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Fifth National Mental Health Plan

The Federation of Ethnic Communities' Councils of Australia (FECCA) is the national peak body representing Australia's culturally and linguistically diverse (CALD) communities and their organisations. FECCA provides advocacy, develops policy and promotes issues on behalf of its constituency to Government and the broader community. FECCA supports multiculturalism, community harmony, social justice and the rejection of all forms of discrimination and racism so as to build a productive and culturally rich Australian society. FECCA's policies are developed around the concepts of empowerment and inclusion and are formulated with the common good of all Australians in mind.

FECCA welcomes the opportunity to provide input into the draft Fifth National Mental Health Plan (the Plan) and thanks the Department of Health for conducting a thorough consultation process to gather feedback to ensure that mental health services are responsive to the needs of consumers and their carers.

Key concerns

Australia has a growing multicultural population: almost a quarter of Australia's population was born overseas and 43 per cent of people have at least one overseas-born parent.[1] It is likely that the 2016 Census will show a further increase in these population groups. Given the diversity of Australia, services and support mechanisms must be reflective of the needs of people from diverse backgrounds.

Nearly 200,000 humanitarian entrants have arrived in Australia between 2000 and 2014.[2] Based on current plans, Australia will welcome an additional 48,750 humanitarian entrants by 2019.[3] In addition, Australia is in the process of resettling 12,000 Syrian and Iraqi

[1] Australian Bureau of Statistics, 2011 Census reveals one in four Australians is born overseas, 2012, accessed at http://abs.gov.au/websitedbs/censushome.nsf/home/CO-59
[2] NEDA data-cube based on Department of Social Services settlement database.
[3] Media release: Minister - Restoring integrity to refugee intake, Peter Dutton MP, Minister for Immigration and Border Protection, accessible at http://www.minister.border.gov.au/peterdutton/2015/Pages/restoring-integrity-to-refugee-intake.aspx

refugees.[4] Further, it is estimated that about 45,000 people who are survivors of torture and trauma have settled in Australia during the last decade[5] and it is likely that many future arrivals will have also experienced trauma and torture.

Considering the data, mental health policy must reflect the large percentage of the Australian Population that come from CALD backgrounds. The needs of people from migrant and refugee backgrounds are distinct to those of the general population. **Therefore, specific focus needs to be given to this cohort within the Plan.**

FECCA welcomes the proposed priority areas. However, **it is disappointing to note that except for a number of *ad hoc* references, the draft consultation paper does not specifically address the challenges and needs of people from CALD backgrounds as a focus.**

With regards to a National multicultural mental health structure in 2014, the Mental Health in Multicultural Australia (MHiMA) was launched to improve the cultural responsiveness of mental health service delivery for people from CALD backgrounds. The Framework is aligned with current policies, plans and standards relevant to multicultural mental health and it is cross-referenced to the relevant standards and accreditation requirements.[6] FECCA reiterates the need for the Australian Government to provide targeted funding for a national multicultural mental health structure. The structure must provide an informed, representative and legitimate leadership that will ensure that mental health reforms achieve positive outcomes for culturally and linguistically diverse individuals and communities.[7]

Pre and post migration experiences have a significant impact on an individual's physical, social and mental wellbeing. **The Plan does not address the key challenges faced by migrants, especially refugees, humanitarian entrants and asylum seekers.** Issues that impact the mental health of this cohort include: time spent in refugee camps or situations of protracted displacement without access to appropriate medical or mental health supports; time spent in refugee camps or situations of protracted displacement without access to formal education, training or employment; torture and trauma; separation from family; poor maternal care; and sexual assault. In addressing these issues, individual settlement experience in Australia, for example familiarity with Australian systems and cultural expectations and norms, must also be given due consideration in designing mental health support services.

The long delays in processing visas and uncertainty of the outcomes also impact on mental health of people on temporary visas.[8] The availability of family reunion is important for successful settlement, allowing migrants to maintain family ties and connections. Many people are forced to choose between being separated from their family or staying in

[4] Australia's response to the Syrian and Iraqi humanitarian crisis, Department of Immigration and Border Protection, https://www.border.gov.au/Trav/Refu/response-syrian-humanitarian-crisis (accessed on 09/02/2016).
[5] The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT), The case for specialist mental health services for refugee survivors of torture and trauma, *Australian Mosaic*, FECCA, Issue 41 (2015), p. 30.
[6] Hamza Vayani, The Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery, *Australian Mosaic*, FECCA, Issue 41 (2015), p. 8.
[7] See further: FECCA and National Ethnic Disability Alliance, *MHiMA Project Consultation: Joint submission from the Federation of Ethnic Communities' Councils of Australia and the National Ethnic Disability Alliance,* 2016, accessible at: http://fecca.org.au/wp-content/uploads/2016/02/MHiMA-project-submission-to-MHA.pdf
[8] See further: Sarah Cemlyn and Linda Briskman, Asylum, Children's Rights and Social Work, *Child and Family Social Work with Asylum Seekers and Refugees,* Ed. Ravi Kohli, Vol 8, Issue 3 (2003), pp 183-178

Australia on a temporary visa without access to services while they wait lengthy periods for their substantive visa to be processed and finalised. As the Plan is intended to be implemented over the next 5 years, it is imperative that these concerns are given due consideration.

People from ethnic and racial minority groups encounter increased social stress.[9] As social stress is associated with the development of mental illness … racism is considered a possible specific risk factor for mental illness in ethnic minority groups.[10] The experiences of racism and discrimination of people from CALD backgrounds, especially the growing negative attitudes towards specific cohorts including African and Muslim communities[11] may result in increasing mental health issues among people from CALD backgrounds, once again highlighting the need to incorporate a specific and adequately resourced mental health framework for people from CALD backgrounds.

The National Mental Health Commission's Review *Contributing Lives, Thriving Communities* identified that people from diverse cultural backgrounds may be less likely to disclose signs or symptoms of mental ill-health and may not feel comfortable seeking help.[12] This could result in people not receiving appropriate supports to manage and alleviate their mental health conditions at early stages. For example, due to lack of awareness of Autism and other learning disabilities these conditions remain under-diagnosed within CALD communities.[13] There is a clear need to improve access to mental health for people from CALD backgrounds. Such a process should incorporate culturally appropriate outreach and education mechanisms that respond to the diverse needs of people from different cultural backgrounds, migration experiences and different linguistic capacities.

Compared to the general population, the utilisation of services, especially those relating to mental health are lower amongst people from CALD backgrounds.[14] Despite the fact that migrants and refugees are considered a high-risk category for mental and physical health problems, mental health services were found to be under-utilised by these groups, especially those with limited English skills.[15] Other key barriers to access for CALD Australians are: low levels of awareness about available services, attitudes towards mental health issues and lack of self-identification of mental health conditions, especially those of episodic nature. **The Plan must identify appropriate communication mechanisms supported by actions to improve awareness and interactions especially with hard to reach communities who are disconnected from the main stream supports.**

Finally, **FECCA wishes to highlight the failure of existing data to properly represent the number of people from CALD backgrounds suffering from mental health and behavioural disorders because of limitations in the data collection methodology.** These limitations include failure to disclose mental health issues due to stigma and shame,

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[9] Kwame McKenzie, 'Racial Discrimination and Mental Health', *Psychiatry*, Volume 5, Issue 11, November 2006, pp 383 – 387.
[10] *ibid*
[11] Scanlon Foundation, *Australians Today,(2016) accessible at* *http://scanlonfoundation.org.au/australians-today/*
[12] National Mental Health Commission, *Contributing Lives, Thriving Communities:* Report of the National Review of Mental Health Programmes and Services, (2014), pp. 105 – 107.
[13] See further: Sandra Labor, Family Adjustment Across Cultural Groups in Autistic Spectrum Disorders, *Advances in Nursing Services,* April 2014, Vol 37, Issue 2, pp 174-186.
[14] See generally: FECCA, *Multicultural Access and Equity: Building a cohesive society through responsive services*, 2015 (accessible at http://fecca.org.au/wp-content/uploads/2015/08/Multicultural-Access-and-Equity-Report-2014-2015.pdf)
[15] Michael Leach and Fethi Mansouri, *Life in a Limbo: Voices of Refugees under Temporary Protection,* (2004), p. 100.

cultural reasons, lack of awareness about services, language barriers and lack of or limited diagnosis of mental health issues.

The Survey of Disability Ageing and Carers dataset captures information about country of birth and language spoken at home as indicators to determine whether a person comes from a CALD background. This excludes a large percentage of people whose parents are from a non-English speaking country and who self-identify as coming from a CALD background based on ancestry. Considering the lack of appropriate data collection mechanisms and other barriers to access mental health services, FECCA is of the view that the number of CALD Australians with psycho-social mental health conditions is potentially much higher compared to the available statistics.

As per current statistics 41 per cent of people with profound to severe mental and behavioural disorders in Australia come from a CALD background.[16] The actual numbers are expected to be larger. Considering the large proportion of people from CALD backgrounds and their particular needs, it is imperative that the Plan adequately focus on the specific needs of this cohort supported by 'proposed actions'.

General comments

Mental health is closely linked to various other factors such as physical health, socio-economic background, employment, education, housing and homelessness and issues of identity and belonging. Challenges experienced by people with mental illness are too often dealt with in isolation rather than through integrated, wraparound programs. This leads to system inefficiencies and poorer mental and physical health outcomes for individuals.[17] **FECCA recommends that this Plan incorporates systems to interact with other areas including employment, education, housing and homelessness.** Such a structure should have a proper plan of engagement that is inclusive of people from CALD backgrounds and be designed to meet the particular needs of CALD people in those areas where CALD communities are often disadvantaged. Such services require adequate resources to ensure any engagement is meaningful.

It is encouraging to see a clear emphasis on the consumer as well as carers, throughout the draft Plan. Carers play a vital role in the decision making process as well as ensuring the general wellbeing of the person with mental health issues. The glossary further elaborates that carers may be a family member, friend, neighbour, member of the broad community or a staff member. In some communities, the decisions about the types of supports, living arrangements and the like are made by the family as a unit. People involved in these decision making processes may or may not be the primary carer of the person with mental health issues. **FECCA recommends that the plan replaces the phrase 'consumers and carers' with 'consumers, their family members and carers'.**

FECCA is pleased to see a strong focus on suicide prevention, physical health of people living with mental health issues and reduction of stigma and discrimination. However, **one notable absence is the discussion of mental health conditions and their relationship with age** in particular mental health conditions common among older people.

[16] National Ethnic Disability Alliance Datacube based on Australian Bureau of Statistics Survey on Disability, Ageing and Carers 2015.

[17] David Butt, *Body and mind: Care for the whole person across the whole system*, Australian Healthcare & Hospitals Association, (October 2015), accessible at: https://ahha.asn.au/news/body-and-mind-care-whole-person-across-whole-system

The Plan discusses the intersectionality between mental health needs and the NDIS; however, very little focus is paid to the link between aged care services and access to mental health services. Australia has a culturally diverse ageing population. In 2011, 36 per cent of Australians aged 65 years and over were born overseas (including people from English-speaking countries such as the United Kingdom, the United States of America, South Africa and New Zealand), compared to 26 per cent in the general population.[18] By 2020, 30 per cent of the population aged 65 and over will be from CALD backgrounds.[19] With the increase of the ageing population from CALD backgrounds, FECCA has highlighted the growing demand for culturally appropriate healthcare including mental health supports for older people from CALD backgrounds. We believe that the Plan should incorporate further discussion of age-specific mental health needs aimed at increasing which will guarantee much needed early intervention and the delivery of targeted services for older people requiring support with mental illness.

Access to public health supports for people with disability living in Australia is dependent upon the type of visas they hold. Differentiating and discriminating between people with disability based on their residential status or visa type is contrary to Article 5 and Article 28 of the *United Nations Convention on the Rights of Persons with Disabilities* (CRPD), which protects equality and non- discrimination and the right to adequate standard of living and social protection respectively. Article 5 (iv) of the *Convention on Elimination of Racial Discrimination* (CERD) stipulates that state parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the [...] right to public health, medical care, social security and social services. Any limitation or restriction on accessing services, including mental health services, will be contrary to the protections guaranteed under these international instruments. FECCA recommends that the Plan focus on the people who are currently ineligible to access services based on their visa status and provide achievable and pragmatic solutions to eliminate systemic discrimination of people and to ensure access to services irrespective of the visa status or mode and time of arrival in Australia.

Proposed Priority Areas

Priority Area 1: Integrated regional planning and service delivery

Integration of supports to ensure availability and accessibility of individually tailored services for consumers and carers is vital and we support all measures adopted to improve the experience of the consumers, their carers and family members in rural, remote and regional areas.

Regional settlement is increasingly being promoted as a settlement option for refugees and for temporary migrants. Social inequalities and isolation contribute to poor mental health outcomes for people. In addition to settlement services; adequate culturally appropriate mental health services must be available in rural and regional areas with large CALD and refugee communities.

FECCA believes that an effective way of reaching these communities is through Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) at the regional level. FECCA has been working with PHNs and LHNs around their strategies for reaching CALD

[18] Australian Bureau of Statistics, Reflecting a Nation: Stories from the 2011 Census (2012-2013).
[19] 2 FECCA, 2020 Vision for Older CALD Australians, available at: http://fecca.org.au/wp-content/uploads/2015/11/FECCA2020Vision.pdf

communities in areas including mental health and ageing. As different PHNs operate autonomously, it would be valuable to incorporate a system where all PHNs and LHNs adhere to a set of basic guidelines in terms of delivery of the mental health services. National consistency in general service delivery—albeit with flexibility to cater for individual needs—is vital.

Priority Area 2: Coordinated Treatment and Supports for People with Severe and Complex Mental Illness

The draft Plan highlights that approximately 690,000 people or 3 per cent of the population have a severe mental illness.[20] FECCA contends that CALD people are likely to be an overrepresented in this cohort. Notwithstanding the under reporting of the number of people from CALD backgrounds with mental health issues, these numbers—as they stand—demonstrate the need to adequately resource and provide culturally appropriate supports for this cohort.

The draft Plan also states that close to 57,000 National Disability Insurance Scheme (NDIS) participants would have significant and enduring primary psychosocial disability, which is expected to increase to 64,000 by 2019-2020.[21] The NDIS is one of the most important social reforms in relation to welfare of people with disability in the recent history. The Scheme provides people with disability, including psychosocial disability, an invaluable opportunity to be independent and pursue their potential through an individually tailored and self-directed funding program.

According to the National Disability Insurance Agency Quarterly Report to COAG Disability Reform Council, 30 June 2016 the CALD engagement was only 4 per cent in the current trial sites.[22] According to the current estimates participation rate of CALD people with disability within the NDIS should be between 20 – 25 per cent.[23] This minimal participation within the NDIS could be a result of inadequate allocation of resources for advocacy services to engage people from CALD backgrounds.

Those from CALD backgrounds affected by psychosocial disability and trying to access the NDIS have compound disadvantages: lower levels of diagnosis and recognition of mental illness and psychosocial disability, and higher barriers to accessing the NDIS. Improving access to the NDIS through the Plan, for priority groups such as people from CALD backgrounds will be a step forward towards improving the overall effectiveness of the coordinated mental health service provision for those with psychosocial disability.

Eligibility for the NDIS is limited to those who hold Australian citizenship, permanent residents or hold a protected special category visa, excluding many people with psychosocial and other disabilities from CALD backgrounds who hold temporary visas.

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[20] Department of Health, *Fifth National Metal Health Plan: Draft Consultation paper,* 2016, p.26.
[21] Ibid p. 27
[22] National Disability Insurance Agency, Quarterly Report to COAG Disability Reform Council (30 June 2016), accessible at https://www.ndis.gov.au/medias/Report-to-the-COAG-Disability-Reform-Council-for-Q4-of-Y3-PDF-2.5MB-?context=bWFzdGVyfHJvb3R8MjU3NDk3M3xhcHBsaWNhdGlvbi9wZGZ8aGUwL2hhMi84Nzk4MDM0NzIyODQ2LnBkZnw0ZjZkYzM0MTI5NDRjZGEzZjkyMmEyZjQyNzJhM2M1YjQyMWNiMDA0YTVhZjJjYjBjNWUzNTU1MzAxMWFjNzg0
[23] See generally: FECCA, Access and Equity in the Context of the National Disability Insurance Scheme, (2015), accessible at: http://fecca.org.au/wp-content/uploads/2015/06/Access-and-Equity-in-the-Context-of-the-National-Disability-Insurance-Scheme-June-2015.pdf

Government agencies must identify and promote alternatives to the NDIS to assist people with disability in Australia who are not currently eligible to participate in the NDIS.

Limited access to disability related supports including the NDIS and access to other medical supports for people with disability, lack of culturally appropriate specialist therapies and inability to participate in community activities may lead to social isolation and increasing the possibility of developing mental health issues. Therefore, FECCA reiterates the need for a holistic approach that factors in other physical, mental and cultural barriers when coordinating supports for people with mental health issues.

The plan aims to ensure that safeguarding mechanisms are in place so that people with severe and complex mental illness have access to, and do access, integrated services where they need them and when they need them.[24] Action 3 under this prority area of the draft Plan relates to Government support for the initiation of a coordinated service delivery for people with severe and complex mental illness through development of national guidelines. It is important to identify the existing guidelines, frameworks and other literature to avoid duplication of work under the Plan.

Priority Area 3: Suicide Prevention

FECCA supports the inclusion of suicide prevention as a key priority area and the incorporation of follow-up support for people who have attempted suicide. It is encouraging to see that the Plan aims at building community knowledge of services available in local areas to support people who are at risk of attempting suicide. Although this is a national mental health and policy issue, it is important to ensure that the focus of the Plan does not deviate from the individual and their carers, family members, friends and other community members and a focus on the 'local' is welcome.

Suicide prevention must be a national priority—nearly 65,000 individuals attempt suicide and almost 600,000 think about suicide each year, and suicide remains one of the largest causes of death in Australia.[25] Regrettably, most of the research conducted in this space does not disaggregate data in relation to a person's cultural background with the exception of people from Aboriginal and Torres Strait Islander background. Accurate and publicly available data is essential in streamlining services and in ensuring that those who are most vulnerable are in receipt of timely and culturally appropriate services.

It is vital to have meaningful measures to ensure that there is a public health response to reduce the number of suicides and suicidal behaviours appropriate to target groups including CALD communities. Detection and treatment of mental health conditions are only one facet of a holistic public health approach to suicide prevention. This approach should encompass a suite a supports such as crisis intervention and management, enhanced support for people at risk of suicide, torture and trauma counselling especially for refugees and asylum seekers, broader community awareness and stigma reduction, and bereavement support for persons impacted by another's suicide, for those who have attempted suicide, and for carers, family members and friends. An approach of this nature was recommended by the *World Health*

[24] Department of Health, *Fifth National Metal Health Plan: Draft Consultation paper,* 2016, p.27.
[25] Suicide Prevention Australia (SPA), 2014, 'Discussion Paper: One World Connected: An assessment of Australia's progress in suicide prevention', accessible at https://www.suicidepreventionaust.org/content/one-world-connected-assessment-australias-progress-suicide-prevention

Organisation.[26] Further, as we have learned from working with Australia's Indigenous communities on suicide and mental health, supports must be culturally and linguistically appropriate.

Further clarity in relation to the roles of the PHNs and LHNs, as an important point of interaction with CALD communities, in reducing the attempted suicides and support for those at risk need to be elaborated in the Plan. It is also important to highlight the relationship between private mental health service providers, private hospitals and what governance structures are in place to ensure those at risk are receiving the best care available irrespective of the cost and visa status of the person receiving those supports.

The high degree of stigma that is associated with suicide and mental health in some cultural and religious communities can lead to 'shame', and social rejection for a person who has attempted suicide or persons bereaved or at risk of suicide, which can have further consequences for these individuals.[27]

The draft Plan underlines the role of family and friends in preventing suicide attempts and the need to educate them about their responsibilities and supports available to assist people with suicidal tendencies.

… A common theme raised, particularly from carers and bereaved family members, was a sense of confusion when faced with service options, both in terms of accessibility (geographical limitations and navigating service channels) and mental health literacy, that is, knowing how to find the right service at the right time for the issue being experienced.[28]

There is limited accessible information about culturally sensitive suicide prevention strategies and support services for people from CALD backgrounds. The Senate Community Affairs Committee recommended implementation of a suicide prevention and awareness campaign which focusses on the provision of culturally sensitive and appropriate information and services.[29] We support the adoption of a similar approach which also targets the family members of people with mental health issues.

Witnessing or living with a person who died by suicide or has suicidal ideation has a ripple effect on people which increases the development of suicidal thoughts.[30] Given the importance of the role of the close knit families in CALD communities, measures must be adopted to educate the relevant parties about the effects of witnessing such traumatic events and about the supports available to the carers, family members and friends of those that died by suicide, attempted or has suicidal ideation.

In addition to migrants, the large numbers of international students studying in Australia were identified as a CALD community with a higher risk of suicide.[31] This particular cohort of

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[26] World Health Organisation, *Practice Manual for Establishing and Maintaining Surveillance Systems for Suicide Attempts and Self-Harm, accessible at* *http://apps.who.int/iris/bitstream/10665/208895/1/9789241549578_eng.pdf?ua=1*

[27] Senate Community Affairs Committee, *The Hidden Toll: Suicide in Australia,* (2010), p. 74.

[28] Suicide Prevention Australia, *The Ripple Effect: Understanding The Exposure and Impact of Suicide in Australia,* 2016, p. 19, accessible at: https://www.suicidepreventionaust.org/sites/default/files/resources/2016/UnderstandingExposureImpactSuicide_layout_full_web%20single%20scroll.pdf

[29] See: Senate Community Affairs Committee, *The Hidden Toll: Suicide in Australia,* (2010).

[30] See further: Suicide Prevention Australia, *The Ripple Effect: Understanding The Exposure and Impact of Suicide in Australia,* 2016, accessible at: https://www.suicidepreventionaust.org/sites/default/files/resources/2016/UnderstandingExposureImpactSuicide_layout_full_web%20single%20scroll.pdf

[31] Senate Community Affairs Committee, *The Hidden Toll: Suicide in Australia,* (2010), p. 74.

people may experience social isolation. They also lack access to familiar community supports, inability to access mainstream medical and mental health supports, and lack of awareness of available supports. The Plan must identify the needs of this cohort and design support and educational services accordingly.

Community organisations, community and religious leaders and the broader community also play key roles in suicide prevention. On one end of the spectrum, they are best placed to identify people at risk of attempting suicide and those with severe mental health issues within their community and direct them to receive appropriate supports. On the other end, cultural, community and religious convictions around gender and sexuality, shame and stigma in relation to mental health issues may further marginalise and isolate people with suicidal behaviours. Alternative methods of engagement and support service provision must be identified for people from CALD backgrounds are unable to access mental health services and supports within their community or locality.

Special attention needs to be paid to ways of developing proper culturally appropriate and effective mechanisms to support the individuals at risk as well as to educate CALD community organisations and CALD community and religious leaders who can identify and offer support to people at risk from their communities.

Action 6 of the draft Plan discusses the establishment of a new intergovernmental advisory group that will report to Health Minister and set the direction for future efforts through joint planning and informed investment. FECCA endorses this initiative considering the importance of evidence based investment to cater for the needs of different priority groups. In establishing the intergovernmental advisory group, it is critical to ensure that the group is inclusive and representative of Australia's diversity to guarantee that voices of people from different backgrounds, including people from CALD backgrounds are heard in the decision making process.

Priority Area 4: Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention

FECCA supports all measures adopted to improve mental health and suicide prevention among people from Aboriginal and Torres Strait Islander backgrounds.

Priority Area 5: Physical Health of People Living with Mental Health Issues

FECCA is pleased to note that the draft Plan endeavours to address issues in relation to physical health of people with mental health issues considering the close link between physical and mental health. People from CALD backgrounds experience multiple barriers in accessing health services and a general lack of awareness about health screening practices.[32] Therefore, it is important to ensure that people with mental health conditions, their family members, carers and community members are educated about physical health and wellbeing through trusted channels. These individuals need to be supported to participate in activities that promote physical and mental wellbeing.

[32] See further: Royal Australian College of General Practitioners, *The RACGP Curriculum for Australian General Practice 2016: Multicultural Health,* accessible at: http://curriculum.racgp.org.au/statements/multicultural-health/ and NSW Government - Cancer Institute NSW, *Breaking down breast screening barriers in multicultural communities, accessible at: https://www.cancerinstitute.org.au/About-us/news/breaking-down-breast-screening-barriers*

Lack of access to cultural appropriate medical services for people with mental health issues including lack of choices in relation to seeing male or female medical/health practitioners, access to culturally sensitive and appropriate medical settings and the like may deter people from CALD backgrounds from accessing services. In such communities, the primary carers are often family members. Thus, proactive measures must be adopted to educate family members about the importance of physical health of people with mental health conditions. These measures could be implemented through the General Practitioners, community leaders and organisations.

The link between medication, appropriate diets and physical activities must also be made clear to people with mental health issues, their family members and carers. The draft Plan does not contain a discussion in depth as to the link between nutritional diets, and mental health with a special reference to the importance of cultural links to and the importance of maintaining a familiar diet in CALD communities.[33] It is important to encourage culturally appropriate prevention strategies that also focus on promotion of physical and mental wellbeing of people from CALD backgrounds.

FECCA supports the establishment of a framework to ensure regular national reporting on the physical health of people living with mental health issues. It is critical that this national reporting mechanism disaggregate data based on diversity of the population, age groups and areas of residence and to make the data available publicly.

Priority Area 6: Stigma and Discrimination Reduction

Stigma as a barrier to seeking help is a particular concerns for those advocating on behalf of people from CALD backgrounds who suffer from poor mental health. It is, therefore, pleasing to note that the draft Plan's recognition of the fact that stigmatising views about mental illness could be more entrenched in certain areas and among CALD communities.[34] However, this recognition is not sufficiently supported by 'actions' within the draft Plan, especially around the CALD community.

It is important to appreciate the different experiences of public stigma and self-stigma affect people with mental health issues from diverse ethnic communities.[35] Self-stigma may result in more serious consequences such as breakdowns in family, suicide and suicide ideation and social isolation. A public campaign to raise awareness about mental health and discrimination is vitally important. A study similar to 'Who is on my Side?',[36] which focusses on experiences of mental health related stigma and discrimination, will be useful in identifying the sources of discrimination and traditional perceptions of mental illness which are emphasised by CALD communities.

People with mental health issues from CALD backgrounds are more vulnerable to be discriminated against based on their health condition coupled with their cultural background.

[33] See further: AMES Australia, *What's for Dinner? An exploration of changes in eating habits and dietary acculturation among new migrants to Australia,* February 2016, p.4, accessible at: https://www.ames.net.au/files/file/Research/AMES%20Australia%20Migrants%20and%20Food%20Survey.pdf
[34] Department of Health, *Fifth National Metal Health Plan: Draft Consultation paper,* 2016, p. 52.
[35] Tahira Abdullah and Tamara L Brown, Mental Illness stigma and ethnocultural beliefs, values and norms: An integrative review, *Clinical Psychology Review,* Issue 31 (2011), pp 934-948.
[36] See further: G. Shefer, et al, *Who is on my Side? – Qualitative Analysis of Ethnic Minorities Experiences of Mental Health Related Stigma and Discrimination,* (2001).

Structural discrimination against minority communities in the form of differential availability of services further marginalises people from minority backgrounds.[37]

Raising awareness and education in relation to culturally appropriate practices is important in assisting people with mental health conditions, their family members and carers. Action 20 refers to Governments working towards reducing stigma and discrimination within the health workforce through leadership and training. This process should include developing cultural awareness, sensitivity and understanding among the workforce.

Priority Area 7: Safety and Quality in Mental Health Care

Maintaining and upholding quality, confidentiality and safety in mental health care is vital for all stakeholders. Guaranteeing quality of care needs to include culturally appropriate service provision including access to language services and access to a mental health workforce with appropriate cultural and language competencies.

Due to the barriers faced by people from CALD backgrounds when navigating complex support service and language barriers, they often rely on other community members, advocates to support them when accessing services. Thus, advocacy is critically important for people from CALD backgrounds.

Informal advocacy should be given due consideration within the Plan as part of the quality and safeguarding mechanism within the mental health Plan. Measures could be adopted to educate CALD consumers, community leaders, family members and carers of people mental health conditions from CALD backgrounds about relevant services, rights and entitlements. While FECCA does not subscribe to a complete reliance on informal advocacy, it should still be recognised and supported as an important component in a holistic advocacy model.

Understanding about rights, entitlements and responsibilities is limited in CALD communities. For many individuals from CALD backgrounds, Australian laws, regulations and processes are different to those in their country of origin and thus they may require additional assistance to understand the system. Information should also be provided in relation to complaint and feedback mechanisms and frameworks. All these concerns should be taken into account when developing the safety and quality frameworks.

As a measure of ensuring quality of services based on Fourth National Mental Health Plan a consumer experience measuring mechanism was developed. In certain states this measure has been translated into 21 other languages.[38] The data gathered by a similar process is imperative in understanding the experiences of diverse people interacting with mental health services and to make continuing improvements to the framework.

Monitoring and Reporting on Reform Progress

A robust monitoring and reporting mechanism must have explicit equity-oriented targets for people from diverse backgrounds, including those from CALD backgrounds. This process will ensure that the Plan delivers on the specified objectives and highlight areas that require further improvements.

[37] P. Guarnaccia, Determinants of Minority Mental Health and Wellness*, Determinants of Minority Health and Wellness,* Ed Marta Sajatovic and Sana Loue*, (2006), p 380.,*

[38] Department of Health, *Fifth National Metal Health Plan: Draft Consultation paper,* 2016, p.27.

Recommendations

- Include an in-depth discussion into the specific mental health needs of people from CALD backgrounds, including the issues highlighted in this submission. These discussions must be supported by pragmatic and clearly identified 'actions'.

- Incorporate a mechanism within the Plan to address intersectional areas such as employment, education, housing and homelessness. This should include a discussion in relation to systemic and cultural barriers for people from CALD backgrounds.

- Develop a long-term multicultural mental health framework as a part of the Plan to address specific issues and needs of multicultural communities. If not, develop a framework that operates parallel to the Fifth National Mental Health Plan.

- Adopt necessary measures, supplemented with Actions that clearly stipulate the role of both the Commonwealth Government and the State and Territory Governments in delivering robust, nationally consistent mental health services with sufficient flexibility to cater for individual needs.

- Place more emphasis on age-specific mental health needs coupled with 'actions' and reportable indicators to provide early intervention and targeted supports. These measures must be flexible to meet the needs of people from CALD backgrounds.

- Ensure that diverse communities (including CALD communities) are adequately represented when establishing the new 'intergovernmental advisory group' that reports to the Health Minister on suicide prevention in Australia.

- Provide cultural sensitivity and awareness training for the health workforce as part of the initiatives to address reduction of stigma and discrimination against people with mental health issues.

- Develop achievable and pragmatic solutions within the Plan to eliminate systemic discrimination of people who are currently ineligible to access mental health services based on their visa status and time of arrival in Australia.