 percent for those with poor proficiency in English (G.W. Stuart *et al.*, 1996b). While proximity of bilingual practices to areas of higher density ethnic minority groups may contribute to this effect, language preferences appear to be germane in the selection of doctors by ethnic minority communities (reference to VTPU unpublished study – what is this?).

Detection of mental disorders in general practice: bilingual and monolingual GPs

With respect to the presentation of mental disorder in general practice, results from a 1996 study (G.W. Stuart et al., 1996b) indicated no difference between bilingual and non-bilingual GPs with both reporting some 15 to 16 percent of consultations to involve a mental health condition. This estimation is in line with other studies in Australia and overseas based on doctor-detected mental health conditions. In Australia an early study (Chancellor *et al.*, 1977) indicated that 14 percent of that day's consultations were considered by primary care physicians to involve significant emotional and social factors and that 14 percent of consultations resulted in a prescription of psychotropic medication. However, a lower estimate of 7 percent was reported within the BEACH sample (Knox & Britt, 2002), representing a more recent and national sample of practices and patients. Nevertheless, it is estimated that among GP patients in the Australian setting, some 17 to 36 percent may have symptoms suggestive of a psychiatric disorder (Chancellor et al., 1977; Finday-Jones & Burvill, 1978; Harris *et al.*, 1996). Discrepancies in estimations are due to different methods of estimation. GPs generally detect only about half of the cases with mental disorders as detected by self-report methods. This is not different in the case of bilingual general practice in Australia. A case study of a general practice for Chinese patients in the north of Melbourne conducted by the VTPU (Klimidis *et al.*, under review) indicated 18 percent doctor-detected mental disorder compared with 38 percent based on two self-report mental health screening questionnaires.

Greater Green Triangle Health Service.

Furthermore the study indicated, in line with overseas findings (Pini *et al.*, 1999; Simon et al., 1999; Tiemens *et al.*, 1999), that the Chinese practitioner detected only the more severe cases.

Reasons for GP under-detection of mental disorders

There are many reasons suggested for doctor under-detection of mental disorder. These include patient under-reporting of psychiatric symptoms due to stigma, somatic presentation of psychological disorder, and co-morbid physical illness distracting therapeutic attention from psychiatric disorder (Goldberg, 1989). Schurman, Kramer and Mitchell (1985) suggested that apart from factors such as physician style and personality and unwillingness to diagnose mental disorder so as not to stigmatise the patient, under-detection may be due to lack of training and skill in diagnosing such disorders. In agreement Spitzer, Williams, Kroenke *et al*, (1994) list inadequate knowledge of diagnostic criteria, uncertainty about what questions to ask in relation to evaluating whether the criteria are met, and time limitations in a busy practice. Bowers *et al*, (1990) also indicated a correlation between doctor diagnosis of depression with patient complaints of mood disturbance. This study also showed that doctors may use more limited indicators to alert themselves to a condition such as depression including depressed appearance, sleep disturbance and weight and appetite changes, perhaps explaining why they tend to detect more severe cases (Pini et al., 1999; Simon et al., 1999). In addition, in multicultural and multilingual communities such as in Australia, cultural and linguistic barriers may increase the difficulty of detection and diagnosis of mental disorders within general practice, as it does in specialist mental health settings (I.H. Minas *et al.*, 1994). Cross-cultural clinical encounters are the most difficult. Although there are no Australian studies, in a British study Shaw, Creed, Tomenson and Cruickshank (1999) indicated that only 27 percent of African Carribeans were identified to have a mental disorder by the doctor compared with 52 percent of white Europeans, despite there being similar levels of disorder between the two groups based on patient self-report measures.

Research results from Better Outcomes study

The Better Outcomes initiative promises to improve matters, particularly in relation to providing sufficient training to GPs and additional assistance in their provision of mental health care. The VTPU and Centre for International Mental Health undertook a survey in the latter part of 2004 of close to 600 GPs working in areas of Melbourne with a high density of CALD communities. In fact over 80 percent of Victoria’s CALD community resided in the areas surveyed. Several key observations are of interest from this study relating to the general provision of mental health care within general practice, the possible effects of the Better Outcomes initiative, the effects of the Better Outcomes initiative on the provision of mental health care to CALD communities, and, issues affecting mental health care in bilingual general practice. These are summarised in the following insert.

Box 4: Findings of the Melbourne GP survey

General findings

- high proportions of GPs endorse the need for training in mental health (mental health assessment and diagnosis, 44%; administering psychotropics, 48%; providing psychological treatments, 67%).
- training should extend beyond a focus on depression and anxiety disorders; the following proportions of GPs endorsed need for training in relation to different mental disorders: depression, 29%, anxiety, 37%, situational adjustment, 45%, psychoses, 60%; neuropsychiatric conditions, 63%, personality disorders, 71%.
- endorsed training needs for different disorders were strongly linked to lack of confidence in dealing with the various conditions in current practice (e.g, personality disorders attracted lowest confidence ratings while depression highest).
- the most important strategy endorsed for improving the GP's capacity to conduct mental health work was an improvement in the co-ordination between general practice and specialist mental health services (this was endorsed by 66% of GPs in the survey, and many made additional unsolicited comments to the effect of requesting better care relationships with public and other psychiatric specialist services).
- Other capacity improvement strategies endorsed included: availability of regular training, advice or supervision, 50%, improved referral processes, 45%, and improved funding arrangements, 40%.
- Over 62% GPs stated that they treated situational adjustment disorders, anxiety disorders and depression alone (without support); for the remaining conditions GPs tended to treat them alone, refer or work together with a mental health service or professional with treat alone preferences overriding other strategies for personality disorders and neuropsychiatric conditions compared with psychoses.

General interest in mental health work was high in this sample as was agreement with the conduct of mental health care within general practice.

Possible effects of the Better Outcomes initiative

- 28 percent of the sample had enrolled in the Better Outcomes initiative, higher than the national estimation of 15 percent (Hickie et al., 2004).
- a lower proportion of those enrolled in the Better Outcomes initiative endorsed training needs in relation to mental health assessment and diagnosis but there were no differences between groups in endorsement of training in relation to administering psychotropics and providing psychological therapies.
- more of those enrolled in the Better Outcomes initiative endorsed need for training in relation to personality disorders but there were no other differences between groups in relation to other disorders.
- more of those enrolled in the Better Outcomes initiative expressed higher confidence in managing situational adjustment disorders,

anxiety and depressive disorders, and psychoses; groups did not differ in relation to confidence for managing personality disorders and neuropsychiatric conditions.

- more of those enrolled in the Better Outcomes initiative endorsed improvements in funding arrangements and availability of regular training and advice; no differences between groups were evident in endorsement of improvements to referral processes and improved co-ordination with specialist services.
- the structure of managing mental disorders (alone, referral or in shared care) did not differ between those enrolled or not enrolled in the Better Outcomes initiative (despite a stated intention of the program to improve linkages with allied health and specialist psychiatry services).
- those in the Better Outcomes initiative endorsed more highly interest in conducting mental health work in their current practice and endorsed more highly agreement with the current emphasis that general practice participates in mental health care.

Possible effects of the Better Outcomes initiative in CALD mental health care

In relation to providing mental health care to those of CALD backgrounds: a lower proportion of those enrolled in the Better Outcomes initiative reported difficulties in:

- having access to bilingual allied health (57% versus 73%),
- access to interpreter services (28% versus 47%),
- access to translated materials (46% versus 61%).

No differences were found between groups in relation to

- accessing guidelines for working with interpreters,
- accessing guidelines on culture and migration issues, and,
- patient compliance difficulties (respectively for the overall group: 38%, 54%, and, 64%). The last of these is concerning in showing low compliance of CALD patients with mental health care efforts of GPs, regardless of their enrolment in the Better Outcomes initiative.

Findings relating to bilingual general practice

We are still at the point of analysing these results. The following are some initial observations from our analysis. For most of the variables reported above there were no differences between bilingual and non-bilingual general practitioners. Thus the overall trends in needs for training, confidence in mental health care with different disorders, endorsement of strategies for improved capacity to provide mental health care, and patient management strategies for mental disorders, pertain equally to the case of bilingual and non-bilingual GPs. Exceptional results were as follows.

- Thirty-seven percent of GPs in the sample were bilingual.
- Nineteen percent of the practice of bilingual GPs was conducted in a language other than English spoken by the GP.
- Use of interpreters accounted for three percent in these practices. For non-bilingual GPs 98% of their practice was in English (2% via interpreters).
- Over 60% of interpreted consultations were via informal/non-professional interpreters regardless of GP bilingualism.
- The rate of enrolment of bilingual and non-bilingual GPs in the Better Outcomes initiative was not different (28%).
- Bilingual GPs were more likely to be operating solo practices rather than in group practices.
- More of the bilingual GPs reported difficulties in accessing bilingual allied health for mental health referrals (75% versus 63%),
- difficulty in accessing translated materials for their patients (64% versus 52%),

- patient compliance difficulties in relation to mental health (70% versus 57%), and,
- difficulty in accessing interpreter guidelines (47% versus 31%) (although they were equally likely to have difficulty in accessing interpreters if needed).
- Costs of interpreters were a particular problem more often reported by bilingual GPs than non-bilingual.
- All other difficulties in accessing, making appropriate arrangements and using interpreters were equally difficult for both bilingual and non-bilingual GPs.
- Use of a language other than English by bilingual GPs was significantly more difficult in conducting mental health work than in their regular clinical work. Moreover, language difficulties were significantly more prevalent in providing psychological treatments, followed by conducting mental health assessment, and lastly administering psychotropics.

Recommendation: GP mental health training (through the Better Outcomes or other programmes) should be extended to cover severe mental illness and neuropsychiatric conditions.

Recommendation: Training in all aspects of GP mental health service provision, including the administering of psychotropics, conducting assessment and diagnosis, and delivering psychological therapies, should be encouraged.

Recommendation: There should be ongoing supervision, psychiatric and specialist allied health supports, advice, training, improved referral processes and improvements in financing mental health care consultations in general practice as a means of increasing GP capacity to conduct mental health work.

Recommendation: There is a continuing need within the Better Outcomes initiative for sustained training of GPs in conducting mental health work, particularly in the provision of psychological treatments.

Recommendation: A concerted effort is required to implement the Better Outcomes initiative with respect to CALD patients. Research is needed to identify the nature of the difficulties being experienced in engaging them and also to evaluate the effectiveness of strategies for improving engagement.

Recommendation: Solutions for mental health training of bilingual general practitioners (often operating from sole practices) needs to occur in order to

support their good position to provide mental health care to members of CALD communities.

Recommendation: Difficulties of accessing and organising interpreter services in general practice need to be resolved, including a strategy for dealing with the cost of hiring professional interpreters.

Recommendation: Improve funding for and access to interpreters as a means of discouraging the practice of utilising informal/non-professional interpreters in mental health work.

Recommendation: Encourage the availability of brief mental health terminology courses aimed at improving bilingual GPs' ability to use their main language other than English in order to improve communication with patients about mental health problems.

Recommendation: There is a need to extend the availability of translated information on mental health conditions and treatments for patients attending general practices by reviewing existing multilingual brochures and through a targeted dissemination strategy.

i. To what extent do mental health services in Australia provide opportunities for reducing the effects of iatrogenesis and promoting recovery-focused care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated?

The VTPU sees the main difficulties in this area to be ignorance of cultural and linguistic factors in mental health service provision and in the clinical practices of assessment, diagnosis and treatment delivery. The work of VTPU contributes to the reduction of the effects of iatrogenesis within clinical practices by providing transcultural mental health education and professional development opportunities for the clinical workforce. This approach focuses on making the clinician aware of cultural difference between him or herself and the patient, and of how this may affect the clinical interaction. In addition the clinician is offered knowledge and skills to avoid the problem of inadequate care or at worst misdiagnosis. An essential part of accurate clinical interaction requires the maintenance of competent and reliable interpreting services, and the skills needed to best use these services, which also forms part of VTPU training for mental health staff. In the broader sense of service delivery VTPU encourages, through its service development programme, cultural sensitivity in the structure and processes of mental health services. In our view, culturally inappropriate structures and procedures potentially institutionalise iatrogenesis (as normal practice). These are systemic interventions requiring dedicated processes (such as relevant committees, a dedicated component of the workforce, accountability for actions, a continuing quality improvement orientation, participation of external expertise to support reflection on service issues and activities, etc.) to monitor and respond effectively to emergent issues, and structural and procedural impediments to service provision in relation to CALD communities. The Northern Area Mental Health service has provided a good model of implementing such an approach in the last two years.

Additionally, the VTPU also contributes to recovery-focused care by employing consumer and carer advocates within its programs, designed for mental health clinicians, psychiatric disability support staff, and consumer and carer groups. These in turn foster methods of encouraging peer support and consumer-led support services, while at the same time inform clinical staff as to their nature and value.

The greatest problem in this area is, again, the ability to implement system-wide models, hence a problem of program reach and therefore impact, due to differing local priorities by AMHSs, attitudes towards organizational change, capacity for organizational change and availability of local ‘champions’ particularly within management to drive the relevant issues.

l. Is education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers adequate?

As noted above, stigma attached to mental disorders is a significant issue in CALD communities. As an example, we are currently preparing a report on a comparison between Greek and Anglo-Australian older persons with respect to their opinions about the concealment of somatic, emotional and psychotic symptoms (Klimidis, Kiropoulos, Minas, in preparation). The study, one of the few in the Australian setting on issues of CALD communities stigma, revealed significantly higher efforts to conceal emotional and psychotic symptoms among Greeks than their Anglo-Australian counterparts. Concealment was graded and differently so between the two groups. Greeks tended to show least concealment of symptoms to family, followed by friends, followed by an employer, while Australians treated friend and family the same and differentiated from employer. Results supported the view that revealing emotional and psychotic symptoms in CALD communities may be particularly problematic from the perspective that they live in small social networks on which they depend on for their cultural identify, cultural continuity and a variety of supports. A loss of social position or estrangement from such networks by revealing mental disorder may be a much more significant threat in CALD communities. The same study showed that doctors were regarded similarly to family in relation to concealment of symptoms but for doctors too emotional and psychotic symptoms were less likely to be revealed than physical complaints. Thus stigma associated with mental conditions may impede access to potential support from medical professionals. The work also suggests an important direction in stigma reduction may be to support those affected (including carers) in managing stigmatising attitudes, including, self-defeating attitudes and behaviours stemming from internalising social attitudes regarding mental illness, understanding of social threat issues, defending against social displacement, identifying ‘safe’ sources for communication of the mental illness, etc.

An additional issue of considerable importance relates attitudes towards mental disorders in health providers and particularly in primary care. A recent study at the Centre for International Mental Health explored stigma-related patient care issues in psychiatric and general nurses of Chinese and Australian backgrounds (unpublished Masters study). Results favoured the view that general nurses carried significantly higher stigmatising attitudes towards the mentally ill than to patients suffering from chronic physical disease when compared with psychiatric nurses. Furthermore, cultural factors such as the clinician’s ethnic background also influenced level of stigmatising attitudes with Chinese-origin nurses holding more negative attitudes than those of Australian-background. Higher stigma towards the mentally ill translated potentially into nursing care practices that were more restrictive, authoritarian and typified by avoidance.

There has been little education directed towards de-stigmatising mental illness in the CALD communities (in Victoria). We have detailed above (Box 1) a couple of projects and in particular MED, but have also noted the limitation of such work in sustainability and due to lack of core funding. Other approaches have also been tried. The VTPU Consumer Advocate delivers a small program of education to students in secondary schools and TAFE colleges in a bid to challenge stigmatising attitudes. Our national scoping study funded on depression in ethnic communities found that there has been relatively little mental health promotion activity undertaken throughout Australia in relation to CALD communities **(**Klimidis, Kokanovic and Minas, 2003 (unpublished). In addition this work highlighted the need and lack of ready availability for translated materials on mental disorders and their treatment and the utility of engaging ethno-specific non-government organizations in the promotion of mental health in CALD communities. The NSW-based project, conducted by the NSW Transcultural Mental Health Centre and focused on promoting mental health issues and access to care for child and adolescent disorders remains the sole Australian-based example of a successful promotion activity within CALD communities. The main strength in this work was not so much due to its use of ethnic media but its ability to provide information to CALD communities through casework by a variety of participating ethno-specific organizations.

In order to de-stigmatise mental illness, considerable efforts need to be made in community education. This requires resources to be allocated towards this task and in the case of CALD consumers and carers, the forming of partnerships with community agencies and ethno-specific services. The BCM program in the Western region of Melbourne is presently actively engaged in these endeavours however is firstly limited by exceedingly high caseloads of AMHS staff and lack or resources dedicated to these activities. These activities are seen typically as peripheral to the mental health care of the community which we would argue is short-sighted and ultimately costs the community more as people continually relapse, take up hospital beds and are arrested for behaviours which may have been averted with support and education.

Recommendation: Case managers in AMHS must be supported to undertake community education activities in partnership with community agencies as part of their core business.

n. What is the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated?

Research is inadequate in relation to guiding policy development, service design and evaluation, knowledge of mental health needs, pathways to care among other factors in relation to CALD communities. Funding bodies do not see value in work that typically focuses on generalising results to different communities but emphasise processes of discovery instead. The former is more crucial in the area of mental health for CALD communities. Our study of depression and CALD communities, carried out nationally, examined Australian based publications, funded projects and priorities of the major Australian funders of research, higher degree theses, surveyed academic and research departments for current research, and explored the content of existing databases. The main conclusion we drew (Minas, Klimidis & Kokanovic, under review) from this was one of inadequacy in the volume of work in order to support policy development, service design, evaluation of service models, and to support professional training in the mental health area in relation to CALD communities. There remain great gaps in knowledge that have been pointed out within the National and State/Territory policies often enough. However, research output in this area is particularly low and surprisingly so given the long-term migrant presence in Australia, the multicultural ethos, and the potential for Australian social and health researchers to lead the field given the population structure available to them. There are major discrepancies between needed research and available research findings and between the nature of research that is needed and the nature of research that is being funded. Relevant academic departments that can contribute the relevant body of knowledge appear not to be focused on CALD communities and health service issues affecting them presently.

Research in the area of mental health is more complex, more costly, requires special approaches and awareness of the influence of cultural variation on the research process itself, and suffers from an issue of focus given the wide diversity of language and cultural groups in the community as well as the wide variety of issues in mental health. Overcoming such problems is a challenge to researchers in Australia but it is also an opportunity for developing new methodologies and approaches.

There is a need for the development of a research agenda and a process to direct and fund this in relation to Australia’s CALD communities. The experience of the Australian Transcultural Mental Health Network (predecessor of MMHA) in dedicating moneys for research provided a useful model for how to do this from a national perspective. The process stimulated work that continues to be topical under the national strategy (on stigma, partnerships, consumer and carer participation, general practice and mental health, among others) and did bring together research interest on CALD communities across the country.

o. Are data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government, and opportunities to link funding with compliance with national standards adequate?

An important factor in the delivery of culturally and linguistically responsive mental health services is CALD patients' English proficiency and staff awareness of clients' proficiency. Staff may overestimate proficiency if a client can communicate about everyday matters, whereas the client may have difficulties in communicating about mental health issues in English (Stolk *et al*, 1998). At present Victorian mental health services do not have a method for recording English proficiency that permits service delivery comparisons for clients with low or high proficiency. As a higher proportion of CALD patients in an inpatient unit were found to have low English proficiency than would be expected on the basis of population projections (Stolk *et al*, 1998) English proficiency may be associated with prevalence of mental disorder and outcomes (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988; Klimidis *et al*, 2004).

Recommendation: That an English proficiency scale be included in a minimum mental health data set to facilitate identification of mental health issues and planning and service delivery strategies for clients with low English proficiency.

In Adult and Aged Persons' Mental Health Services the influence of cultural and linguistic factors on service access and delivery can be estimated from the recording of clients' birthplaces and preferred languages. In Child and Adolescent Mental Health Services (CAMHS) however, children's recorded birthplace and preferred language may provide unreliable indicators of cultural and linguistic influences, which are more likely to have their source in the parents' ethnic background. At present Victoria's CAMHS do not record parents' birthplace or preferred language, despite lobbying of the Mental Health Branch by the VTPU. A one-month intake study across Victoria's CAMHS by Luntz & Klimidis (2002) in which parents' ethnic background was recorded by intake staff showed that, on the basis of children's birthplace data, 6 per cent were of culturally and linguistically diverse backgrounds, but when parents' birthplaces were taken into account, 27 per cent were of CALD backgrounds. The study demonstrated that questions about parents' background elicited "richer information about the ethnic background of the children and adolescents" (Luntz & Klimidis, 2002, p. 21). As pointed out by Luntz (2000) "Obtaining a more accurate profile would increase awareness of the size of the client group and provide useful information for service planning, workforce development and research".

Recommendation: That information regarding a child or adolescent's parents' ethnic background be included in the minimum data set for Child and Adolescent Mental Health Services.

p. What is the potential for new modes of delivery of mental health care, including e-technology?

While most federal and State policies have included special provisions for addressing the mental health needs of CALD communities, the experience of the VTPU is that implementation of new models is very difficult. The bilingual case management model was demonstrated to be effective but many services exposed to the model have not readily adopted it. The VTPU has argued for the need of a secondary consultation service to be funded in Victoria to support the work of AMHS, an argument that has been running for the last five years combined with a business plan, demonstration of the utility of a similar enterprise in NSW, and support from Victorian-based mental health service managers. A main impediment is not development of innovative models and demonstrating their effectiveness but setting adequate funding priorities for addressing the mental health needs of CALD consumers in the context of financial constraints resident in the mental health system. Unless such barriers are lifted by an injection of funding and specific accountability mechanisms ensuring expenditure is directed to such programs or by such models receiving greater priority in mental health services, it is unlikely that these innovative approaches will be implemented.

We have also alluded to issues of engaging non-government organizations in aspects of mental health service delivery, and particularly ethno-specific organizations. There willingness to participate in mental health care need to be, at least, supported by acceptance of their role, clearer definition of roles (including when their capability becomes limited), and training of workers in mental health responsiveness.

The prospect of e-technologies for direct contact with communities is low in relation to CALD communities. We see however great advantages in such technologies (internet and CD rom) in education of clinicians and communication between clinicians and organizations regarding mental health care (and especially in relation to providing clinical transcultural expertise to rural and remote settings), and in the sharing of materials (e.g., translated clinical instruments, information brochures, etc.). However the use of e-technologies, in our experience with such media there is a need to have substantial resources for promotion and dissemination and where internet based technologies are used, sufficient resources for ongoing management (websites, chat rooms, etc.) and support to users.

Annex A – References

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Annex B: National Standards for Mental Health Services[6]

Standard 1: RIGHTS	The rights of people affected by mental disorders and/or mental health problems are upheld by the MHS.
Standard 2: SAFETY	The activities and environment of the MHS are safe for consumers, carers, families, staff and the community.
Standard 3: CONSUMER AND CARER PARTICIPATION	Consumers and carers are involved in the planning, implementation and evaluation of the MHS.
Standard 4: PROMOTING COMMUNITY ACCEPTANCE	The MHS promotes community acceptance and the reduction of stigma for people affected by mental disorders and/or mental health problems.
Standard 5: PRIVACY AND CONFIDENTIALITY	The MHS ensures the privacy and confidentiality of consumers and carers.
Standard 6: PREVENTION AND MENTAL HEALTH PROMOTION	The MHS works with the defined community in prevention, early detection, early intervention and mental health promotion.
Standard 7: CUTURAL AWARENESS	The MHS delivers non-discriminatory treatment and support which are sensitive to the social and cultural values of the consumer and the consumer's family and community.
Standard 8: INTEGRATION	
Standard 8.1: SERVICE INTEGRATION	The MHS is integrated and coordinated to provide a balanced mix of services which ensure continuity of care for the consumer.
Standard 8.2: INTEGRATION WITHIN THE HEALTH SYSTEM	The MHS develops and maintains links with other health service providers at local, state and national levels to ensure specialised coordinated care and promote community integration for people with mental disorders and/or mental health problems.
Standard 8.3: INTEGRATION WITH OTHER SECTORS	The MHS develops and maintains links with other sectors at local, state and national levels to ensure

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[6] (http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-mhinfo-standards-nsmhs.htm)

	specialised coordinated care and promote community integration for people with mental disorders and/or mental health problems.
Standard 9: SERVICE DEVELOPMENT	The MHS is managed effectively and efficiently to facilitate the delivery of coordinated and integrated services.
Standard 10: DOCUMENTATION	Clinical activities and service development activities are documented to assist in the delivery of care and in the management of services.
Standard 11: DELIVERY OF CARE – PRINCIPLES	The care, treatment and support delivered by the MHS is guided by: choice; social, cultural and developmental context; continuous and coordinated care; comprehensive care; individual care; and least restriction.
Standard 11.1: ACCESS	The MHS is accessible to the defined community.
Standard 11.2: ENTRY	The process of entry to the MHS meets the needs of the defined community and facilitates timely and ongoing assessment.
Standard 11.3: ASSESSMENT AND REVIEW	Consumers and their carers receive a comprehensive, timely and accurate assessment and a regular review of progress.
Standard 11.4: TREATMENT AND SUPPORT	The defined community has access to a range of high quality mental health treatment and support services.
Standard 11.4A: COMMUNITY LIVING	The MHS provides consumers with access to a range of treatment and support programs which maximise the consumer’s quality of community living.
Standard 11.4B: SUPPORTED ACCOMODATION	Supported accommodation is provided and/or supported in a manner which promotes choice, safety and maximum possible quality of life for the consumer.
Standard 11.4C: MEDICATION AND OTHER TECHNOLOGIES	Medication and other technologies are provided in a manner which promotes choice, safety and maximum possible quality of life for the consumer.
Standard 11.4D: THERAPIES	The consumer and the consumer’s family/carer have

	access to a range of safe and effective therapies.
Standard 11.4E: INPATIENT CARE	The MHS ensures access to high quality, safe and comfortable inpatient care for consumers.
Standard 11.5: PLANNING FOR EXIT	Consumers are assisted to plan for their exit from the MHS to ensure that ongoing follow-up is available if required.
Standard 11.6: EXIT AND RE-ENTRY	The MHS assists consumers to exit the service and ensures re-entry according to the consumer’s needs.

Annex C: Inquiry Terms of Reference

A select committee, to be known as the Select Committee on Mental Health, was appointed on 8 March 2005 to inquire into and report by 6 October 2005 on the provision of mental health services in Australia, with particular reference to:

a. the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;

b. the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

c. opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;

d. the appropriate role of the private and non-government sectors;

e. the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;

f. the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;

g. the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;

h. the role of primary health care in promotion, prevention, early detection and chronic care management;

i. opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;

j. the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;

k. the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion;

l. the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;

m. the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;

n. the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;

o. the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards; and

p. the potential for new modes of delivery of mental health care, including e-technology.