A review of mental ill health for culturally and linguistically diverse communities in Western Australia

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Executive Summary

A comprehensive review of literature on mental health, and approaches used to address mental health issues, among culturally and linguistically diverse (CaLD) communities in Western Australia was undertaken. The review sought to identify published literature and grey literature exploring mental illness among CaLD communities, demographics and trends, services and supports, and the efficacy of services and supports. Due to the low volume of literature on Western Australia, the review extended to national and international literature.

- **Prevalence of mental health issues in CaLD communities in WA**

Capturing information about prevalence rates is complex because CaLD communities are not homogenous, and members of defined communities are also not homogenous, with different experiences influenced by gender, class, age, sexuality, first or subsequent generation migration experiences, temporary or permanent settler status, forced or voluntary migrant status, and other parameters of difference. Additionally, there are cultural differences in understandings of mental illness and appropriate treatments.

There is no reliable research on the prevalence of mental health issues for CaLD communities in Western Australia.

International and Australian literature is contradictory. A systematic review of international research suggests migrants may have higher incidence of mental illness; but Australian literature indicates significantly lower diagnosis of mental illness among overseas born compared to Australian born, including anxiety disorders, affective disorders, substance use disorders, and all mental disorders. Note, neither of these reviews focus on CaLD rates. The Productivity Commission draft report on 'Mental Health' (2019), using an unclear methodology based on Australian Bureau of Statistics 2007 statistics, reports CaLD communities have lower levels of mental illness.

Lower levels of diagnosis do not necessarily mean lower prevalence, because CaLD communities may not 'recognise' mental ill health and therefore not present to practitioners for diagnosis, or may choose to treat it within the family or community, or

practitioners may not recognise cultural manifestations of mental ill health.

A range of factors may dispose some members of CaLD communities to mental health issues, including demographic factors, age at arrival, level of social/spiritual support, employment, pre-migration experiences including torture and trauma, and vulnerability may change over time as part of the acculturation process.

Numerous reports and reviews recommend the collection of comprehensive, reliable statistics on mental health for migrants and refugees in Australia.

- **Demographics and trends regarding mental health in CaLD communities in WA**

As there is no WA literature on prevalence, there is no information about which communities, age groups, gender or other demographic categories may be suffering more, nor about which conditions are more prevalent. Appendix C summarizes a number of studies of particular language or country of origin groups, but prevalence rates cannot be deduced due to sampling issues, as most are small studies using non-random or clinical samples.

- **Key experiences and circumstances related to mental health issues in CaLD communities**

A number of factors concerning the **experience of migration** may place people at greater risk of mental health problems, although there are also resilience factors. Some of the risk factors include:

- low socioeconomic status, or drop in socioeconomic status following migration (status inconsistency), often the result of lack of recognition of professional qualifications;
- un/underemployment;
- culture shock/culture conflict/cultural distance;
- inability to speak the language of the host country;

- separation from social, religious and cultural networks, particularly one's family and extended kin;
- housing distress;
- prejudice, racism and discrimination in the host society;
- traumatic experiences or prolonged stress before or during immigration (as in the case of refugees);
- gender and inter-generational conflict;
- economic pressures;
- breakdown of traditional and family support structures;
- being adolescent or elderly during the time of migration;
- the degree to which people have adjusted positively to living in a new culture and adopted new cultural practices and norms (level of acculturation); and
- language and cultural barriers to mental health service access, including stigma about mental illness and lack of knowledge about services.

Note again that these factors are identified mainly for migrants, not necessarily CaLD communities, which include second and further generations.

Protective factors include:

- religious belief and observance;
- younger age at migration;
- better English proficiency;
- a greater sense of personal control;
- stronger social support and sense of belonging to family and community; and
- and higher self-efficacy.

Risk of suicidal behaviour among immigrants is influenced by:

- living circumstances in the host country;
- experiences in the country of origin; and

- low socio-economic status.

Strong family ties, religious adherence and maintenance of traditional values may lead to lower suicide rates in immigrants.

Refugees and asylum seekers are particularly vulnerable. Their mental health is negatively affected by:

- pre-migration trauma;
- long-term detention, temporary protection, restriction of access to services, human rights violations;
- exposure to threats and fears for family remaining in the country of origin; and
- greater adjustment problems.

The more culturally distant from the mainstream population, the more pronounced the stress. In clinical populations Post-Traumatic Stress Disorder and depression are the most common diagnoses.

CaLD carers of those with mental health issues may be particularly vulnerable to health and mental health issues themselves.

- **Barriers/enablers to mental health support and treatment for CaLD communities**

CaLD communities are diverse, including migrants arriving under a range of temporary and permanent visa categories, and second and further generations of culturally and visibly different (from the mainstream) Australians, as well as significant ethnic differences across and within countries of origin. Therefore, it is difficult to generalize barriers and enablers. Some of these specifics are covered in Appendix C.

Additionally, the Western biomedical model of mental illness may not resonate with CaLD communities. Two-way listening is necessary to ensure communities recognise the value of Western treatments, and that health professionals recognise the value of some traditional approaches. Any attempts to develop mental health literacy (MHL) should be respectful of both perspectives.

There is contradictory evidence about whether CaLD and migrant communities use mental

health services less than others. A WA study found those speaking languages other than English at home are less likely to access services.

Barriers to access include

- stigma (including shame or fear of being judged by others and the treatment provider);
- lack of mental health 'literacy';
- language barriers;
- cultural barriers;
- Medicare ineligibility, and health care costs;
- logistical issues (transport, childcare, waiting lists);
- impacts of social, financial and psychological difficulties;
- concerns about confidentiality/inadequate interpreter services;
- lack of culturally aware staff and processes;
- lack of links with other services;
- fear of hospitalization, and other fears based on misinformation;
- high regard for religious beliefs and traditional customs; and
- a tendency not to identify people with mental health issues who are functional as having mental health problems (mental illness is understood as extreme and debilitating).

CaLD communities may use internal systems of support, from families, elders, religious leaders and religion itself, to deal with mental health problems.

Protective factors among humanitarian entrants include self-esteem, personal efficacy, and positive self-concept; language ability; social support (especially from members of one's own ethnic community); employment; moderate amounts of cultural involvement and cultural maintenance; and young age.

- **Service delivery**

There is a lack of evidence based evaluations of the most effective service delivery models.

There is no reliable research determining whether mainstreamed or dedicated services are most effective, although migrant communities and service providers tend to prefer either dedicated, or mixed dedicated and mainstream, service delivery.

Few sources exist providing evidence of best practice for the delivery of services to those of CaLD backgrounds. However a range of sources offer guidelines, examples and recommendations, included in Appendix B. Most emphasise that community based interventions, using a community development model, appear suited to supporting CaLD communities.

- **Recommendations from a number of reports identify the following needs:**
    - Ensuring that the increasing cultural and linguistic diversity of the Australian population is a core consideration in all mental health policy-making and funding for policy implementation of mental health service design, delivery and evaluation;

    - Full participation of representatives of CaLD communities and people with mental illness and their families and support persons in policy making and implementation processes at local, state and national levels;

    - Ensuring mental health policy is explicitly translated for relevance to CaLD communities. This includes Commonwealth-funded mental health initiatives such as Beyond Blue and Headspace, which should include dedicated CaLD-focused services and programs; and targeted CaLD performance benchmarks for all publicly-funded mental health services;

- The provision of both mainstream and dedicated services, including resources allocated to 'mainstream' organisations specifically for cultural competency training, the engagement of interpreters and translators, and employment of bicultural workers. This could involve encouraging the adoption of the 'Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery';

- Implementation of national cultural competency standards for mental health services across Australia;

- Building workforce capacity (improving supply, productivity and access to mental health nurses and peer workers). This could include supporting initiatives such as the Certificate IV in Mental Health Peer work;

- Training for interpreters, and for service providers in the use of interpreters;

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

- Requiring partnerships between mainstream providers and dedicated services, and knowledge transfers state-wide and nationally;

- Greater community education and outreach programs to counter stigma, discrimination and other barriers to engaging with mental health services, with a focus on those particularly vulnerable to mental health issues such as the aged, newly-arrived, youth, men, women, regional, homeless, people with co-occurring disabilities, and those with torture and trauma backgrounds;

- Targeted initiatives for the above groups;

- Engaging employers, schools, community organisations and workplaces in local initiatives which improve both mental health understanding and reduce stigma and discrimination;

- A person-centred approach and an integrated stepped care model that designs and wraps services around the needs of the whole person. This requires a shift to community based services, primary health care, prevention and early intervention. Services should be community based and focused on supporting individuals and families, particularly in the early years. Services must be coordinated, and delivered locally;

- More research and culturally-appropriate campaigns regarding suicide in CaLD communities

- Improved data collection, reporting and analysis of suicide in CaLD communities; and targeted suicide prevention programs for CaLD communities;

- Reporting on progress on policy objectives (and therefore the need for systematic evaluations);

- A funded national CaLD mental health research agenda;

- The need for reliable statistics about prevalence rates. This could be achieved through national surveys of mental health which include representative samples of at least some CaLD populations. CaLD-relevant variables must be included;

- Ensuring adequate reporting of patterns of use of mental health services, and the experience of mental health services, of CaLD communities; and

- More research into and recognition of the social determinants of mental health and illness; different cultural explanatory models of mental illness; beliefs, knowledge and attitudes towards, and experiences with, health services; and help-seeking practices among CaLD communities. Ensuring research involves participation of people with mental illness and their families and support persons. Improving research capacity in the area of CaLD mental health.

Introduction

Western Australia has among the highest rates of overseas born in the world at around 32 per cent in 2016. Nearly 17 per cent of Western Australians were born in non-main English speaking countries. Most migrants are healthier than the general population due to strict visa requirements. However, some experience a range of health problems, including mental health issues, particularly those from humanitarian backgrounds. This review seeks to ascertain the prevalence, demographics and trends, experiences and circumstances, barriers and enablers to effective treatment or support for culturally and linguistically diverse (CaLD) groups experiencing mental illness, and best practice in service delivery.

Overview of the process and methodology of the literature review

As part of a Mental Health Commission review of mental health among CaLD communities in Western Australia, Multicultural Futures commissioned a review of literature pertaining to mental health issues and services targeting either a single CaLD group or CaLD communities more broadly from 2000 to the current date. As per the project plan, the report covers

- Overview of the process and methodology of the literature review;
- Prevalence of mental health issues in CaLD communities;
- Demographics and trends of mental health issues in CaLD communities;
- Key experiences and circumstances related to mental health issues in CaLD communities; and
- Barriers/enablers to mental health support and treatment for CaLD communities.

The report also describes

- the Australian and West Australian context;
- mental health issues among refugees and asylum seekers;
- attitudes towards mental health and its treatment;

- sources of information on approaches to service provision including best practice guidelines internationally and nationally;
- existing services federally, and state-based sources identifying areas for improvement;
- a summary of government reviews on mental health among CaLD communities in Australia (Appendix A);
- some examples of programs and tools (Appendix B);
- an outline of some recent literature for specific communities in Australia including Asian, African, Indian and Middle Eastern (Appendix C); and
- a set of recommendations.

Electronic searches were conducted of published and grey literature databases from 2000 to present day [last search on 2 December 2019]. Electronic sources of grey (eg. government reports, service provider websites) and peer-reviewed literature (eg. published journal articles, meta-analyses and Cochrane reports) were consulted. Selected forward citation analyses and backward bibliographic sampling were performed on relevant articles. Articles selected for this review are those relating to mental health/ill-health and service provision among CaLD communities in Australia and Western Australia, with international literature included where appropriate. Where literature specific to a particular country of origin group within Australia could be found it is referenced.

Initially keyword searches in Google Scholar were used, including: 'mental health', 'mental ill-health', 'mental illness', IN 'CaLD', 'multicultural', 'non-English speaking', 'ethnic', 'migrant', 'immigrant' and 'refugee' groups/communities; further qualifying search terms used, included: 'Australian', 'Western Australia', 'Indian', 'Chinese', 'Malaysian', 'Vietnamese', 'Arab', 'Iraq', 'Iran', 'Syrian', 'Afghan', and 'Middle Eastern'. A Google Scholar search for 'evaluation mental health service delivery CaLD' was also undertaken. A general Google search was also conducted for 'best practice mental health CaLD' and 'best practice mental health migrants/migrant communities'. A Pub Med search for 'Cochrane' AND 'CaLD mental health', and 'migrant mental health', and 'meta-analyses' AND 'migrant mental health'; and 'Cochrane' AND 'migrant mental health service provision', and 'meta-analyses' AND 'migrant mental health service provision' were also undertaken. Note the term CaLD is not

commonly used outside of Australia, hence a wider search term (migrant) was used.

As there were very few sources covering Western Australia, articles selected relate to mental health/ill-health provision among CaLD communities in western nations generally and in Australia and Western Australia, where available. Because little literature was found post 2000, some classic Australian literature from before this period is included. Where literature specific to a particular country of origin group within Australia could be found it was included. During the search process in Google Scholar and PubMed, ten articles a time were searched until the search no longer produced articles of relevance.

No literature was discovered on evaluations of WA best practice.

Definitions

This report uses the definition of CaLD assumed by the Western Australian Office of Multicultural Interests (OMI): "*Culturally and linguistically diverse (CaLD) includes groups and individuals who differ according to religion, race, language or ethnicity, except those whose ancestry is Anglo Saxon, Anglo Celtic, Aboriginal or Torres Strait Islander*" (Office of Multicultural Interests, 2009). In the Australian context, CaLD relates particularly to migrants from developing countries and/or countries where the predominant language(s) is not English, and the children of these migrants, who are not themselves overseas born. However data collection is generally based on the single indicator 'born in a non-main English speaking country', which is one of the four core Australian Bureau of Statistics cultural and linguistic indicators. The term CaLD is not generally used outside of Australia. CaLD communities are not homogenous, with differences based on gender, class, age, sexuality, first or subsequent generation migration experiences, temporary or permanent settler status, forced or voluntary migrant status, and other parameters of difference.

We use the definition of mental illness as described by the Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV (DSM-IV) (American Psychiatric Association, 1994): clinically significant behavioural or psychological syndromes or patterns that occur in individuals. The following factors may be associated with mental illness:

- distress (eg. feeling very sad or very anxious); and/or;
- disability (eg. problems with work or family relationships); and/or
- an increased chance of pain, disability, loss of freedom, death, or suffering.

Mental illness involves a response that is not considered "normal" within the sufferer's culture (e.g. feelings of sadness when a loved one dies) and is viewed as either a psychological, or biological, or behavioural dysfunction in the individual. There are a wide range of problems identified by DSM-IV as a mental illness. The more common include:

- anxiety (e.g. agoraphobia, post-traumatic stress disorder);
- mood disorders (e.g. depression);
- personality disorders; and
- psychotic disorders (involving a loss of touch with reality) such as schizophrenia.

Cultural background will influence the way one perceives mental illness in a number of ways, and this will affect clinical interactions (Castillo, 1997) through:

- culture-based subjective experience – attitudes, feelings and behaviours which are defined by, and constructed within, a particular cultural framework e.g. grief, love, shame, pride and associated behaviours;
- culture-based idioms of distress – ways people act to express their illness;
- culture-based diagnoses –practitioners' methods of assessing and diagnosing the problem;
- culture-based treatments – appropriate treatment within the cultural meaning system; and
- culture-based outcomes – outcomes will be based on how the illness has been culturally constructed and treated.

A note of caution

Some scholars are critical of the Western biomedical model of mental health/illness, and the imposition of Western notions of mental health and illness on other populations

(Summerfield, 2012), and argue for a complete reconsideration of not only mental illness treatments, but also the categories used to define mental health and illness. Summerfield argues that there is no evidence that Western categories are accurate or that many treatments work. While social psychologists draw clear links between life events such as unemployment, family breakdown/death/separation, illness and so on, and psychological distress, the medical establishment remains focused on biological, rather than social solutions to psychological problems (Fozdar, 2009). The Western psychological framework for mental illness has been taken up on a global scale. This influences research outcomes as participants frame their experiences as 'mental illness' in an attempt to translate their experience of distress (Tilbury, 2007). Scholars conclude there are risks in medicalising and individualising migrant experiences of distress, rather than recognizing the social and structural factors influencing mental ill health. Additionally, cultural differences in understandings of mental illness and appropriate treatments affect perceptions of illness and treatment.

The Australian context

In order to understand the context for mental health issues and service provision, it is useful to provide a brief overview of the Australian and West Australian contexts.

Australia is one of the most diverse countries in the world, with over half its population (10.6 million) born overseas (26%) or with at least one parent who was born abroad (19%) (Australia Bureau of Statistics, 2017). Many come from non-English speaking backgrounds, with 21% speaking one of 300 languages other than English at home (Australia Bureau of Statistics, 2017). Over time the demographics of Australia's CaLD population have changed, from large, and now aging, Italian and Greek populations to greater numbers of people of Chinese and Indian backgrounds, with emerging and more 'visible' communities from African and Middle Eastern backgrounds. The largest numbers of migrants remain those from the UK, who would generally not be classified as CaLD.

The following Table, from the Australian Bureau of Statistics (2019), identifies the population's source countries of birth in 2018.

Australia's population by country of birth - 2018(a)

Country of birth(b)	no.	%(c)
England	992 000	4.0
China	651 000	2.6
India	592 000	2.4
New Zealand	568 000	2.3
Philippines	278 000	1.1
Vietnam	256 000	1.0
South Africa	189 000	0.8
Italy	187 000	0.7
Malaysia	174 000	0.7
Scotland	135 000	0.5
All overseas-born	**7 343 000**	**29.4**
Australian-born	**17 650 000**	**70.6**

(a) Estimates are preliminary
(b) With top 10 overseas-born countries listed in order for 2018.
(c) Proportion of the total population of Australia.

The same source notes that in the year to 30 June 2018, 526,000 people arrived to live in Australia, and of those, 62% were temporary visa holders including 30% who were international students.

The most commonly spoken languages other than English are Mandarin, Arabic, Vietnamese, and Italian. Australia is one of the world's main recipients of skilled migrants; and also takes significant numbers under family categories, and between 14,000 and 20,000 annually under humanitarian schemes. Total numbers of permanent migrants annually are around 160,000 to 200,000, with equivalent numbers coming as international students and on temporary work visas.

Most migrants are healthier than the general population due to strict visa requirements (Fozdar and Banki, 2017). However some experience a range of health problems, including mental health issues, particularly those from humanitarian backgrounds. These are outlined below.

There has been debate in Australia about the best approach to service delivery for migrant populations. Since the early 1970s Australia has explicitly supported multiculturalism, with a range of policies designed to support migrant communities to retain their cultures, and policy settings focused on equity. The Galbally Report (1978) which reviewed post-arrival services for migrants recommended a pluralist model with dedicated specialized service provision for migrant communities. Subsequently Federal and State governments have moved between policies that support specialized services and mainstreaming services.

Conservative governments tend to prefer mainstreaming. Mental health services have been subject to changes due to these different policy models. There is no reliable literature demonstrating better outcomes using one or other approach, although service providers and migrant communities tend to prefer dedicated services.

Australia has among the best settlement services for humanitarian entrants, but few dedicated services for other migrants (Fozdar and Banki, 2017).

The Western Australian context

The 2016 Census shows that there are 2,474,440 people in Western Australia, an increase of 10.5% since 2011 (OMI, 2016). WA has a higher population growth rate than the national average at 2% as compared with 1.7% annually. The proportion of Australia-born has been declining steadily from 67.7% in 2001 to 60.3% in 2016. The proportion of people born overseas has increased to 32.2% in 2016 and is significantly larger than the national average of 26.3%. 53% of Western Australians have one or both parents born overseas and 77.2% had a non-Australian ancestry.

However, this does not necessarily mean there are more people from culturally and linguistically diverse (CaLD) backgrounds in WA compared to Australia-wide, as WA receives larger proportions of migrant populations from England, New Zealand and South Africa than most other Australian jurisdictions. However, proportions of migrants from CaLD backgrounds are growing—for the first time in 2016 in WA, migrants from non-main English speaking (NMES) countries outnumbered those from English-speaking countries (to become similar to other States). The top 10 non-main English speaking ancestries of Western Australians are Italian, Chinese, German, Indian, Dutch and Filipino, with the fastest growing birthplaces of the overseas-born being the Philippines, India and China. In WA, 90% of people born in non-main English speaking countries live in Metropolitan Perth along with 75% of all Western Australians. The most culturally and linguistically diverse local government areas are Canning (39.3%), Gosnells (30.1%), Bayswater (27.2%), and Stirling (24.9%).

More than 240 languages are spoken in WA and the 2016 census shows that 17.7% of the population spoke a language other than English at home. The number of Western

Australians with low English proficiency has increased slightly by 0.5% since 2011 bringing the total of low English proficiency speakers to 2.5%. Language groups with the largest number of speakers with low English proficiency are Mandarin followed by Vietnamese, Cantonese, Italian and Arabic. Also worth consideration are language groups with the highest proportion of people with low English proficiency, including: Karen, Chin Haka, Mon, Hazaraghi and Timorese.

The Office of Multicultural Interests regularly reports on new and emerging communities in WA. The majority of new and emerging communities arrive through Australia's Refugee and Humanitarian program and the Family Stream (OMI, 2018). New and emerging communities are of relevance as they may face greater disadvantages in the settlement process than more established communities. New and emerging communities are disadvantaged due to factors including visa status; low English proficiency, education and income; high unemployment rates; lack of resources and support systems; and lack of familiarity with Western mainstream services (OMI, 2018). Having come from refugee-like situations they face mental health challenges due to pre-migration, migration and post-migration experiences (Murray et al., 2008). OMI (2018) identified 19 birthplaces, with 10 birthplaces providing the newest or still emerging groups, including: Afghanistan, Ethiopia, Democratic Republic of Congo, Rwanda, Republic of Congo, Syria, Thailand, Uzbekistan, Eritrea and Liberia. The remaining countries were seen as still new and emerging, but less so and included: Iraq, Libya, Malawi, South Sudan, Somalia, Albania, Sierra Leone, Burma and Uganda (OMI, 2018). The OMI report also shows that a "significant proportion of people from Syria, Afghanistan, Democratic Republic of Congo, Republic of Congo, Eritrea, Ethiopia, Burma, Iraq, Libya, Somalia and South Sudan have both lower levels of income and English proficiency, and higher levels of unemployment, compared with average figures for Western Australians and people from NMES countries".

The prevalence of mental health issues in CaLD communities

Reliable prevalence data is non-existent for Western Australia, and of limited generalizability from Australia. We therefore cover international and Australian literature suggesting prevalence rates more generally.

International

There are no international prevalence rates for mental ill health. Bas-Sarmiento et al. (2017), in a meta analysis of 817 studies, of which 21 met the inclusion criteria (including that they must provide comparisons with the native population), found 13 studies identified a higher prevalence of mental illness, suggesting migrants are more likely to have mental illnesses, although several studies found lower levels. They note theories and evidence that suggest that those likely to develop mood disorders might be less likely to migrate, being more attached to countries of origin, with those with predispositions to schizophrenia more likely to migrate. Data confirms this. They also note studies that confirm second generation are at greater risk of developing schizophrenia than preceding generations; and a previous meta analysis that found no evidence of increased risk of bipolar, depression or mood disorders among migrant populations. Most studies in the review focused on depression and anxiety, and attribute higher rates to acculturative stress. Risk is not in migration itself but traumatic experiences involved in the migration process (generating high levels of stressors) plus individual vulnerability. Studies noted a greater tendency towards somatization. Being female, single or divorced, unemployment/low income/economic difficulties, length of settlement (less than 10 years for men, over 10 years for women), poor physical health, difficulties of acculturation, and living conditions were all positively correlated with greater risk.

A meta analysis of depression among migrants reviewing 25 studies found an aggregate prevalence rate of 15.6% among migrants (Foo et al., 2018). They restricted their selection to research on rates among voluntary migrants only. They note this figure is not significantly different from that of the native born population, and note resilience factors. The study found level of educational attainment, employment status, and length of residency were significant moderators contributing to depression prevalence. They argue newly arrived migrants appear to be susceptible to developing depression and that preventive strategies and increased assistance should be provided.

The World Health Organization's (WHO) *Mental Health Atlas 2017* reports vulnerabilities affecting mental health include minority status, living in poverty and experiencing discrimination. Mental health issues have co-morbidities with a range of other diseases such

as cancer, cardiovascular disease and HIV infection/AIDS, and may increase the likelihood of premature death.

Australia

The Australian Bureau of Statistics (ABS) National Survey of Mental Health and Wellbeing (NSMHWB), using data from 2007, provides the most comprehensive (albeit dated) estimates for mental disorders in Australian adults generally. It estimated 45% of all Australians had experienced a mental disorder in their lifetime, with 20% experiencing a mental disorder in the previous year. Data was not broken down by ethnicity. This is the most recent data and the Department of Health confirms no plans for another survey on mental health by the ABS (Cook, 2019).

There is no recent data on prevalence rates of mental illness among people from CaLD backgrounds in Australia. Searches across PubMed, Google and Google Scholar confirmed that there are no prevalence statistics for CaLD communities. Older data indicates lower diagnosis rates of overseas-born compared to Australian born (Minas et al., 2013), but note this refers to migrants, not CaLD communities specifically. The recent Productivity Commission Report confirms, using 2007 ABS data, that 'at an aggregate level, the prevalence of mental illness in the CaLD population is lower than that of the general population' (Productivity Commission, 2019: 169). However, their method for arriving at this conclusion is unclear. Using data from 1997, the Mental Health in Multicultural Australia (MHiMA) project estimates that over a quarter of a million first-generation adult Australians from CaLD backgrounds will experience some form of mental disorder (MHiMA, 2018). More recent data would likely produce a higher number.

Some studies indicate that immigration per se is not associated with an increase in mental health problems (Jayasuriya et al., 1992; Dusevic et al., 2001). This does not mean CaLD Australians have lower rates of mental ill health, there is simply a lack of evidence.

The table below, clipped from Minas et al. (2013:17), demonstrates the rates of diagnosis of a range of mental health issues for those born overseas compared with those born in Australia. These are not CaLD rates of mental illness, but rates for all migrants; and the sample is not representative (excluding those with low English levels, and children of

migrants born in Australia). The data appears to confirm that migrants in Australia have lower levels of diagnosed mental illness across a range of disorders than the general population.

Table 1: Prevalence by Country of Birth and Year of Arrival, 2007 National Survey of Mental Health and Wellbeing

	Country of birth		Year of Arrival to Australia		
	Born in Australia	Total born overseas	Arrived before 1986	Arrived 1986–1995	Arrived 1996–2007
	% of sample^	% of sample^	% of sample^	% of sample^	% of sample^
Anxiety Disorders	15.4%	11.6%	13.4%	11.3%	8.7%
Affective Disorders	6.6%	5.1%	5.4%	4.4%	5%
Substance Use Disorders	6.0%	2.8%	*1.6%	*5.7%	*3.0%
Any 12-month Mental Disorder	21.8%	15.1%	15.8%	17.5%	12.5%
No 12-month Mental Disorder	78.2%	84.9%	84.2%	82.5%	87.5%

*Source: Australian Bureau of Statistics, 2008.[5] * Estimate has a relative standard error of 25% to 50% and should be used with caution.*
^ Sample includes only persons aged 16–85 years.

Minas et al. (2013:15) note that in the 1997 National Survey of Mental Health and Wellbeing, people from English-speaking and Non-English Speaking Backgrounds (NESB) were equally likely to experience anxiety disorders and affective disorders, but the latter were less likely to experience substance-use disorders and any mental disorder.

It is generally agreed that the collection of data on mental illness among CaLD communities in Australia is inadequate. Minas et al. (2013:13) report that there are no comprehensive or viable statistics for migrants and refugees in Australia.

> "Available research findings on prevalence of mental disorders in immigrant and refugee populations are incomplete and contradictory. There is no comprehensive Australian study of prevalence of mental disorders in immigrant and refugee populations that is adequate in scale and that enables valid disaggregation (e.g. by country of birth language or duration of residence groups) in the analysis of results".

They go on to say

> **"**The failure to collect CALD-relevant data as part of the national program of outcomes data collection is one of the most important and glaring gaps in CALD mental health data collections. This makes it impossible to evaluate the effectiveness of mental health services received by immigrant and refugee communities, care utilisation and continuity of care."

A report from Beyond Blue (2019): Culturally and Linguistically Diverse Communities (https://www.beyondblue.org.au/media/statistics) also makes the point that there is a need for more conclusive prevalence data, stating:

> " The last known prevalence rates can be drawn from Australian Bureau of Statistics' (ABS) 2008 analysis of a large national survey, which found that *respondents born overseas recorded lower prevalence of some mental disorders*, in comparison to respondents born in Australia (ABS, 2008). However, more recent research suggests that the majority of mental health research does not adequately include immigrant and refugee samples and more research is required to make conclusions about prevalence of mental health conditions in Culturally and Linguistically Diverse Communities" (emphasis added).

Western Australia

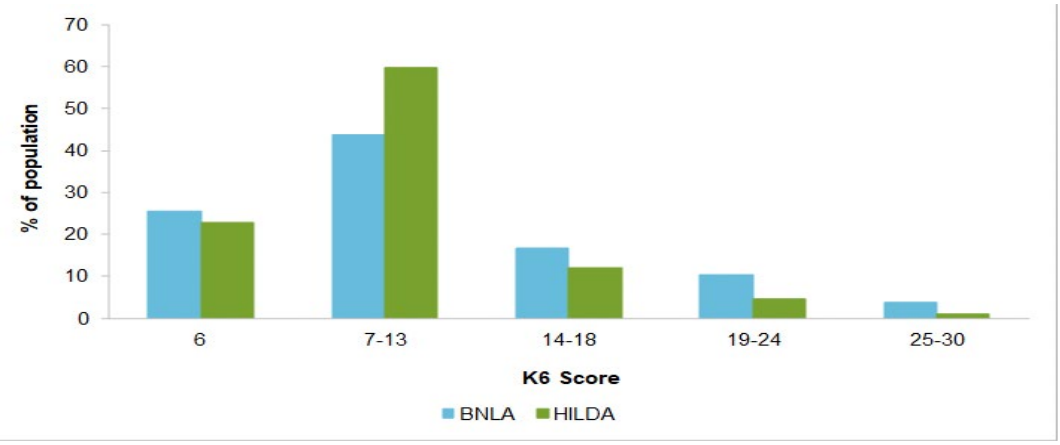
There is no data on prevalence rates of mental ill health among CaLD communities in Western Australia. While there are a number of small scale studies based on non-representative samples, and focused on particular communities and conditions, none is of sufficient rigour to generalize from. A selection of these studies are included in Appendix C.

Humanitarian migrants (refugees and asylum seekers)

For those coming under humanitarian provisions such as refugees and asylum seekers, there is some international and Australian evidence that mental health problems are greater than the general population. The most robust international findings for psychopathology are that Post-Traumatic Stress Disorder (PTSD), and posttraumatic and depressive symptoms are found at higher prevalence in those who have been exposed to war experiences (Hodes & Vostanis, 2019; Giacco & Priebe, 2018; Priebe, Giacco & El-Nagih 2016). Between 37% and 77% of adults seeking asylum experience PTSD, and are ten times more likely to have PTSD than the general population (Keller et al., 2003; Fazel et al., 2005; Steel and Silove, 1998). In

long-term resettled refugees, rates of anxiety and depressive disorders are higher and linked to poor social integration (Giacco & Priebe 2018). Poor socioeconomic conditions are associated with increased rates of depression five years after resettlement (Priebe, Giacco & El-Nagih 2016). Refugees or those seeking asylum have high levels of distress and social impairment (Momartin et al., 2004), as well as a range of social determinants that affect mental health such as unemployment, lower educational attainment and decreased earning capacity (Steel et al., 2009). In addition, there is evidence that PTSD and resettlement stress may cause drug misuse in response to trauma-associated flashbacks, nightmares/ painful hyper-arousal symptoms, or adaptation and resettlement worries in a foreign country (Weaver and Roberts, 2010).

In Australia, using data from the BNLA (Building a New Life in Australia) survey of humanitarian migrants and the HILDA (Household Income and Labour Dynamics in Australia) survey representative of the whole Australian population, humanitarian entrants have been found to be more likely to have higher levels of psychological distress compared to the general population (Productivity Commission, 2019:170). The higher the K6 score, the higher the psychological distress, and a score of 19 or higher suggests the presence of a probable serious mental illness.



For asylum seekers who have been held in detention, there is growing evidence of the harmful effects of detention on mental health, although prevalence rates are unclear (see Section 9).

Demographics and trends regarding mental health in CaLD communities

In line with the lack of prevalence data generally (see Section 7), there are no longitudinal studies identifying demographics or longitudinal trends in mental health issues among CaLD communities in Western Australia. However some of the key issues appear in Section 9 and issues for selected communities in Appendix C. In terms of volume of literature, interest in depression, dementia, and issues for young people, including suicide, is growing.

Key experiences and circumstances related to mental health issues in CaLD communities

In this section we review issues identified in the literature in relation to mental health among Australians from CaLD backgrounds, and in the following section, issues for humanitarian entrants.

CaLD communities

Regardless of whether the existing rates of prevalence reflect actual rates of mental health problems, there are a number of predisposing factors which may incline people from migrant backgrounds to increased risk of mental illness. The effect of these factors will vary depending on the circumstances surrounding migrations, particularly the degree to which it was voluntary (Dusevic et al., 2001). Some of these social factors include:

- Low socioeconomic status, or drop in socioeconomic status following migration (status inconsistency), often the result of lack of recognition of professional qualifications;
- Un/underemployment;
- Culture shock/culture conflict/cultural distance;
- Inability to speak the language of the host country;
- Separation from social, religious and cultural networks, particularly one's family and extended kin;

- Housing distress;
- Prejudice, racism and discrimination in the host society;
- Traumatic experiences or prolonged stress before or during immigration (as in the case of refugees);
- Gender and inter-generational conflict;
- Economic pressures;
- Breakdown of traditional and family support structures;
- Being adolescent or elderly during the time of migration;
- Extent of acculturation; and
- Language and cultural barriers to mental health service access, including stigma about mental illness and lack of knowledge about services.

(Chu, 1998; Minas et al., 1996; Ward et al., 2001, Tilbury et al., 2004; Murray et al., 2008; Blignault et al., 2008; Fozdar, 2009; MMHA, 2010; Minas et al., 2013; du Plooy et al., 2019; OMI, 2018; Gunasekara et al., 2019).

Minas et al. (2013:14) report factors found to be associated with increased risk of mental disorders among immigrants generally:

- limited English proficiency;
- separated cultural identity;
- loss of close family ties;
- lack of opportunity to use occupational skills;
- trauma exposure prior to migration; and
- and the many stresses associated with migration and adjustment to a new country.

Protective factors include:

- religious belief and observance;
- younger age at migration;
- better English proficiency;

- a higher sense of personal control;
- stronger social support and sense of belonging to family and community; and
- and higher self-efficacy.

They also find risk of suicidal behaviour among immigrants is influenced by factors including:

- living circumstances in the host country;
- experiences in the country of origin; and
- and low socio-economic status.

Strong family ties, religious adherence and maintenance of traditional values may lead to lower suicide rates in immigrants (Minas et al., 2013).

Considerable literature exists on issues of dementia in Australia for older CaLD communities; and some literature exists on mental health issues, including suicide, for young people. These have not been included in the review.

CaLD carers of those with mental health issues

There are additional issues for carers of those with mental health issues. A longitudinal study of the health and wellbeing of culturally and linguistically diverse caregivers of people with psychosis in Australia found that CALD carers experienced social isolation (34.7%), psychological distress (28.9%), moderate grief and poorer quality of life than the general population (Poon et al., 2015). Younger CALD carers and spouse carers experienced greater negative caregiving consequences. Poon et al. (2015) conclude ethnic-sensitive interventions and support are needed, especially for younger carers or spouses (see also Poon and Lee, 2019; Kokanovic et al., 2006).

Refugees and asylum seekers

Many of the circumstances which may predispose immigrants to mental illness are heightened in refugees, making them particularly vulnerable to adjustment difficulties, psychotic disorders, substance abuse and other antisocial behaviours (Chiu and Minas, 1988; Ward et al., 2001; Tilbury et al., 2004; Murray et al., 2008; Martin et al., 2016; Minas

et al., 2013).

Minas et al. (2013) report the mental health of refugees and asylum seekers has been found to be negatively affected by pre-migration trauma, long-term detention, temporary protection, restriction of access to services, human rights violations, exposure to threats and fears for family remaining in the country of origin.

Studies of refugees indicate greater adjustment problems than general migrants, including acculturative stress in the form of depression, anxiety and psychosomatic symptoms (Berry et al., 2002). The more culturally distant from the mainstream population, the more pronounced the stress (Ward et al., 2001). In clinical populations Post-Traumatic Stress Disorder and depression are the most common diagnoses (see Ward et al., 2001; Murray et al., 2008). Refugees may suffer from mental health problems, such as major depressive disorders, schizophrenia, anxiety and neurotic conditions, which are far more severe than those of voluntary migrants. Clinical approaches concentrate on symptoms and diagnoses rather than the experience of refugee adaptation.

A number of researchers have modelled refugee adjustment through chronological stages which may map onto risk of mental illness, with excitement and euphoria characterising the first stage (the first months), then a time of culture learning and providing for basic needs (up to six months) and finally a period of adjustment to the realities of displacement and living in a foreign country which is a period of high risk for psychological dysfunction, followed by recovery. Others have suggested personal differences in acculturation styles may lead to more or less successful settlement outcomes (Colic-Peisker and Tilbury, 2003). However few well designed studies exist to support these hyptheses (Ward et al., 2001).

Some studies indicate that refugee populations actually fare very well in terms of mental health, once settled, being better adjusted and achieving academically and economically. Protective factors include self-esteem, personal efficacy, and positive self-concept; language ability; social support (especially from members of one's own ethnic community); employment; moderate amounts of cultural involvement and cultural maintenance; and young age (Ward et al., 2001).

In a review of research into the barriers to mental health services access for CaLD immigrant and refugee women in Australia, Wohler and Dantas (2017) identify the following key

issues:

- logistical issues (lack of knowledge, financial barriers including insurance, transport, childcare, waiting lists, and a range of fears based on misinformation);
- language and communication barriers (including cultural differences in communication styles and culture bound syndromes);
- dissonance between participants and care providers; and
- preference for alternative interventions.

In two Perth based studies, Casimiro et al. (2007) found everyday settlement experiences are seen by Muslim women of refugee backgrounds as leading to depression, as did Tilbury and Rapley (2004), in a study of women of African backgrounds. Likewise McMichael and Manderson (2004) found social networks important for Somali women's wellbeing in Australia.

Asylum seekers are a special category with significant mental health impacts resulting from detention and the uncertainty of their status in Australia (Steel and Silove, 2001; Silove, Austin and Steel, 2007; Murray et al., 2008; Newman, Proctor and Dudley, 2013; Minas et al., 2013). Silove et al. (2007) report that data from all sources converges in demonstrating that prolonged detention of asylum seekers has adverse mental health and psychosocial impacts on adults, families and children (including depression, self-harm and suicidal behaviour, emotional disturbances in young children); and that the mental health effects may be prolonged, extending well beyond the point of release (see also Minas et al., 2013; Murray et al., 2008). A small pilot study conducted at a school in Perth, Western Australia, investigated mental stress in Australian community-living adolescents who are seeking asylum (Martin et al., 2016). It argues the high risk associated with escaping trauma and involuntary migration intersects with compounding factors like developmental vulnerabilities, culture shock, long-term parental unemployment and inter-generational conflict, to increase adolescent asylum seekers' risk of mental illness.

Barriers/enablers to mental health support and treatment for CaLD communities

Barriers

Barriers to access include:

- stigma (including shame or fear of being judged by others and the treatment provider);
- lack of mental health 'literacy';
- language barriers/interpreters;
- cultural barriers;
- Medicare ineligibility;
- health care costs;
- logistical issues (transport, childcare, waiting lists);
- impacts of social, financial and psychological difficulties;
- concerns about confidentiality/inadequate interpreter services;
- lack of culturally aware staff and processes;
- lack of links with other services;
- fear of hospitalization, and other fears based on misinformation;
- high regard for religious beliefs and traditional customs; and
- a tendency not to identify people with mental health issues who are functional as having mental health problems (mental illness is understood as extreme and debilitating).

(MHiMA, 2018; Minas et al., 2013; May et al., 2014; Abdullah and Brown, 2011; Na et al., 2016; Kayrouz et al., 2015; Tilbury, 2004; Blignault et al., 2008; Wynaden, et al., 2005; Dardas and Simmons, 2015; Russo et al., 2015; Yousef and Deane, 2006; Wohler and Dantas, 2017; Wamwayi et al., 2019; Gunasekara et al., 2019; Slewa –Younan et al., 2017a, b; Sneddon, 2018; Transcultural Mental Health Unit, 1995).

Lack of consumer participation in decision making processes and program design has been identified as a problem in Australian mental health service provision (Mitchell et al., 2000).

Help seeking and use of services

MHiMA (2018) notes that CaLD communities often do not seek help for mental health concerns and may not access suicide prevention services because of cultural and/or language barriers (MHiMA, 2018). Further CALD communities may not understand how services operate or how to access them and also lack awareness of the range of services available. This results in much greater responsibility being placed on family members without adequate support and education (Department of Health, 2014).

Older literature confirms this. Migrant populations in Australia generally may be less likely to access services at the primary or tertiary level (McDonald and Steel, 1997). A general lack of timely mental health help-seeking behaviour by ethnic minorities results in a lower rate of voluntary admission to in-patient services and an equal (or higher) rate of involuntary admission and higher drop-out rates, and they are more likely to be admitted to psychiatric hospitals as involuntary patients (McDonald and Steel, 1997).

Logan et al. (2017), investigating region of birth and use of a specialised mental health service in Sydney (using data from patient files 1996-2010), found South East (SE) Asian- and Middle Eastern-born accessed the service less than Australian born, with SE Asian-born patients reporting low service use across all cohorts studied. However, Middle Eastern-born patients' service utilisation increased over time, becoming commensurate with the local population.

A recent review of access to health care in WA (Department of Health, 2018) found evidence of varying use of mental health services and treatment for CaLD groups. Those speaking languages other than English at home were less likely to access health services. 5.8% of those speaking a language other than English at home accessed a Medicare Benefits Schedule subsidised mental health-related service in 2011, compared with 7.9% of people who spoke English at home. The rate of dispensing of prescription medications for mental-health related medications also varied by country of birth and language spoken at home.

In contrast, Minas et al. (2013:15) note people from non-English speaking and English-

speaking backgrounds were equally likely to use services for mental health problems and there was no difference between birthplace groups in terms of their likelihood of reporting that their needs were fully met. They also report research demonstrating that refugees and asylum seekers in Australia have low hospital admission rates for treatment of mental disorder and low access to mental health care services. This was due to the presence of a range of impediments including Medicare ineligibility, unaffordable health care costs and the impacts of social, financial and psychological difficulties. They also note that shame or fear of being judged by others and the treatment provider, and fear of hospitalization, have been reported as barriers to access to health care services among refugees. Minas et al. (2013:16) suggest the pattern of under-utilisation of mental health services by particular groups may point to systematic inadequacies in service systems.

Attitudes and knowledge regarding mental health treatment

Cultures may have different approaches to understanding mental health issues which can impact on access to services. We focus on two issues, stigma, and mental health literacy, as these recur in most of the studies reviewed, and are social rather than biomedical in nature, where community based interventions could be targeted.

Stigma

There are often strong cultural taboos against mental illness (Abdullah and Brown, 2011; Minas et al., 2013). The stigma associated with 'mental illness' may result in underutilisation of mental health services, with many clients only accessing mental health service providers when their condition has become acute. Stigma is multifaceted and can be exacerbated by other problems, such as unemployment, marital difficulties, and social isolation.

Among Chinese, Indian, African and Islamic cultures, the stigma attached to psychiatric disorders has a number of themes. Mental disorders are not separated from physical disorders but are handled in an integrated psychosomatic or somatopsychic way (manifesting in physical symptoms). Somatic illnesses are less stigmatised than those defined as 'mental'. Alternatively, families may use religious or moral explanations to

account for the kinds of 'unusual behaviours' that, under a Western diagnostic system, would be regarded as evidence of a 'mental illness' (Ng, et al., 1997; Gunesekara et al., 2019; Marmanidis et al., 1994; Tilbury et al., 2004; Brijnath, 2015; Kayrouz, 2015; Dardas and Simons, 2015; Yousef and Deane, 2006; Endrawwes et al., 2007; Russo et al., 2015; Tanhan et al., 2019). Thus bad spirits, or past actions, may be causal explanations for 'mental illness' and carry a degree of blame.

Some studies suggest stigma has been overstated, or is reducing among ethnic minorities (Abdullah and Brown, 2011; Shim et al., 2009), but this is an area needing further research.

Mental health literacy and communication

U.S. based scholars Aggarwal et al. (2016) conducted a systematic review of clinician descriptions of communication strategies to improve treatment engagement by racial/ethnic minorities in mental health services. In the 23 studies identified, lower patient treatment initiation was most commonly due to perceptions that the mental health system 'could not address patient illness experiences, somatic interpretations of mental illness leading to treatments in other settings, and interpretations of mental illnesses as existential rather than biomedical problems' (Aggarwal et al., 2016:207). Expectations played a key role in delay or cessation of treatment. Communication context was additionally important to ongoing treatment where decreases were attributed to 'patient discomfort in discussing emotions with strangers, unmet expectations of communication style, and concerns about clinician power whereas increases were attributed to patient-centred communication and positive effect, discussions of background differences with minorities, use of simplified language, and communication tailored to patient preferences' (Aggarwal et al., 2016:207).

Mental health literacy programs (MHL) are a common public health approach aiming to increase help-seeking. MHL programs present information on common mental health problems including appropriate help-seeking approaches. However, MHL programs generally adopt a monocultural approach that assumes similar reception and modes of understanding among diverse populations. Thus, Na, Ryder and Kirmayer (2016), in a critical assessment of the relevance of mental health literacy approaches among East Asian immigrants living in Western countries, found that modifications are needed in order to develop a culturally

responsive framework for mental health literacy. They note that the application of MHL programs to migrant populations raises specific issues including cultural fit, relatability and appropriate/adequate reach. They call for more research, particularly into whether being able to recognise symptoms of mental illness, and having positive attitudes toward mental health professionals are associated with actual help-seeking behaviours (Na et al., 2016: 222).

In an older study undertaken in Perth by the Transcultural Mental Health Unit (1995), the meanings and issues of mental health and illness for the Arabic, Greek and Italian speaking communities were investigated. Community members felt they knew little about mental illness. The Arabic speaking community was characterised by misinformation and a lack of knowledge about mental illness, perceiving it as threatening. Life's stresses were seen as important causes of mental illness, including migration. The Greek speaking also held a number of misconceptions about mental illness. A clear distinction was made between mental illness (mainly depression - 'illness or debility of the soul' in translation), and 'madness' like schizophrenia. The importance of language and the difficulty of direct translation was clear. Mental illness was seen as due to stress or an imbalance of brain processes. Stigma was high among these communities. Those from Italian speaking backgrounds saw mental illness as caused by adverse life events. Black magic (evil eye etc) was also thought to be a cause. Mental illness was simultaneously seen as a brain disorder, caused by variety of factors including stress, preoccupation, loss, shock, individual disposition or the failure of the collective to support one. The term 'having nerves' was preferred to mental illness. Mental illness was seen generally as unfathomable, mysterious and difficult to talk about. Interestingly, depression was not seen as a mental illness.

More recent studies of MHL in Australia have found similar results. May et al. (2014) investigated differences in mental health knowledge and beliefs between participants from the Iraqi and Sudanese refugee communities, and Australian-born individuals, in Sydney. They gave 97 people vignettes of characters describing symptoms of major depressive disorder and posttraumatic stress, and asked them to identify psychological symptoms as disorders, rate beliefs about the causes of and helpful treatments for these disorders, and rate attitude statements regarding the two characters. They found that Australian participants recognized the presented symptoms as specific mental disorders significantly

more than Iraqi and Sudanese-background participants, and reported causal and treatment beliefs more congruent with expert beliefs as per the western medical model of mental disorder. The Sudanese group endorsed supernatural and religious causal beliefs regarding depression and post-traumatic stress symptoms most often; and both Sudanese and Iraqi participants strongly supported supernatural and religious treatments. Evidence for pluralistic belief systems was also found.

In other studies, Chinese in Australia are much less likely to identify depression and early schizophrenia from such descriptions (Wong et al., 2017); and Iraqis and Afghans tend not to identify symptoms of PTSD (Slewa-Younan et al., 2017a, b). Further detail can be found in Appendix C – (see Wong et al., 2017; Slewa-Younan et al., 2017a; Slewa-Younan, et al., 2017b; Yasser et al., 2016).

Approaches to service provision

A range of studies have identified preferences for service provision among migrant communities, however there is very little evidence of systematic evaluations of programs to determine effectiveness. Recommendations are therefore less evidence-based, and more reliant on expert, service provider and community preference. Examples of service provision nationally, and an outline services available in Western Australia are available in Appendix B. In this section we outline key features of best practice internationally (general and refugee), and in Australia.

Best practice internationally

It is generally recognized that service provision must be culturally sensitive (Alegria et al., 2010; George et al., 2015). A search for best practice in CaLD mental health service provision generated a few resources, mostly focused on refugees. However, there are some comprehensive resources available that provide some standard best practice approaches across diverse localities internationally. The common themes from the three most relevant reports (WHO, 2018; Benson, Thistlethwaite and Moore, 2018; Mind Equality, 2017) are reviewed here.

At a general level best practice involves the following:

- A focus on promoting mental health through social integration;
- Ensuring clear and accessible information on entitlements to care;
- Facilitating access to care;
- Fostering engagement with care;
- Mapping outreach services (or setting up new services if required);
- Making interpreting services and/or cultural mediation services available;
- Working towards integration of mental, physical and social care;
- Ensuring that the mental health workforce is trained to work with migrants and CaLD communities;
- Investing in long-term follow-up research and service evaluations for service planning and provision;
- Treating patients with manifest disorders; and
- Sharing principles of good practices across countries.

At a clinical level, Benson, Thistlethwaite and Moore (2018) outline practical ways of using psychotherapy skills, modified cognitive behavior therapy, modified narrative therapy, recognizing resilience and spirituality, across cultures. The guide also explains the importance of social context; and the value of consultation; as well as more technical, psychopharmacological information. Workers in the field can benefit from: self-reflection on cultural context; networking and mentoring; cultural mentors; hearing the patient's story; and choosing appropriate therapeutic options

Refugee-focused best practice guidelines

Research on mental health care for refugees in high-income countries has been extensive, but often of limited methodological quality and with very context- and community-specific findings (Giacco & Priebe, 2018). Evidence suggests several general principles of good practice (Giacco and Priebe, 2018: Gaicco et al., 2016), many of which overlap with the

above:

- Promoting social integration;
- Overcoming barriers to care, including language barriers;
- Facilitating engagement with treatment;
- Developing outreach services that are easily available, familiar with the specific background of the group they support, are trusted, can facilitate access to the appropriate service and help patients to engage with clinicians; and can respond in a timely fashion;
- Providing information on entitlements and available services;
- Training professionals to work with these populations;
- Coordinating healthcare; and
- Providing specific psychological treatments to deal with traumatic memories, when appropriate.

With respect to the treatment of defined disorders, only for the treatment of PTSD has there been substantial refugee-specific research (Giacco & Priebe, 2018). These groups encounter barriers to accessing mental health care. Multimodal approaches to treatment are recommended, including dealing with housing, employment, income, social support, social isolation and discrimination, as well as psychological support (Sneddon, 2018). A 'stepped approach' to disorder-specific care delivery by culturally aware providers has been found to be effective for refugee children and young people (Hodes and Vostanis, 2019).

The majority of the literature argues that more systematic research is required to explore how precisely the general principles can be specified and implemented for different groups of refugees and in different societal contexts in host countries, and which specific interventions are beneficial and cost-effective (Hodes & Vostanis 2019; Giacco, Priebe and El-Nagih 2016; Giacco & Priebe 2018). Such interventions may utilise new communication technologies.

Australia

Existing mental health services and strategies

Summaries of reviews of CaLD mental health and Information about existing federally funded mental health services, most of which are mainstream, are provided in Appendices A and B.

A focus has been on encouraging mainstream service providers to become culturally competent. The *Framework for Mental Health in Multicultural Australia: towards culturally inclusive service delivery* (the Framework) (Embrace, nd), a free online resource allowing organizations and individuals to evaluation and improve their cultural responsiveness, was designed to be used by organisations seeking to deliver culturally competent and responsive mental health care (Vavani, 2015). It contains 3 components – 1. Completion of the Organisational Cultural Responsiveness Assessment Scale (OCrAS), 2. Reviewing the OCrAS scores (categorized as Entry, Developing or Advanced), and developing an action plan of time bound actions focusing on two or three key priorities over a 12 month period. 3. Accessing resources and information (strategies, good practice examples) which can be used to inform the development of the action plan. Actions may include improving data collection to ensure CaLD demographics are collected, revising hospital discharge planning to be more culturally responsive, as well as considering more culturally appropriate care. The framework works best where there is committed senior management and dedicated transcultural mental health services.

It must be noted that Cross and Bloomer (2010) found Australian mental health clinicians strongly supportive of respecting CaLD communities (including respecting language differences, the role of family, gender differences) and of the need to develop cultural understanding (about cultural understandings of mental illness, internal diversity, and familial differences), and recognized this impacted the development of the therapeutic relationship.

Recommended improvements in service provision

In this final section we review the recommendations of three major Australian reports into migrant mental health, and a major Western Australian report:

- the Minas report 'Mental health research and evaluation in multicultural Australia: Developing a culture of inclusion', which focuses on research and data collection, but also makes recommendations about improving service delivery (Minas et al., 2013);
- the Federation of Ethnic Communities Councils (FECCA) submission, 'Mental Health and Australia's Culturally and Linguistically Diverse Communities' to the Senate Standing Committee on Community Affairs, critiquing lack of government funding (FECCA, 2011)and related commentary (Butt, 2015);
- the Multicultural Mental Health Australia (MMHA) (2010) report of results of extensive consultation about CaLD mental health issues; and
- the WA Multicultural Health Initiatives 2015 report.

Each of these reports identify the need to recognize the special needs of CaLD communities, and to work closely with CaLD communities and to improve dialogue between these communities, policy makers and service providers. Their key recommendations are as follows:

- The need to ensure that the increasing cultural and linguistic diversity of the Australian population is a core consideration in all mental health policy-making and funding for policy implementation of mental health service design, delivery and evaluation;
- Full participation of representatives of CaLD communities and people with mental illness and their families and support persons in policy making and implementation processes at local, state and national levels;
- Ensuring mental health policy is explicitly translated for relevance to CaLD communities. This includes Commonwealth-funded mental health initiatives such as Beyond Blue and Headspace, which should include dedicated CaLD-focused services

and programs; and targeted CaLD performance benchmarks for all publicly-funded mental health services;

- The provision of both mainstream and dedicated services, including resources allocated to 'mainstream' organisations specifically for cultural competency training, the engagement of interpreters and translators, and employment of bicultural workers. This could involve encouraging the adoption of the 'Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery';
- Implementation of national cultural competency standards for mental health services across Australia;
- Building workforce capacity (improving supply, productivity and access to mental health nurses and peer workers). This could include supporting initiatives such as the Certificate IV in Mental Health Peer work;
- Training for interpreters, and for service providers in the use of interpreters;
- Funding Transcultural Mental Health Centres and Networks in each state and territory; and increasing the capacity of existing transcultural mental health networks to address the existing mental health gaps for CaLD communities;
- Requiring partnerships between mainstream providers and dedicated services, and knowledge transfers statewide and nationally;
- Greater community education and outreach programs to counter stigma, discrimination and other barriers to engaging with mental health services, with a focus on those particularly vulnerable to mental health issues such as the aged, newly-arrived, youth, men, women, regional, homeless, people with co-occurring disabilities, and those with torture and trauma backgrounds;
- Targeted initiatives for the above groups;
- Engaging employers, schools, community organisations and workplaces in local initiatives which improve both mental health understanding and reduce stigma and discrimination;
- A person centred approach and an integrated stepped care model that designs and wraps services around the needs of the whole person. This requires a shift to

community based services, primary health care, prevention and early intervention. Services should be community based and focused on supporting individuals and families, particularly in the early years. Services must be coordinated, and delivered locally;

- More research and culturally-appropriate campaigns regarding suicide in CaLD communities;
- Improved data collection, reporting and analysis of suicide in CaLD communities; and targeted suicide prevention programs for CaLD communities;
- Reporting on progress on policy objectives (and therefore the need for systematic evaluations);
- A funded national CaLD mental health research agenda;
- The need for reliable statistics about prevalence rates. This could be achieved through national surveys of mental health which include representative samples of at least some CaLD populations. CaLD-relevant variables must be included;
- Ensuring adequate reporting of patterns of use of mental health services, and the experience of mental health services, of CaLD communities; and
- More research into and recognition of the social determinants of mental health and illness; different cultural explanatory models of mental illness; beliefs, knowledge and attitudes towards, and experiences with, health services; and help-seeking practices among CaLD communities. Ensuring research involves participation of people with mental illness and their families and support persons. Improving research capacity in the area of CaLD mental health.

Conclusions

There are clear gaps in the literature about prevalence, trends, issues and effective mental health service provision for CaLD communities generally, and in Western Australia specifically. A range of sources recommend improvement to data collection mechanisms, particularly collecting and centralising demographic information to allow CaLD prevalence rates to be determined. Currently policy makers and service providers have no information

about prevalence generally, and about which conditions and which communities or sub-groups specifically may require support and services. This is not just a West Australian problem, but an issue Australia-wide, and ultimately an Australia-wide solution will be needed. However, in the short term, within WA, collecting, collating and making available such data would assist with service provision.

There is also a need for rigorous evaluations of services and interventions to determine their effectiveness, particularly for CaLD groups. Again, quantitative data about effective treatments, stigma reduction and awareness raising is necessary to enable the design of more effective services and programs.

Although conclusions about whether migrants have higher or lower levels of diagnosis of mental illness cannot be made, CaLD communities experience a range of challenges that may affect their well-being and mental health. These include pre-migration factors such as trauma as well as post-migration and settlement issues related to the practicalities of life in a new country, and associated emotional and cultural adaptation. They also may experience a range of barriers to accessing mental health services including internal (stigma, misapprehensions, language and cultural barriers) and external (cost, lack of awareness, inadequate service provision and service integration). A set of recommendations for overcoming these is included in the above, and the executive summary, and focuses on the need for explicit recognition of the issue, for dialogue with communities, the provision of culturally appropriate services and training and accreditation for providers, a whole-of-community approach to reduce stigma and raise levels of 'mental health literacy', as well as a person-centred approach to treatment, and targeted approaches for particular at-risk groups.

The review did reveal numerous reports containing sets of recommendations built on research and consultation. These provide useful general suggestions for the provision of services. What was striking in reviewing the literature was the consistency of these recommendations over time. What is needed is action, to improve the accessibility and quality of mental health services for people from CaLD backgrounds.

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Appendix A

Government reviews reviews of CaLD mental health

Multicultural mental health remains one of the key challenges for reform in Australia, with a commitment that 'Australia has a responsibility to promote services that are accessible, equitable and culturally responsive to reflect Australia's diverse population' (MHiMA 2016: 3). The MHiMA report recommended the development of a national multicultural mental health program with 'robust governance and accountability', noting that accountability must not only include Government, but also CaLD communities (MHiMA 2016).

The *Mental Health in Multicultural Australia* (MHiMA) project wrapped up in 2016 and is being replaced by the *National Multicultural Mental Health* project, funded through to December 2020 (Mental Health Australia 2018).

In the almost two decades under investigation there have been three reviews and subsequent renewals of the National Mental Health Plan. The last was in 2014, which led to the COAG endorsed Fifth Plan (2017-2020) (Department of Health 2017). As the national focus informs local service provision it is worth understanding the type of messaging being delivered to State and local governments with regards mental health provision more generally.

The Fifth National Mental Health Plan contains no explicit reference to CaLD, multicultural, migrant, or refugee groups' experience of mental illness or access (Vayani 2015) but identifies 'Priority Area 1: Achieving integrated regional planning and service delivery' (Department of Health, 2017: 18). The Fifth Plan also dedicates space to a discussion of 'diversity of experience of mental-illness across populations' but does not reference CaLD/migrants specifically, although it does mention trauma (Department of Health, 2017:4-8). In the eight priority areas identified only two mention CaLD communities specifically.

The last review of mental health found that the Australian mental health system had some fundamental shortcomings. The impact of a 'poorly planned and badly integrated system is a massive drain on people's wellbeing and participation in the community - on jobs, on families, and on Australia's productivity and economic growth' (Department of Health 2017:.3). The review was framed on the basis of making change within existing resources. Recommendations are based on three key components:

- Person-centred design principles;
- A new system architecture; and
- Shifting funding to more efficient and effective 'upstream' services and supports.

The principles underpin the Commission's 25 recommendations across nine strategic directions (see Department of Health 2017).

Previous reviews, such as the Department of Health and Aging 'Review of Multicultural Mental Health Australia (MMHA) Project (Roberts et al., 2009) highlight common barriers, including:

- Language - reluctance to use services due to language and cultural differences, lack of interpreter use or misuse of interpreters, limited information available in community languages;

- Cultural differences between client and clinician - culturally insensitive attitudes of organisations and service providers, lack of appropriately trained staff to work with CALD consumers;
- Knowledge - limited of awareness/knowledge about available services and GP referral patterns;
- Experience - pre-migration experience and/or trauma experiences; and
- Stigma - differences in cultural explanations and perceptions surrounding mental health.

A range of barriers to effective service delivery were identified including funding cycles, funding levels, model flexibility and responsiveness, lack of strategic focus, poor evidence based, inherent state/national tensions, and lack of systemic commitment to multiculturalism. It found the Project had become 'out of step' with the reality of recent changes in the multicultural mental health landscape, and recommended changes to the program model as follows:

- The MMHA model is based on a highly collaborative and partnership engendering philosophy which is appropriate for the issues of the transcultural mental health and suicide prevention. However the model has not been effectively implemented;
- MMHA has established various forums with which to engage with these stakeholders however these forums have not worked effectively for a range of reasons. The key issues relate to the size of some of the forums, the lack of transparency and clear role delineations as well as overall management of the project; and
- The current form of the MMHA model is not sustainable. Clearer reporting lines need to be established, greater clarity in the respective roles and responsibilities of the respective stakeholders of the MMHA project need to be defined and stronger governance arrangements need to be implemented.

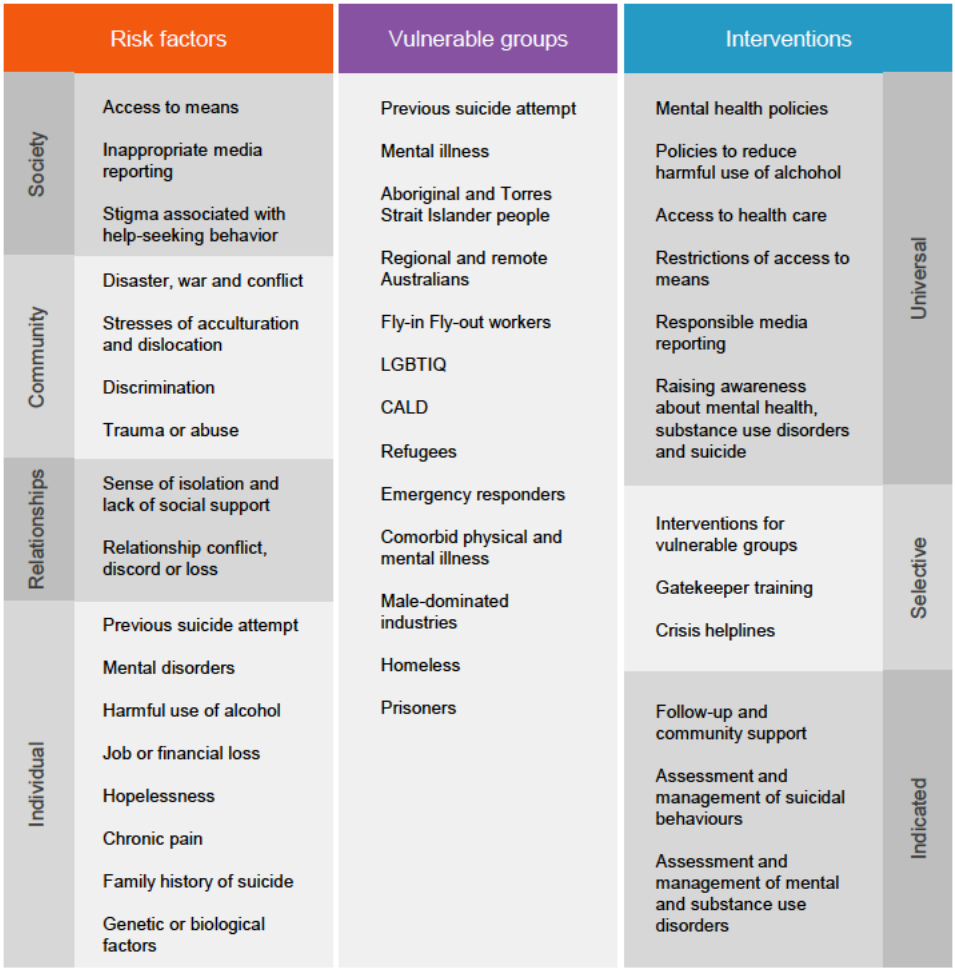
In 2019 the Australian Government, through its Productivity Commission, conducted a national mental health inquiry. 522 submissions were received from national, state, non-government organisation (NGO) bodies and individuals, educational institutions, state and local governments and advocacy groups. The draft inquiry report notes generational change, with awareness about mental illness increasing, while the mental health system has not kept pace (Productivity Commission, 2019:4). The Inquiry finds that the treatment and support available for people with mental illness in Australia is coming from a 'system largely designed around the characteristics of physical illness' (Productivity Commission, 2019: 4). Significant reforms are suggested, with increasing resources required. These include prevention and early intervention for mental illness and suicide attempts; the need to close critical gaps in healthcare services; the need for investment in services beyond health; assistance for people with mental illness to get into work and enable early treatment of work-related mental illness; fundamental reform to care coordination, governance and funding arrangements.

Two paragraphs concern people of CaLD backgrounds, based on four submissions and the 2007 National Mental Health Survey. The Inquiry confirms that 'at an aggregate level, the prevalence of mental illness in the CaLD population is lower than that of the general population' (Productivity Commission, 2019: 169), but recognizes the dated sources of data,

which do not include the recent increases in overseas born CaLD migrants. It notes that 'immigrants and refugees would be expected to differ in mental illness prevalence, given the different circumstances surrounding their arrival', noting in particular issues for humanitarian entrants (Productivity Commission, 2019: 169).

The findings of the report reflect the findings of this review. It acknowledges limited data on mental health within the CaLD population, and argues there is a significant case for CaLD specific considerations in mental health service delivery. In particular, all identified risks for mental ill-health affect the CaLD population with the additional burden of CaLD experiences adding further risks (although in some instances these can provide protective factors), in particular for humanitarian migrants. The figure below from the draft report Volume 2 (Productivity Commission, 2019:852), reproduced below, demonstrates how CaLD people may experience an intersection of risk, being a vulnerable group with a range of co vulnerabilities, leaving them at risk of suicide.

Figure 21.7 **Key suicide risk factors, vulnerable groups and interventions**



Source: Adapted from WHO (2014a).

Appendix B

National and State Services, and examples of good practice

National Resources and Services

The following information about national resources and services is taken directly from the Federal Department of Health (2014) Fact sheet (additional comments have been added in square brackets). It outlines existing services for those from CaLD backgrounds, funded federally. All are mainstream services, apart from PASTT, reflecting a policy approach that sees provision of services to CaLD communities as most appropriately delivered through mainstream services.

Mental Health Services

- People with a diagnosed mental disorder can access mental health services through Primary Health Networks (PHNs) or Medicare subsided services under the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative.
- The Government provides funding to PHNs to lead mental health and suicide prevention planning at a regional level. Through a flexible primary mental health care funding pool, PHNs improve outcomes for people with or at risk of mental illness and/or suicide, in partnership with relevant services.
- PHNs are required to commission primary mental health services within a person-centred stepped care approach, so that a range of service types are available within local regions to better match with individual and local population needs. Each PHN is required to commission services across six priority areas, namely:
    - Low intensity mental health services to improve targeting of psychological interventions to most appropriately support people with mild mental illness;
    - Early intervention for children and young people with, or at risk of, mental illness, including those with severe mental illness who are being managed in primary care;
    - Psychological therapies for people in under-serviced and/or hard to reach populations, including rural and remote populations;
    - Primary mental health care services for people with severe mental illness being managed in primary care, including clinical care coordination for people with severe and complex mental illness;
    - Encourage and promote a regional approach to suicide prevention; and
    - Enhance and better integrate Aboriginal and Torres Strait Islander mental health services at a local level.
- More information about the primary mental health services that are provided through PHNs and any eligibility requirements is available from your local PHN. The contact details for all PHNs can be obtained from the following website: www.health.gov.au/phn.

- The Better Access initiative aims to improve outcomes for people with a clinically-diagnosed mental disorder through evidence-based treatment. It is available to patients with an assessed mental disorder who would benefit from a structured approach to the management of their treatment needs. To find out more about how to access these services, please visit the following website: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-fact-pat.
- For more detailed information on the Better Access initiative MBS item descriptors and explanatory notes, please visit the Department of Health's MBS Online website.

Programme of Assistance for Survivors of Torture and Trauma (PASTT)

- The Department of Health provides funding to PASTT service providers to deliver mental health and other support to permanently resettled humanitarian entrants and those on temporary visa products living in the community who are experiencing psychological and/or psychosocial difficulties resulting from their pre-migration experiences of torture and trauma.
- PASTT services include:
    - Direct counselling and related support services, including advocacy and referrals to mainstream health and related services to individuals, families and groups who have experienced torture and trauma;
    - Education and training to mainstream health and related service providers;
    - Provision of resources to support and enhance the capacity of specialist counselling and related support services to deliver effective services and to respond to emerging client needs;
    - Community development and capacity building activities to emerging community groups; and
    - Outreach services to rural, regional and remote areas.
- Agencies delivering PASTT services are all members of a network of specialist rehabilitation agencies that work with survivors of torture and trauma, known as the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT). There is a FASSTT member agency in each state and territory in Australia.
- Clients can be referred through a wide range of sources including Humanitarian Settlement Services (HSS) administered by the Department of Social Services (DSS), other settlement services, general practitioners and other health services, education providers, legal services, community services, family, friends, community members and through self-referral.
- [In Western Australia this service is run by the Association for Service to Torture and Trauma Survivors (ASeTTS). ASeTTS provides services in Community Development, Counselling, Family and Children, Support for those working with Traumatized clients, and Youth Support Services, as well as offering a Place of Reflection for those who have experienced torture and trauma.]

Support for Day to Day Living in the Community

- The Support for Day to Day Living in the Community (D2DL) program is transitioning to the National Disability Insurance Scheme (NDIS).
- The D2DL program is a structured activity program which aims to improve the quality of life for individuals with severe and persistent mental illness, including individuals from CALD communities.
- This program seeks to increase the ability of clients to participate in social, recreational and educational activities with the aim of living with an optimal level of independence in the community.
- 38 organisations around Australia are funded to provide D2DL services at 60 sites to approximately 8,700 people including difficult to reach groups such as people from CALD communities.

Partners in Recovery

- The Partners in Recovery (PIR) program is transitioning to the National Disability Insurance Scheme (NDIS).
- PIR aims to better support people with severe and persistent mental illness with complex needs and their carers and families, by getting multiple sectors, services and supports they may come into contact with (and could benefit from) to work in a more collaborative, coordinated, and integrated way.
- Through system collaboration, PIR promotes collective ownership and encourages innovative solutions to ensure effective and timely access to the services and supports required by people with severe and persistent mental illness with complex needs to sustain optimal health and wellbeing.

Head to Health

- Central to the Australian Government's mental health reforms is making optimal use of digital mental health services, including through the development of a consumer-friendly digital mental health gateway, Head to Health.
- Head to Health aims to help people more easily access information, advice and digital mental health treatment options (and non-digital options if considered more appropriate to need).
- People seeking help and support, and anyone wanting to learn more on how to maintain good mental health wellbeing are encouraged to visit the website at: www.headtohealth.gov.au
- Head to Health includes information for people from culturally and linguistically diverse backgrounds. Information supporting culturally and linguistically diverse people is available at: https://headtohealth.gov.au/supporting-someone-else/supporting/culturally-and-linguistically-diverse-people

Department of Social Services (DSS) measures

Free Interpreting Service for medical practitioners

General Practitioners and approved medical specialists can use the Free Interpreting Service when delivering Medicare-rebateable services in private practice to anyone with a Medicare Card. Information on the Free Interpreting Service is available on the Department of Social Services Website.

Free Translating Service

The Department of Social Services provides a free translating service for people settling permanently in Australia. The purpose of the Free Translating Service is to support participation in employment, education and community engagement.

Permanent residents and select temporary or provisional visa holders are able to have up to ten eligible documents translated, into English, within the first two years of their eligible visa grant date.

More information and applications for the Free Translating Service can be accessed online at www.translating.dss.gov.au.

[A report by FECCA (2016) recommends the implementation of a national, multi-jurisdictional training and credentialing program to increase the quantity and quality of translation and interpreting services in new and emerging languages. Hlavac (2017) makes a range of recommendations for practices and protocols for interpreters to follow in mental health situations.]

[The recent roll out of 'My Health Record' that provides a single source of information for health care providers and professionals, allowing continuity of care for people with complex needs has come with fear among the general population, including CALD persons living with a disability, about their data being available online. Dr Siyat Abdi, who has worked extensively with migrant communities in SA and WA, warns that many CALD consumers, 'particularly those living with a disability, lack confidence in accessing and using an online system' (FECCA 2018:36), meaning they may be disadvantaged. There are also issues of privacy and confidentiality for young people from CALD backgrounds, since My Health Record is accessible by parents of children until they are 18. Young people of CALD background may be reluctant to see medical professionals, if their privacy cannot be maintained.]

Western Australian Resources and Services

A range of resources and services targeting CaLD communities, or health professionals working with CaLD communities, exist in Western Australia. We outline these below. It must be noted that dedicated services for humanitarian entrants, which are provided by a range of organisations including Red Cross, Metropolitan Migrant Resource Centre, MercyCare, Communicare, Multicultural Services Centre, assist with the settlement process more generally, providing a range of support and assistance programmes which, while not directly 'mental health' services, do assist with these migrants' wellbeing.

Multicultural Resources for Health Professionals

https://ww2.health.wa.gov.au/Articles/J_M/Multicultural-resources-for-health-professionals

This site provides generic resources for health professionals useful for engaging CaLD clients. It is not specifically about mental health.

Multicultural resources for health professionals

Multicultural resources and services are available for people from culturally and linguistically diverse (CaLD) backgrounds.

WA health system Multicultural Services Directory

This Directory (PDF 496KB) is a compilation of programs and services offered by the WA health system that directly address or are inclusive of health needs of Western Australians from culturally and linguistically diverse backgrounds (CaLD). It also includes those that are provided by community based organisations which are funded by the WA health system.

Office of Multicultural Interests resources

Search Diversity WA (external site) is an online search facility that details the demographic, cultural and social economic backgrounds of Western Australians, including profiles of all WA electoral divisions and local government areas.

The report Cultural Diversity in Western Australia – a Demographic Profile (external site) is based on the 2016 Census and outlines Western Australia's cultural and linguistic diversity.

The Office also holds information on new and emerging communities in Western Australia (external site).

The Western Australian Office of Multicultural Interests (external site) has a number of fact sheets and resources on working with CaLD communities.

Framework towards culturally inclusive service delivery

The Mental Health in Multicultural Australia (MHiMA) (external site) is a project designed to provide advice and support to those working in mental health and suicide prevention in CaLD communities.
Information on the website can be translated by selecting a preferred language.

WA Public Patient's Hospital Charter

The Western Australian Public Patients' Hospital Charter (external site) has been translated into 15 languages explaining the rights and obligations of a public hospital patient and providing details about how feedback can be provided about an experience in a public hospital.

Australian Charter of Health Care Rights

The Australian Charter of Health Care Rights (external site) has been translated into 17 languages by the Australian Commission on Safety and Quality in Health Care.
The charter specifies the key rights of patients and consumers when seeking or receiving healthcare services.

Federation of Ethnic Communities Councils of Australia (FECCA)

Visit FECCA (external site)

The people of Australia

The People of Australia – Australia's Multicultural Policy (external site) reaffirms the importance of a culturally diverse and socially cohesive nation.

WA Multicultural Health Initiatives

https://www.healthywa.wa.gov.au/~/media/Files/Corporate/general%20documents/Multicultural/PDF/wa-health-multicultural-health-initiatives.ashx

In 2015, a mapping of multicultural health initiatives was undertaken by the Cultural Diversity Unit to identify health policies, programs and services offered by the WA Health system that directly address or are inclusive of the health needs of Western Australians from culturally and linguistically diverse backgrounds (CaLD).

In the process of collecting information they found a wide range of initiatives being implemented across the whole public health system that encompassed health services delivery, workforce capacity building, consumer participation and understanding population diversity and health needs. While these were sometimes stand-alone initiatives and run by disparate parts of the health system, when put together, they argue, these demonstrate an organisational approach to cultural diversity and a strong commitment to the provision of safe, high quality and welcoming health care.

From the literature, the report identifies 6 domains essential to a culturally competent health service:

1. Deliver accessible and culturally appropriate health services and information for people from CaLD backgrounds.

2. Disseminate linguistically and culturally appropriate health education materials, including feedback about health care.

3. Demonstrate commitment to multicultural health through organisational policies, principles and strategies across WA Health agencies.

4. Build organisational and staff understanding of the health needs of CaLD communities in WA.

5. Develop cultural competence of WA Health staff at all levels through training and other professional development activities, staff meetings, induction sessions and the like.

6. Enable participation of consumers and carers in feedback, service planning and program development.

While the mapping exercise managed to capture a broad range of multicultural health activities across WA Health, it does not purport to present a complete picture of all activity within the system.

This site mentions the WA Transcultural Mental Health Service (TMHS), which was funded by Royal Perth Hospital (RPH), and underwent a review in 2015. The TMHS had submitted a proposal to continue its work through a hub and spoke model of service delivery, which was ultimately not supported for funding. No dedicated mental health unit has been funded for several years. Other migrant and CaLD specific services, as well as mainstream services, have been providing services and support. In 2018 an evaluation found that the decision to mainstream the service, embedding it in RPH's usual services, has worked well.

Related to this debate, an article was published by the ABC news (Shine, 2019) focussing on mental health issues for international students, using anecdotal evidence based on a number of suicides. The article quotes a number of Western Australian sources advocating for a dedicated mental health service for migrants including international students. ISHAR, WA Ethnic Communities Council, Ethnic Disability Advocacy Centre, African Collective and Greens party spokespeople identified the need for a specialised statewide service, arguing NGOs are having to fill the gaps. The main issues raised include that there are no specialist, culturally appropriate mental health services in WA; that community groups have had to fill the gaps in mental health care; and that this is despite a review finding this service should have been set up in 2017.

Relevant WA services include the following:

Association for Services to Torture and Trauma Survivors (ASeTTS)

https://asetts.org.au/

The Association for Services to Torture and Trauma Survivors (ASeTTS) has a proud history of serving humanitarian entrants and refugees settling in WA since 1992. ASeTTS provides services to people who are humanitarian entrants or are from a refugee type background and who have experienced torture or trauma in their country of origin, during their flight to Australia, or while in detention.

ISHAR Multicultural Women's Health Services

https://www.ishar.org.au/

ISHAR Multicultural Women's Health Services provides a range of services to women from all cultural backgrounds. Services include counselling about sexual and reproductive health including post miscarriage, domestic violence assistance, and a Clinical Psychologist with experience and knowledge in the trans-cultural mental health field, who offers psychological therapy and counselling.

Multicultural Services Centre

http://mscwa.com.au/our-programs/multicultural-wellness-program/

The Multicultural Services Centre offers, among other programs, a wellness program for the frail, elderly and people with disabilities. It includes social support, but does not appear targeted to mental health.

The Mental Health Access Service – Multicultural Futures

http://multiculturalfutures.org.au/services/mental-health-wellbeing/

The Mental Health Access Service is a metro-wide service for people from a migrant or refugee background. It works in partnership with government and non-government service providers and private practioners to support individuals, carers, and families experiencing difficulties and concerns with mental health and emotional wellbeing to create life experiences that make a difference and enhance recovery.

Multicultural Communities Council of WA Mental Health Program (MCCWA)

https://mccwa.org.au/mhp.html

MCCWA delivers mental health education and awareness programs for multicultural communities in Western Australia. These appear to focus on substance abuse. They also host a range of youth support projects aimed at well-being and relationships (not specifically mental health related).

Women's Health and Family Services (WHFS): Multicultural Women's Advocacy and Support Service

https://www.psychologytoday.com/au/counselling/multicultural/wa/city-of-perth

The broader Service includes counselling, and help with eating disorders and mental health, among other things. It offers individual and family counselling, as well as art therapy groups, advocacy and support and informal coffee mornings for women experiencing mental health issues. The Multicultural Women's service appears restricted to domestic violence issues, but CaLD women could access the other mainstream services through the WHFS.

Children and young people

https://www.ccyp.wa.gov.au/media/1292/policy-brief-mental-health-children-and-young-people-from-culturally-and-linguistically-diverse-communities-september-2013.pdf

This policy brief focuses on the mental health and wellbeing of children and young people from culturally and linguistically diverse (CaLD) communities, including those from a refugee background.

Private counsellors

https://www.psychologytoday.com/au/counselling/multicultural/wa/city-of-perth

There is a website within Psychology Today entitled Multicultural Counselling in Perth, WA. It lists private counsellors who offer culturally sensitive counselling services.

Examples of specific programs and interventions

In this section we highlight several examples of dedicated interventions, specifically a guideline for GPs, a tool for use by health providers; a peer leader program that brings on board community members; a program that uses support groups; a community play; and a consumer participation model. Few of these have been evaluated.

Guideline

It is recognized that mainstream services are often the first port of call for CaLD members with mental health issues. GPs have some useful resources available to them, including the RACGP's online resource, 'Managing mental illness in patients from CALD backgrounds' (Kiropoulos, Blashki and Klimidis, 2005). It includes issues such as somatization (presenting with physical rather than psychological symptoms), stigma, language issues, the role of family and friends, religious beliefs, expectations (reticence) of medication, and issues related to the general practice setting (lack of recognition of some mental health issues such as depression, greater likelihood of identifying more severe mental illnesses), non-compliance with pharmacological management, and the relevance of the patient's social context; plus details of how to elicit the patient's explanatory model of illness.

Tool

The 'Cultural Awareness Tool' (Seah et al., 2001) is an online resource useful for medical practitioners to assist with diagnosis of patients from CaLD background. It outlines different cultural beliefs in relation to mental illness, including beliefs about sources of mental illness, examples of the types of differences in understandings of mental illness that may exist across cultures, and offers a set of questions which can be asked of patients to understand the mental issue from their perspective in culturally appropriate terms. It also has cultural competence self-assessment questions for practitioners, and tips of communicating effectively, including use of interpreters (see http://www.mhima.org.au/pdfs/Cultural_aware_tool.pdf)

Peer Leader Program

Research affirms that lay health workers are becoming increasingly recognised as critical tools in mental health, while not replacing professional health workers (Lewin et al., 2010). The 'Community Navigator Model' draws on local natural leaders selected by community members. These leaders provide a conduit between their community and health service providers (Henderson & Kendall 2011). This paper looks at a health module introduced into a culturally and linguistically diverse (CALD) community in Logan Queensland. The paper

reviews the approach used in the 'Navigator Model' that uses bilingual health workers from the community to address disparities in reducing health problems within the local population. This study revealed several challenges faced by the chosen leaders, which included an intrusion into their personal time.

Social Support Group

The World Health Organisation (2010) found that improved social support, a sense of comfort and belonging improves mental health. Eftimovska-Tashkovska et al. (2016) reviewed a program to support Australian based Macedonian and Serbian migrants with a serious mental illness such as depression or anxiety. As an alternative to medication, a peer support group method of treatment was trialed which includes individuals who have lived experiences and are able to assist others with similar problems (Eftimovska-Tashkovska et.al 2016). The 'Mental Health and Living Skills' involves discussions and focus groups, using bilingual health district personnel. Results indicate a reduction in social isolation and the prevalence of depression and anxiety among those who do not feel a sense of belonging. The results revealed a marked improvement in the mental health and wellbeing of the participants.

Community Drama

Research demonstrates mental illness is highly stigmatised, mental health services have low levels of utilization, and there is widespread discrimination towards people with mental illness in Sydney's Macedonian community. Many families conceal it, only seeking professional help when the situation becomes intolerable. Blignault et al. (2009; 2010) report attribution of mental illness to evil spells or demons is widespread, and in many cases a folk healer or priest is consulted prior to seeking professional help. Statistics showed that when contact was made it was often for acute or involuntary treatment. As part of a multifaceted community intervention to improve mental health literacy and reduce stigma, a Macedonian-language play was produced, using information from qualitative studies and professional experience to craft a script that was performed by actors from the Macedonian community. Eight performances at three venues were attended by approximately 1,600 people. Telephone interviews with 236 audience members (including 76 with personal or family experience of mental illness) and 25 key informants were conducted 1–10 months later. Data were analysed and compared with data collected pre-intervention. Compared with the earlier data, the audience was significantly more likely to report positive community attitudes toward people with mental illness and their families, and to favour disclosure to extended family and friends. They also indicated greater willingness to seek help from health services. Key informants reported greater service utilisation since the play was staged. A Macedonian- language family education group was less successful in encouraging mutual support and sharing of experiences than other language-specific groups.

Consumer Participation

A model for CALD Consumer Participation in Mental health, (Queensland Transcultural

Mental Health Centre and Multicultural Centre for Mental Health and Wellbeing, 2005) outlines an action project designed to improve CaLD communities' consumer participation in mental health support. It engaged a range of communities including Arabic-speaking, Bosnian, Farsi-speaking, Filipino, Samoan, Spanish-speaking, Vietnamese, Sudanese and Somali. It used a staged approach to make communities open and ready; used media campaigns; engaged community leaders; conducted mental health literacy workshops; held community events such as Mental Health Week Community; offered Cultural Perspectives Seminars; and employed a project coordinator and a team of bilingual/bicultural community workers. The report includes a list of self-reflexive questions for organisations desiring to engage CaLD communities in consumer participation and a range of learnings are also included. They make the point that culture affects consumer participation in a number of ways including levels of familiarity with the concept of consumer participation, familiarity with and acceptance of concepts of advocacy, unrealistic expectations of outcomes, styles of consumer participation (e.g. committees, boards, voluntary advocates, paid representatives), models of understanding of illness and health and frameworks for understanding mental health or mental illness (e.g. spiritual, holistic). They note the need to deal with issues of stigma and shame and develop understanding, to recognize differences of language and communication styles, to deal with mistrust in the mental health system, to acknowledge the different beliefs about mental illness, to increase mental health literacy. They recognize the need for commitment, integration in 'core business', reciprocity, trust and respect, cultural competency of mental health services, ongoing community mental health literacy and a community development approach. The report identifies key issues for consumer participation and offers practical advice. It recommends increasing mental health literacy and destigmatizing mental illness, as well as increasing cultural competence of mental health services through ethnic media campaigns, engaging community leaders, conducting mental health literacy workshops within communities using bilingual workers, holding community events such as 'mental health week', engaging communities and practitioners in community cultural perspectives seminars, establishing consumer groups to provide input and participation in mental health service planning, development and implementation.

Appendix C

CALD country of origin mental health issues (Australian literature)

As part of the current literature review, searches were undertaken using Google Scholar to identify Australian and West Australian research on CaLD mental health issues among selected communities. Summaries of the results are provided below.

We begin this section with a cautionary note. We have outlined a range of ways in which culture may impact CaLD mental health. But culture should not be assumed to be monolithic, as within country of origin groups there are likely to be multiple ethnic, racial and language groups, as well as complex intersections of social locations such as class, gender, age, stage in life, language ability, sexuality, and so on, that will impact the experience of and engagement with mental health issues (see Tilbury et al., 2004; Tilbury 2007; Blignault, Ponzio, Rong & Eisenbruch, 2008). For example, Tilbury et al. (2004) discusses the experiences of communities from four different countries of origin within the region known as the Horn of Africa. Eritrea, Ethiopia, Somalia and Sudan (Sudan is discussed pre-South Sudanese independence). Among the WA participants representing these four African nations there are more than 21 different ethnic groups, 13 languages and 7 religions evident. Thus where country-based cultural profiles are produced, they do not represent the views or beliefs or cultural practices of all those originating from that country (Tilbury et al., 2004). Within the context of assessing or addressing mental-ill health among these communities, the importance of acknowledging diverse cultural differences among and between groups cannot be understated. Having made this point, we outline briefly the literature about mental illness and selected ethnic communities in Australia, since 2000, noting that none of these studies use representative samples.

Asian

A growing proportion of Western Australia's migrant population are from China. In 2008 Chinese-language speakers comprised the largest non-English speaking population in Australia, but they had the lowest rates of use of mental health services utilisation (Blignault, Ponzio, Rong & Eisenbruch 2008). Blignault et al. (2008) conducted in-depth interviews with an unrepresentative (predominantly female) sample of China-born mental health patients, members of the general community and mental health service providers. Several barriers to mental healthcare access and quality of care were identified: mental health literacy, communication difficulties, stigma, confidentiality concerns, service constraints and discrimination (Blignault et al., 2008). Communication issues include culturally sensitive aspects like the appreciation of idioms, cultural and social references. Again the recommendation is for cultural competencies among mental health services when providing both acute and continuing care to persons from CaLD communities (Blignault et al., 2008).

In a study of mental health literacy among Chinese, Wong et al. (2017) compared mental health literacy of Chinese people in Australia, China, Hong Kong and Taiwan, considering implications for mental health promotion. Participants were asked questions that assessed their recognition of depression and schizophrenia. The study found that much lower percentages of Chinese in the four Chinese communities could 'correctly' identify depression and early schizophrenia (using Western diagnostic criteria). Cultural factors such as Chinese

perceptions of mental illness, and socio-contextual factors such as differences in mental health care systems in the four communities were offered to explain these commonalities and differences.

Wynaden, Chapman, Orb, McGowan, Zeeman & Yeak (2005) found six main themes that influenced Asian communities' access to mental health care and how mental health care is delivered to them: shame and stigma; causes of mental illness; family reputation; hiding up; seeking help; and lack of collaboration. The findings suggest those of Asian backgrounds may be unwilling to access help from mainstream services because of their beliefs, influenced predominantly by stigma and shame. The authors also highlight that refugee women are a particularly vulnerable group within Australia.

In a study of Vietnamese parents' perceptions of child and adolescent mental illness McKelvey et al. (1999) discovered that psychotic symptoms, disorientation and suicidal thoughts and behaviour were considered psychopathological. Vietnamese migrants preferred Western style treatment options, but were unaware of community mental health services for children. Likely causes of mental illness were identified as a biological/chemical imbalance, traumatic experiences, or metaphysical/spiritual imbalance.

African

Of the 32.2% of Western Australians born overseas, African immigrants make up 3.1% (Wamwayi et al., 2019). The largest percentage of African migrants are from South Africa (27183) followed by a significantly lower number from Zimbabwe (7686) and then Kenya (3053). The majority of African-born permanent migrants to Australia arrive on visas other than a Humanitarian entry/visa, but these are mainly white South Africans. Of humanitarian entrants a majority originate in Sudan, followed closely by South Sudan. Those born in Sudan and South Sudan also form a majority of the African patients admitted to the tertiary mental health facility studied by Wamwayi et al. (2019).

Wamwayi et al. (2019) argue that providing culturally appropriate care to African immigrant mental health inpatients 'may require a paradigm shift for healthcare organisations in Australia' (p. 1114). They report a Caucasian Australian ethnocentric focus that is not culturally appropriate to African immigrant inpatients, especially those survivors of humanitarian crises. The study identified seven themes relating to the provision of services in an Australian tertiary mental health hospital: inadequate interpreter services, lack of cultural awareness staff training, lacking links with other services, unmet spiritual needs, use of staff/families as interpreters, provision of culturally inappropriate information, and inadequate culturally appropriate policies (Wamwayi et al., 2019). Despite ample evidence that cultural awareness is important for best practice, culturally inappropriate care for CaLD inpatients continues. Recommendations include adaptations that

> incorporate language service strategies; linkage with other expert agencies that may assist in providing care; education and training opportunities supporting the development of cultural competencies at undergraduate levels as well as through continuing professional development updates; and frameworks and policies for best practice and optimal outcomes of safe, quality mental health nursing care for African immigrant inpatients (Wamwayi et al., 2019: 1119).

African women carry an extra burden as humanitarian migrants with a range of psycho social factors affecting wellbeing (Tilbury et al., 2004; Tilbury & Rapley, 2004; Tilbury, 2007;

Wamwayi et al., 2019; Okegbile, 2014).

Religion, folk healing, and the support of elders may be important in mental health treatment for those of some African backgrounds (Okegbile, 2014; Tilbury et al., 2004).

Tilbury and colleagues (2004; Tilbury and Rapley, 2004; Tilbury 2007, Fozdar 2009) undertook a study in Perth, WA, of understandings of depression among African and other communities. More detail about mental health issues for Sudanese, Somalis, Ethiopians, and Eritreans in WA can be found in their reports. They found that mental health is often a source of shame for African communities. The study reports that post migration experiences (employment, culture shock, intergenerational and gender conflict, discrimination, bureaucratic difficulties, family reunion, language issues, lack of opportunities for interaction with other Australians, etc) were understood as being causes of depression, rather than pre-migration traumas. Mental health issues are understood in some African cultures as a result of disequilibrium; for some evil spirits, the evil eye, or 'an act of God', may be understood as causes. Traditional forms of healing, including herbal and religious healing, may be sought before medical, although medications are also highly valued. Beliefs will depend on level of education. Some communities are predominantly Muslim, others predominantly Christian. They recommend interventions designed to promote positive settlement experiences including support for employment, education, social interaction, family reunion, and understanding culture shock. They also found that African communities prefer information about mental health to be conveyed at community events in a fun, social way, or through community magazines or radio, or with customized videos, and by members of their own communities. African communities also suggested a community centre and community activities would alleviate some of causes of distress, along with structural changes to improve access to language, education and employment. Bicultural community educators, the use of elders, 'medical visitors', and cross cultural engagement steering group were also suggested as ways to improve access.

See also Ngayua and Harris (2008); Drummond et al. (2011); Schweitzer et al. (2006), Sheikh-Mohammed et al. (2006), Savic et al. (2016), Tempany (2009).

Indian

According to Gunasekara et al. (2019) when compared to other skilled migrant groups, such as European migrants, Sri Lankan and Indian migrants have distinct characteristics such as a 'non-English speaking background; strong sense of belonging to the country of birth; strong values towards ethno-cultural relationships; high regard for religious beliefs and traditional customs; and maintaining multigenerational households' (Gunasekara et al., 2019: 43). There is very little literature discussing Indian or Sri Lankan mental illness in Australia, although some discussing wellbeing in this usually skilled migrant group. One article refers to high levels of wellbeing reported among this migrant subgroup, although the sample was not representative and more research was called for (Gunasekara et al., 2019).

In a study of 30 Anglo-Australians and 28 Indian-Australians living with depression in Melbourne, Australia, the CHIME model was applied (connectedness, hope and optimism about the future, identity, meaning in life and empowerment) (Brijnath 2015). The study found CHIME was applicable in both groups, but culture mediated how cross-cutting issues (e.g. stigma) and how sub-components of CHIME were operationalized. Socio-economic

context influenced recovery among both these groups.

Middle Eastern

Arabic-speaking

Little is known about the intergenerational and cross-cultural differences in emotional wellbeing and acceptability of psychological treatments for Arab Australians (Kayrouz et al., 2015; Dardas & Simmons, 2015). Kayrouz et al. (2015) found higher psychological distress among Arab Australians compared to the Australian population. However, Dardas and Simmons (2015) argued professionals should avoid making generalisations about cultures that are not based on specific research findings from that culture.

Kayrouz et al. (2015) investigated psychological distress and functional impairment among Arab Australians, including queries about help-seeking behaviours, barriers to accessing psychological treatments and preferences for delivery of psychological treatments. The significant barriers reported by respondents with high psychological distress (Kayrouz et al., 2015; Dardas and Simmons, 2015; Yousef and Deane, 2006) included poor mental health literacy, lack of time, stigma and shame. Yousef and Deane (2006) who conducted interviews with 35 key informants from Arabic-speaking backgrounds, exploring their perceptions of mental illness in the Arab community revealed concerns about confidentiality and lack of trust in service providers.

In another study, a literature review of Egyptians' beliefs about mental illness, Endrawes, O'Brien, and Wilkes (2007) attempted to shed light on the Australian context for migrant Egyptians by looking at mental illness in Egypt. The Zar cult and related practices (evil eye, magic and evil possession) along with education and religion are important influences. Unsurprisingly, this article recommends that mental health practitioners in Australia should provide culturally sensitive care (see also Logan et al., 2017).

Traditionally, the utilization of mental-health services by Arabic-speaking communities in Australia has been low (Kayrouz et al., 2015; Youssef and Deane, 2006), although as noted, Logan et al. (2017) found that Middle Eastern-born patients' service ultilisation increased over time. Dardas and Simmons' (2015) research revealed that a 'holistic and patient-centered' nursing approach was vital to helping Arab identifying patients to incorporate values, beliefs and cultural perspectives into their treatment plans. Another study found that religious leaders were identified as important sources of help for mental-health problems (Yousef and Deane, 2006). Better promotion of existing mental-health services (Kayrouz et al., 2015; Yousef and Deane, 2006), working more closely with Arabic religious leaders and families, modifying online services and understanding the impact of ethnicity on service use were some of the suggested strategies to improve help-seeking and mental-health service utilisation.

Iran

Two papers were found that discussed Iranian migrants to Australia specifically. Alizadeh-Khoei, Khoshin and Khavarpour (2010) looked at well-being and depression among Iranian elderly. Their findings show that 44% the research participants experienced a moderate level of anxiety and depression; and that socio-demographic and acculturation were

significant predictors of physical and mental health. The study concludes that chronic medical conditions, physical and social activity, accessing information and awareness of aged care services predict both mental and physical health status of Iranian elderly respondents.

Hosseini (2016) investigated how the challenges of migration to Australia adversely influence mental health among Iranians, as well as resilience and subjective well-being, using results from an online survey (n=182), followed by participation in semi-structured interviews. The quantitative findings indicate lower levels of subjective well-being and higher levels of psychological problems including: psychological distress, depression, anxiety and stress. Contributing factors were found to include: unemployment, incomplete tertiary education, living in Australia for less than 5 years, being younger and unmarried, high levels of discrimination, and refugee status. Higher levels of well-being were reported by participants proficient in English. Hosseini (2016) finds that resilience mediated the association between personal well-being and migration. Resilience also partially mediated the association between satisfaction with life as a whole and migration. Additionally this study suggests that resilience mediated the association between discrimination and depression and partially mediated the association between marital status and the level of education, and psychological distress, anxiety or depression. Resilience also partially mediated the association between migration and anxiety. Personal competency was the only key predictor of anxiety and satisfaction with life as a whole.

Some specific elements relevant to Iranian migrants in Australia and seen as contributing to what Hosseini (2016) identifies as 'integration risk factors' are a lack of knowledge about Iran and Iranian culture in Australia and tensions over Iranian/Muslim cultural practices (e.g. controversy surrounding the wearing of the Hijab). In turn Iranian migrants found engaging in Iranian cultural practices (e.g celebrating Iranian national holidays) and being proud of their Iranian nationality to be protective factors. Recommendations include improving employment opportunities, reducing discrimination, approaches that minimise the stress of the settlement process, and interventions that aim to strengthen resilience.

Iraq

Iraqis currently form one of the largest groups being resettled through the humanitarian program in Australia. Four papers were identified relating specifically to this Middle Eastern sub-group.

Guajardo, Slewa-Younan, Santaluca and Jorm (2016) aimed to determine cultural considerations required when providing mental health first aid to Iraqi refugees experiencing mental health problems or crises. Using a Delphi method, 16 experts were presented with statements about possible culturally-appropriate first aid actions via questionnaires and were encouraged to suggest additional actions not covered by the questionnaire content. Statements were accepted for inclusion in a guideline if they were endorsed by ≥90 % of panellists as 'Essential' or 'Important'. From a total of 65 statements, 38 were endorsed (17 for cultural awareness, 12 for cross-cultural communication, 7 for stigma associated with mental health problems, and 2 for barriers to seeking professional help).

Guajardo et al. (2016) aimed to explore psychological distress in two samples of Iraqi

refugees, those who recently arrived (n = 225, average length of stay = 0.55 months) and those with a longer period of resettlement (n = 225, average length of stay = 58.5 months). A significant difference between groups was found, indicating that study participants with longer periods of resettlement were experiencing higher levels of psychological distress than recent arrivals. The key recommendation is the need for assistance programs beyond the initial arrival period.

Utilising a culturally adapted Mental Health Literacy survey method, Slewa-Younan et al. (2017a) surveyed 225 Iraqis and 150 Afghans of refugee background. Approximately 52% of the Iraqi participants selected 'experiencing a traumatic event' as the 'most likely' cause for the clinical vignette. While both groups identified being 'born in war torn country' as the most likely risk, at 34.4 and 48% of the Iraqis and Afghans respectively, differences regarding other risk factors selected were noted. The results suggest the need for culturally sensitive health promotion and early intervention programs seeking to improve MHL relating to PTSD in resettled refugee populations, and the need to recognize the gap between Western, biomedical models for mental health care and the knowledge and beliefs of resettled refugee populations.

In another study, Slewa-Younan (2017b) used a culturally adapted Mental Health Literacy Survey method to determine knowledge of, and beliefs about, helpfulness of treatment interventions and providers for posttraumatic stress disorder (PTSD) amongst resettled Iraqi refugees. Only 14.2% of participants labelled the problem as PTSD, with "a problem with fear" being the modal response (41.8%). A total of 84.9% respondents indicated that seeing a psychiatrist would be helpful, followed by reading the Koran or Bible selected by 79.2% of those surveyed.

It must be noted that these studies all focus on Iraqis of refugee background, and therefore should not be generalized to the wider population.

Syria

Maldari, Elsley and Rahim (2019) describe the health status of Syrian refugees seen at the Refugee Health Service in South Australia in 2016, based on a cross-sectional study of data from medical records, revealing a relatively young cohort with large families. In the adult population, 26.9% reported symptoms such as anxiety, depressed mood and poor sleep. The study reinforces the importance of comprehensive health screening for new arrival refugees. A validated mental health screening tool was not used, and this requires further research.

Afghanistan

A small scale study (n=28) of recent mothers of Afghan background in Melbourne found emotional challenges following birth, identifying symptoms commonly associated with postnatal depression were attributed to separation from family and culture, leading to loneliness, isolation, and disconnection (Russo, Lewis, Joyce & Luchters 2015). Participants expressed resistance towards professional support due to cultural stigma associated with mental illness. Partner support was seen to be positive but difficult to negotiate. Religion, strong relationship with child, forming friendships, education, and utilising childcare were

identified as positive influences on the emotional wellbeing of women. Findings confirm the need for innovative community-based models to support the mental health of Afghan women (Russo, Lewis, Joyce & Luchters 2015).

Another study, discussed previously for Iraqi migrants, also addresses Afghans of refugee background (Slewa-Younan et al., 2017a, b; Yasser et al., 2016)). 150 Afghans were surveyed using a culturally adapted mental health literacy survey. This study sought to determine the beliefs regarding the causes of and risk factors for post-traumatic stress disorder (PTSD). 31.3% of the Afghan sample selected 'coming from a war torn country' as their top cause (Slewa-Younan et al., 2017). Both groups identified being 'born in war torn country' as the most likely risk, at 34.4% and 48% of the Iraqis and Afghans respectively. In the vignette study, which described a fictional person suffering from posttraumatic stress disorder (PTSD), 31% of the respondents identified the problem depicted as being PTSD, while 26% believed that the main problem was 'fear' (Yaser et al., 2016). 18% believed that 'getting out and about more/finding some new hobbies' would be the most helpful form of treatment for the problem described, followed by 'improving their diet' and 'getting more exercise' (16 %). Of this group of participants, 44% met criteria for clinically significant PTSD symptoms and all but one reported being exposed to one or more traumatic and/or conflict related events, such as 'losing your property and wealth'. 14.7% of participants had symptoms suggestive of clinically significant depression. In terms of help seeking, general practitioners were the most common source of help in relation to mental health problems, with very few participants (4.6%) seeking help from specialist trauma and torture mental health services. Self-recognition of PTSD-related mental health problems and functional impairment levels were both found to be independent predictors of help-seeking. The findings provide further evidence for high rates of PTSD symptomatology and low uptake of mental health care among resettled refugees. Mental health literacy promotion programs, health promotion and early intervention programs, and mental health services, are recommended. The authors note that variation in MHL may be a function of both the cultural origin of a refugee population and their resettlement country