

CARE –GIVING AND THE
SOCIAL CONSTRUCTION OF
'MENTAL ILLNESS' IN
IMMIGRANT COMMUNITIES



Eastern Perth Public and Community Health Unit
& Murdoch University

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March 2001

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This project was funded by Eastern Perth Public and Community Health Unit and Murdoch University

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Care-giving and the social construction of mental illness
in immigrant communities.

Bibliography.
ISBN 0 9577567 4 7.

1. Mental illness - Western Australia. 2. Minorities - Health and hygiene - Western Australia. 3. Immigrants - Health and hygiene - Western Australia. 4. Minorities - Services for - Western Australia. 5. Immigrants - Services for - Western Australia. 6. Immigrants - Western Australia - Attitudes. 7. Caregivers - Western Australia - Attitudes. 8. Mental health personnel - Western Australia - Attitudes. I. Kokanovic, Renata. II. Murdoch University. III. Western Australia. Eastern Perth Public and Community Health Unit.

362.208691

Cover designed by White Castle Design & Illustration and printed by Della Print.
Report printed by Royal Perth Hospital, Perth, Western Australia.

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Citation

The citation below should be used when referencing this work:

Kokanovic, R., Petersen, A., Mitchell V. & Hansen, S., 2001, *Care-Giving and the Social Construction of 'Mental Illness' in Immigrant Communities*. Eastern Perth Public and Community Health Unit and Murdoch University, Perth, WA.

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Acknowledgments

The Eastern Perth Public and Community Health Unit would like to thank all who gave their time to the consultations that made this project possible. Their contribution is very much appreciated. A sincere thanks goes to all Bosnian, Chinese, Croatian and Polish community members who participated in focus groups, and to all health and mental health professionals who participated and were very generous with their time and expertise. Most of all thanks must go to people who shared their experiences of caring for their relatives.

We are grateful to the following people for providing feedback on the earlier version of this report:

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EXECUTIVE SUMMARY

This is a collaborative project between the Eastern Perth Public and Community Health Unit (EPPCHU) and the School of Social Inquiry, Department of Sociology, Murdoch University. Funding from EPPCHU and a Special Research Grant from Murdoch University were secured in order to conduct this investigation.

This study investigates how carers' understandings and experiences of 'mental illness' and their utilisation of support services is influenced by factors such as culture, language, the experience of migration, and social relationships. Carers were drawn from the Bosnian, Chinese, Croatian and Polish communities of Perth, Western Australia.

Qualitative methods were employed in order to investigate the support services available to the carers of people who have been diagnosed with a mental illness; and the informal support systems utilised by carers. Focus group discussions and semi-structured interviews were used to explore carers' lived experience of the settlement process in Australia; their understanding of mental health and illness; their 'help-seeking behaviour'; and the roles they played in the lives of their relatives.

Focus group discussions were conducted with community members from each of the four cultural groups. In-depth semi-structured interviews were conducted with health and mental health practitioners who had an interest in, and experience of, cross-cultural health and mental health. In-depth semi-structured interviews were also used to collect information from carers who were members of these communities.

All focus group discussions and interviews were recorded, transcribed, and analysed according to the conventions of thematic analysis. Common themes were summarised and supported with relevant quotes from the original transcripts. This report presents a separate synopsis for each group of participants (community members; carers; health and mental health practitioners). Thus, there is considerable repetition in the themes described. A condensed version of these results is available, upon request.

This report outlines the key findings of this investigation, and sets forth recommendations for culturally sensitive policy and culturally competent support for carers from culturally and linguistically diverse communities.

Specifically, the stigma associated with 'mental illness' in culturally and linguistically diverse (CALD) communities tends to prevent people from seeking assistance from external agencies. Further, a general lack of awareness of the Australian health system, and a disinclination to utilise existing services because they are experienced as culturally inappropriate, contributes to the under-utilisation of support services by CALD carers. It is thus imperative that mental health and support services are encouraged to become culturally competent.

1. INTRODUCTION

Cultural competency is appropriate and effective communication which requires the willingness to listen and learn from members of diverse cultures, and the provision of services and information in appropriate languages, at appropriate comprehension and literacy levels, and in the context of an individual's cultural health beliefs and practices.

(The California Cultural Competency Task Force, 1994, in Chin, 2000:26)

Western Australia has an ethnically and linguistically diverse population. As migration may have a major impact on emotional and social well-being, there is a need for a more focused investigation of the links between cultural values, social relationships, language, the migration experience and the experience of mental health and 'illness'. Such an investigation necessitates a detailed analysis of the views of the users or 'consumers' of mental health services, and their carers. Chin (2000) suggests that 'the contribution of socio-cultural factors and "racial" or ethnic differences in health beliefs, lifestyle behaviours, and health behaviours make this an issue of cultural competency' (Chin, 2000:26).

Chin argues further that:

With the growing diversity of the...population, members of minority "racial"/ethnic groups have sought to eliminate the adverse effects of racism on the delivery of health care services. Demands for culturally competent health and mental health services grew out of the failure of service delivery systems to be responsive to all segments of the population. Despite a call for responsiveness to cultural differences in attitudes, behaviours, beliefs, values, and lifestyle as well as language, mainstream health and mental health care systems continued to fail for those under served groups. (Chin, 2000:25)

Unfortunately, to date, clinical research in the area of mental health has tended either to exclude the views of 'patients' and relatives or to treat them as passive objects of study (Pilgram and Rogers, 1993). The research that has been undertaken emphasises the influence of the 'patient's' personal resources, and of wider social structures and cultural values, on the experience of mental health and 'illness' and on the utilisation of services (Littlewood, 1991). Studies suggest that the migration experience, and a 'sociopolitical context of poverty, racism and culture' influence both the utilisation of services and the health status of culturally and linguistically diverse communities (Chin, 2000:28). Migrants are less likely to seek out and utilise mental health services than are Australian born citizens. The literature emphasizes the need for research that explores the effects of dislocation and settlement in a new country on people's experiences of emotional well-being. (Jayasuriya, Sang, and Fielding, 1992). However, to date, few studies have focused specifically on the experiences of *the carers* of migrants in psychological distress.

Both Australian and international research into mental health service provision for CALD communities has outlined a number of common issues (Minas, 1990; Minas 1991). Researchers express concern about the stigma associated with 'mental illness', and emphasise the need for community education, access to information, improved support services for CALD communities and their carers, and for cultural competency training for those working in mental health service provision and promotion. Social isolation, and lack of support for carers from CALD families with a relative who has been diagnosed with a 'mental illness' is

common (Rooney *et al.*, 1998). This may be compounded by insufficient information about the mental health of their relative, how to best care for them, and how to access available services. The high level of stigma associated with ‘mental illness’ may prevent those who are in distress, and their carers from seeking psychological assistance or external support. Further, people’s lack of understanding of the way that health services operate in Australia, and a disinclination to use services because they are experienced as culturally inappropriate, may contribute to their under-utilisation of support services. We believe that the experience of caring for a family member diagnosed with a ‘mental illness’ in immigrant communities cannot be properly understood without appreciating people’s experiences of migration, cultural values, and community responses to ‘mental illness’ and to those described — in Western cultures — as ‘mentally ill’.

Mainstream mental health services have been criticised for their lack of sensitivity to cultural and linguistic differences; for their failure to recognise cross-cultural differences in definitions of emotional well-being, and differences in preferred approaches to treatment. They also often lack an appreciation of the repercussions of the stigma that may come with a diagnosis of ‘mental illness’ — both for those so diagnosed, and for their families (Pilgram and Rogers, 1993). The shortcomings of mental health provision have been of concern to policy makers in Western Australia for some time. The Multicultural Mental Health Steering Committee, established by the Minister for Health in Western Australia, reported that the problem of adequate mental health provision is twofold. According to this report there is a range of ‘identified barriers’ to timely and effective mental health care, which includes language and communication, limited information on the availability and accessibility of services, and a perception of the lack of cultural relevance of certain services offered. Further, ‘the WA mental health services do not provide a sensitive, comprehensive, and consistent response to migrants’ mental health needs’ (The Multicultural Mental Health Steering Committee, 1995: 3-4). This report and others (e.g., Commonwealth of Australia, 1988) have underlined the importance of increasing cultural competency among service providers and policy makers about the impact of migration, culture, language, and social relationships on lived experience, mental health, and on the utilisation of mental health services. This project contributes to this goal by promoting an awareness amongst service providers and users that patterns of belief about ‘mental illness’ — which are likely to significantly affect carers’ experiences of caring and utilization of services - are systematically connected to, and are part of, the socio-cultural system (Kleinman, 1980).

In light of the above, this project explores the experience of ‘having a ‘mental illness’ in the family’ in immigrant communities, and on carers’ awareness and utilisation of available services. Carers have been drawn from the Bosnian, Chinese, Croatian and Polish communities of Perth, Western Australia. Additional information was sought from other members of these communities, and from a number of health and mental health practitioners. We identify and assess the strategies currently adopted by service providers in their efforts to support people from CALD communities diagnosed with a ‘mental’ illness. Such a study is timely in the light of recent concerns about the social and economic impact of ‘mental illness’, and particularly that of depression, on the community. There is a strong need for culturally competent mental health services in Western Australia (Hickman, 1999). We hope that this project will contribute to the goal of facilitating the development of such services, and of stimulating further research.

2. LITERATURE REVIEW

Because he is my husband, a person dear to me, things are not always that difficult. But they are not that easy either...

- Polish Carer

Nobody can help me. Simply...you can talk with me, but I'm living through it alone, do you understand? And who can help? Who can comfort me?

- Bosnian Carer

Even during the most difficult times, if I had enough help it would have been alright...

- Chinese Carer

Everybody...if they knew you had somebody like that in the family, they would insult you, they looked at you as though you were different, they looked at you like you were the same.

- Croatian Carer

If you put it in terms of simply 'stress' and it's the way a person deals with a very stressful event, rather than some sort of madness that is in them, you change the whole way they approach it ... and it makes it easier for them to deal with. Because it is a huge hurdle for a lot of these people to overcome... It's the initial hurdle of "I need help. I need some assistance with my problem."

- Mental Health Practitioner

Carers, as a group, work 24 hours a day, seven days a week, 365 days of the year. They do not get shift allowances ... they do not get recreational leave, and they certainly do not get long-service leave. They have got a huge responsibility ... and there have not been appropriate resources applied to their support (Burdekin, 1993: 455).

2.1 International Principles

Under international law, people who have been diagnosed with a mental illness are entitled to the full range of human rights, without discrimination. Principle 1.4 of the United Nations' *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, states that:

Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognised in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and in other relevant instruments International human rights provisions also make it clear that special measures of assistance or protection may be required in order to ensure that people who are particularly vulnerable or disadvantaged have an equal opportunity to enjoy their human rights (Burdekin, 1993: 20).

However, the non-discrimination provisions embodied in the *International Covenant on Civil and Political Rights* do not specifically cover health care for the 'mentally ill' (Burdekin, 1993).

The United Nations' *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* states that 'all persons have the right to the best available health care, which shall be part of the health and social care system' and emphasises that people who have been diagnosed with a mental illness should not be stigmatised or disadvantaged because of the nature of their illness. The Principles further assert that people have the right to be treated and cared for as far as possible in their community, and that each person has the right to treatment that is suitable to their cultural background (Burdekin, 1993).

2.2 The Australian National Mental Health Strategy

The United Nations' *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* have been endorsed by the Australian Commonwealth government and have been incorporated into the National Mental Health Strategy, which was in operation between 1992 and 1998. The Strategy acknowledges that people with a mental illness often require access to services over and above public and private mental health services. With the shift from hospital to community based mental health care, the need for these supplementary services has increased (Mihalopoulos *et al.*, 1999).

The National Mental Health Strategy also recognises that some groups in the community, for example, people from non-English speaking backgrounds, have particular needs. Further, needs within these groups may vary considerably. Thus, services should cater for and be responsive to the variance both within and between ethnic groups. The Commonwealth government has provided funding of one million dollars over three years to disseminate information on mental health issues and to conduct research into the needs of people from

culturally and linguistically diverse backgrounds who have been diagnosed with a mental illness. Furthermore, the second National Mental Health Plan, released in 1998, strongly encourages increased partnerships between general practitioners (GPs), and public mental health services (Mihalopoulos *et al.*, 1999).

2.3 Western Australia's Mental Health Policy

Western Australia's Mental Health policy, *Making a Commitment: The Mental Health Plan for Western Australia* (Smith *et al.*, 1996) acknowledges the need for specific strategies and actions to cater for people from non-English speaking backgrounds who are experiencing problems in living (Mihalopoulos *et al.*, 1999)¹. This plan specifically identifies refugees and survivors of torture and trauma as amongst those who are most likely to require specialised mental health services. Due to the circumstances of the refugee experience, involuntary migrants may have an understandable preference for seeking help from community organisations rather than government agencies. In accordance with the overall strategy, the policy recognises that people from non-English speaking backgrounds should be involved in the planning, delivery and evaluation of mental health services. It also places importance on the need to train 'the entire mental health workforce about transcultural issues and service delivery' (Smith *et al.*, 1996).

2.4 Carers from Culturally and Linguistically Diverse Communities

The focus of this project is on the lived experience of the carers of people who have been diagnosed with a mental illness. These carers are from four ethnic groups: Bosnian, Chinese, Croatian and Polish. Whilst there is a plethora of English language literature about Chinese perceptions of mental illness and related topics, there is a dearth of similar material on Bosnian, Croatian and Polish perceptions. There is even less material which deals with the experience of carers from these particular ethnic groups.

The focus of this study is on unpaid care. That is, it is unpaid assistance with daily living activities to a family member who is unable to provide self-care because of physical or mental health problems, intellectual damage or delay, or frail ageing (Morse and Messimeri-Kianidis, 1997; and Schofield *et al.*, 1998).

The family's role in caring for the 'mentally ill' became a subject of discussion and research in Western countries with the introduction of widespread policies of de-institutionalisation in the 1960s (Guarnaccia, 1998; Guarnaccia and Parra, 1996). A consequence of moving the 'mentally ill' out of institutions and into the community was that families found themselves shouldering the 'burden' of caring for their relatives. In best practice, the family's care is supplemented with caring from informal and formal resources that are available in the community. Thus, families who are caring for a relative with a mental health problem should

¹ As one of the primary issues in research and practice in the area of mental health and cultural diversity is that of the stigma that often pervades discussions of 'mental illness', we have employed a variety of non-stigmatising alternatives throughout this report. Thus, people may be described as having 'problems with living', as being 'in distress', and so on. Our intention is not to belittle the mental health needs of CALD people through these terminological substitutes. Rather, we take seriously the suggestion that people are more likely, on the whole, to respond to non-stigmatising accounts of their thoughts and behaviour, than to clinically exact, yet less culturally sensitive explanations.

ideally be encouraged to form partnerships with mental health professionals and others working in community based care facilities (Horwitz and Reinhard, 1995). If mental health care is to be optimal, and to be a joint undertaking between family and community mental health practitioners, an understanding of ethnic differences in perceptions of 'mental illness', and of associated caring responsibilities, is of major importance.

The treatment of 'mental illness' within the community has provided many challenges for both those in psychological distress, and their carers. A report focussing on stigma and mental illness in families from non-English speaking or migrant backgrounds showed clearly that carers and their relatives experienced severe isolation and an almost total lack of support from outside the family (Rooney, *et al.*, 1998). In addition, since de-institutionalisation, research in both Australia and the United States of America has shown that families from minority groups and non-English speaking backgrounds under-utilise in-patient and community health services. They also have higher drop-out rates and a greater likelihood of being admitted to psychiatric hospitals as involuntary patients (Schofield *et al.*, 1998; McDonald and Steel, 1997; Sozomenou *et al.*, 2000).

2.5 Gender Differences in Caring Responsibilities

Women are usually the principal care-givers. This responsibility usually rests with the family of origin, and usually with the mother of the person in need of care. (Morse and Messimeri-Kianidis, 1997; Horwitz and Reinhard, 1995; Potasznik and Nelson, 1984). Although the caring role most often falls to women, carers are a heterogeneous group and have widely differing family and personal circumstances, caring situations and feelings about their responsibility for care. Some carers receive external assistance, whilst others prefer to cope within the family. Whilst caring is reported to be fulfilling, stress and social isolation is a likely consequence of taking on a full time caring role. Although some full time carers manage to continue paid work, many more claim a carer's pension, or other forms of support (Fisher, 1996).

Several commentators (e.g., Plunkett and Quine, 1996) have suggested that the increase in the participation of women in the paid work force means there are fewer women available to fulfil everyday caring roles. The 'decreased pool of women available' for full-time, unpaid caring work highlights the need for, and importance of, a variety of community support services (Plunkett and Quine, 1996; Mui *et al.*, 1998).

Research on family care-giving conducted by the Victorian Health Promotion Foundation found a higher proportion of non-English speaking background men, than Anglo-Australian men, amongst carers. The researchers stated that previous studies had shown some ethnic variation in caring, for instance, more Chinese sons had assumed caring responsibilities than had Greek sons. However, they also suggested that this 'high' incidence of male carers could have been produced by the wording of a question on 'the main responsibility in caring'. As non-English speaking background males from some ethnic backgrounds may be more likely to regard themselves as head of their family, their response to this question may have indicated their instrumental position rather than their participation in everyday care-giving. Nevertheless, the finding indicates that greater attention may need to be paid to the role played by male carers and more generally to variations between men and women's care-giving roles in different ethnic communities (Schofield *et al.*, 1998).

2.6 'Objective' and 'Subjective' Burden

Much research on unpaid caring has focussed on 'burden'. Researchers have devised various criteria, including a distinction between 'objective' and 'subjective' burden, in order to determine the effect that caring has on families. Objective burden refers to the effects that caring has on the household, whereas subjective burden describes the interviewee's perception as to whether the household is experiencing a burden (Jenkins and Schumacher, 1999). This division, though useful in terms of drawing attention to the experiences of carers, ultimately serves to dismiss such concerns as 'subjective', as opposed to the more 'objective' effects of caring on households. Further, this dichotomy establishes a hierarchy that prioritizes 'objective' over 'subjective' effects. In any case, the unproblematic deployment of the term 'burden' to describe the effects of caring on carers and their families is potentially offensive to those actually engaged in the daily care of their relatives, who may derive pleasure and meaning from their work.

The use of simple dichotomies to describe complex situations is problematic. Dividing experience into 'burden' or 'duty', and further dividing 'burden' into 'subjective' and 'objective', conceals the complexities and multi-dimensional aspects of caring work. We need to recognise that unpaid care may not be experienced as a 'burden', and may be viewed as essentially pleasurable, especially where loved ones are involved. While recognising the complex and diverse experiences of caring, here we are particularly concerned to make visible the often unacknowledged difficulties associated with caring.

In their comparison of the African American and White American carers of people diagnosed with a mental illness, Horowitz and Reinhard (1995) differentiate between care-giver duties, which encompass the involvement and responsibility of care-givers, and care-giver burden, which they define as the consequences that care-giving activities have for families. They assert that the separation of these two is important in determining how different ethnic groups respond to their care-giver role because the relationship between the two categories differs among different ethnic groups (Horowitz and Reinhard, 1995).

A number of factors are likely to adversely influence the experiences of carers from any cultural or linguistic background. These include psychological and emotional distress, physical illness, disruption to family, and to social and sexual relationships, curtailment of social activities such as hobbies and holidays and financial hardship. Money mismanagement by their 'dependants' may compound problems for carers who are often the primary source of financial support. For many carers, frustration, anger, loneliness and despair are common (Potasznik and Nelson, 1984; Winefield and Harvey, 1993; Bentelspacher *et al.*, 1994; Morse and Messimeri-Kianidis, 1997).

In an Australian study designed to investigate the effects of 'carer burden', Greek-Australian caregivers, when asked to compare their physical health with others (from different ethnic groups) in the same age range, mostly rated it as similar (Morse and Messimeri-Kianidis, 1997). In contrast, Plunkett and Quine (1996) report that carers from non-English speaking backgrounds tend to have chronic health problems, such as diabetes and asthma. They were also likely to have been diagnosed with stress-induced nervous disorders. Other problems reported by carers included insomnia, hypertension and fatigue. It was not uncommon for

carers to have been prescribed anti-depressants, or to have attended psychiatric counselling (Potasznik and Nelson, 1984).

Greek-Australian caregivers assessed their psychological and emotional health as much worse than others of the same age, and directly related their condition to the unrelieved strain and stress of caregiving (Morse and Messimeri-Kianidis 1997). Those caring for a family member reported a chronic state of stress, which they attributed to the difficulty they had in accessing accurate information about the 'condition' of their relative, and the 'uncertainty and unpredictability' of this family member's behaviour. Other reports have found that carer stress is often associated with guilt (e.g. Morse and Messimeri-Kianidis, 1997). Often parents report being concerned that they might be 'to blame' for their child's 'mental illness' (Morse and Messimeri-Kianidis, 1997; Potasznik and Nelson, 1984).

A frequent problem encountered by carers of relatives who have been diagnosed with a mental illness is social isolation. A needs assessment of Bosnian survivors of torture and trauma living in Queensland and their carers - who in many cases had also suffered torture and trauma - suggests an added complication for some ethnic groups. The war in Bosnia destroyed many people's trust in their fellow country folk and thus there is little sense of community among the survivors. Carers in this situation are likely to find themselves even more isolated than most in carrying out their duties.

A similar situation for Bosnian immigrants has been noted in Victoria. There, carer isolation was attributed to political and religious divisiveness and was exacerbated by the isolation of living in areas where there was affordable housing but few service providers. In the outer suburbs of Melbourne, most assistance for Bosnian migrants appears to be provided on a one-to-one basis by fellow Bosnians who have been resident in Australia for longer periods of time (Open Mind Research Group, 1997).

Self-help groups may reduce the social isolation and stress experienced by many carers. A survey of members of three such groups for the families of people diagnosed with schizophrenia in Southern Ontario, Canada showed that having a satisfactory support network, and understanding counsellors, helped lower carers' levels of stress and reduced their sense of isolation. Members of these self-help groups reported learning new information about schizophrenia and the mental health system, and new coping strategies from their interactions with fellow members. Through their involvement in advocacy work, members gained a sense of empowerment. This was expressed in terms of reduced feelings of victimisation and impotence in dealing with the mental health system (Potasznik and Nelson 1984).

Members of the South Australian branch of the Schizophrenia Fellowship took part in a research project that collected information on the tasks undertaken by care-givers, their psychological and physical well-being and the sources of their stress (Winefield and Harvey 1993). As with the Canadian study, it showed that care-givers with inadequate family support were more at risk of psychological distress than were those with reliable networks. Although the information presented on schizophrenia was 'highly appreciated' by the participants, carers drew attention to their need for ongoing support, and indicated a need for greater assistance from the mental health system, including improved accommodation for those not living at home and better vocational training (Winefield and Harvey 1993).

Contrary to the popular belief that people from culturally and linguistically diverse backgrounds use extended family members to distribute caring responsibilities, a number of research surveys have shown that CALD carers are generally unassisted by those outside of their immediate family (e.g., Morse and Messimeri-Kianidis, 1997; and Plunkett and Quine, 1996). The Victorian Carers' Program's findings also challenge the commonly held assumption of extended family support. They found that there was no difference between non-English speaking background groups and Anglo-Australian groups in the number of secondary carers, or in the amount of assistance provided. The report suggests that women from non-English speaking backgrounds shoulder most responsibility for care, since they reported worse health and significantly greater overload, anxiety and depression than English speaking background carers, and that their everyday life with their spouse and children had suffered as a result. The report also showed a lower use of respite, home and community based services than Anglo-Australian families (Schofield *et al.*, 1998). Further action is necessary in order to render support services more accessible to carers from non-English speaking backgrounds.

Although community support may seem cost-effective for the state, empirical evidence suggests otherwise. Research on the long term care of the elderly, including those with dementia has found that in-home and community based care in the USA is more likely to increase rather than decrease long term care costs (Hicks and Lam, 1999). Finances aside, researchers argue, the real goal and benefit of home care needs to be looked at in terms of improving 'quality of life'. Some carers opt for home care without the provision of formal service (Morse and Messimeri-Kianidis, 1997). Because few monetary costs are demanded of the state it appears as if family based care is 'free'. It is not. The toll may be heavy in terms of compromised personal health and well-being, and significant disruption to the families of care-givers. In the area of mental health care-giving, as in many other areas, the contribution of women from non-English speaking backgrounds to the economy is underestimated, and not accounted for in economic terms (see Waring, 1988).

2.7 The Under-Utilisation of Mental Health Services

People from non-English speaking backgrounds tend to under-utilise mental health services (Sozomenou *et al.*, 2000; McDonald and Steel, 1997; Morse and Messimeri-Kianidis, 1997; Plunkett and Quine, 1996; Trauer, 1995). The low rate of hospitalisation of NESB people with mental health problems is not compensated for by correspondingly high rates of utilisation of community mental health services. Rather, these services are also seldom utilised. There is no evidence to suggest that the low hospitalisation rates of NESB people is necessarily indicative of lower levels of psychological distress in culturally and linguistically diverse communities (McDonald and Steel, 1997; Sozomenou *et al.*, 2000).

The under-utilisation of services does not mean that no services are used. Rather carers tend to use a restricted set of services, for example, they may use day care, or respite care or recreational programmes, but not all of the services available to them (Morse and Messimeri-Kianidis, 1997).

There are many factors that are likely to contribute to the consistent under-representation of people from non-English speaking backgrounds in the mental health service utilisation figures. Differing cultural perceptions of 'mental illness' between patients and GPs, the

stigma attached to 'mental illness' and the appropriateness with which mental health services are delivered - and their accessibility, affordability and availability - all need to be considered.

A reason for the low utilisation of support services by CALD carers may be found in the influence of family and friends. Many non-English speaking background migrants in Australia come from cultures where caring for unwell relatives is a family obligation. In a large study of carers from non-English speaking backgrounds in Sydney, respondents overwhelmingly reported that they did not want to commit their relatives to residential care. This research also found that if the immediate relatives of carers considered that caring was a part of everyday family commitment, they either did not pass on information about support services, or conveyed inadequate or incorrect details (Plunkett and Quine, 1996).

Family obligation towards those diagnosed with a mental illness may exert a strong influence on Chinese families, in particular. Fugita (1990) found that amongst newly arrived Chinese immigrants to the United States of America, family and friends were considered the best option for caring for a relative diagnosed with a mental illness, especially if the person was not violent or acting in socially unacceptable ways. Only about half of the group said they would recommend community mental health centres as a preferred treatment (Fugita, 1990). Such findings indicate that support for carers in the home is crucial. However, some report that they do not want or need support groups to assist them (van Vliet, 1998).

2.8 The role of General Practitioners

General practitioners (GPs) are often the first, and sometimes the only, health professionals approached by people in psychological distress, and their carers. Yet an Australia-wide study conducted in order to determine the role of GPs in the delivery of mental health care to people from non-English speaking backgrounds identified a number of widespread shortcomings in the provision of culturally appropriate care (Mihalopoulos *et al.*, 1999). The first is structural, and arises from the lack of relevant strategic policies, planning and intersectoral collaboration. The second is a product of the knowledge, attitudes and practice of GPs, themselves (Mihalopoulos *et al.*, 1999).

2.9 Structural Barriers

One of the most commonly reported structural barriers lay in the difficulties many GPs reported in accessing interpreters. Interpreters need to be booked in advance, and the practitioners tend to be concerned about their cost to the practice. Interpreters are generally booked in two-hour segments, but are rarely required for such a long period. Indeed, the Medicare remuneration system favours short consultations. Further, many GPs were not proficient in working with interpreters, and some asserted that interpreters had acted in inappropriate ways, for example, crying in the middle of an interpreting session (Mihalopoulos *et al.*, 1999). The need for interpreters across mental health and health consultations far from straightforward. Research involving Bosnian refugees living on the Gold Coast indicated that they did not wish to have interpreters present during counselling sessions. However, for consultations with a general practitioner, interpreters were often requested (Ethnic Communities Council, Gold Coast Inc., 1997). The GPs who participated in the study requested information available in translated forms that they could use, in the

absence of an interpreter, to communicate with their patients about the issues associated with mental health problems (Mihalopoulos *et al.*, 1999).

A further structural problem is the dearth of policy and planning in relation to the coordination of primary care with mental health and multicultural health services (Mihalopoulos *et al.*, 1999). The lack of coordination in these services is undoubtedly related to the lack of knowledge that many GPs have about the range of services available for their CALD patients. A number of surveys have demonstrated that the under-utilisation of mental health support services is due to carers' lack of awareness of the existence of support or supplementary services. These surveys showed that general practitioners and nurses generally provided reliable information. However, very few of respondents had actually referred carers onto other providers or had given information about the financial benefits that might be available to either the carers, or those being cared for (Schofield, *et al.*, 1998; Ethnic Communities Council, Gold Coast Inc., 1997; Plunkett and Quine, 1996).

2.10 Knowledge and Practice Based Barriers

Besides the structural barriers that may inhibit practitioners from providing their patients and their carers with optimal care, GPs also reported a general lack of confidence in dealing with people from different cultures, and an associated difficulty with patients who may be presenting with physical symptoms that 'mask' psychological distress. Reported 'physical symptoms' are readily incorporated by Western medical practitioners' tendency to approach ill health via a biomedical model. The somatisation of 'mental illness' has been well documented in Chinese people, and is not uncommon in other migrant groups (Luntz, 1998; Morse and Messimeri-Kianidis, 1997; Ng, 1997; Lin, 1982).

This Australia-wide survey of the role of GPs in the delivery of mental health care to people from non-English speaking backgrounds also identified two 'cultural' issues. These issues were argued to prevent some GPs from "accurately diagnosing 'mental illness'" (Mihalopoulos *et al.*, 1999). The first issue is that of the stigma commonly associated with 'mental illness'. The second was that inadequate cultural knowledge, on the part of practitioners, resulted in "lower rates of detection and diagnosis" (Mihalopoulos *et al.*, 1999).

A further difficulty is that the standardised psychiatric classification systems employed by many GPs may not be helpful, as they have a Western orientation to psychological disorder. Unless GPs are familiar with their client's (cultural) understanding of mental health problems, classificatory systems will lead to a poor apprehension of patients' difficulties. In an attempt to address this problem, screening tools designed for use with specific cultural groups have recently been developed (Mihalopoulos *et al.*, 1999). However, such instruments risk reinforcing the very Western classificatory systems that were reported to lead to 'misdiagnosis' on the part of the GPs surveyed in the study above. By employing 'culturally adapted' screening tools, practitioners continue to assume the existence of an underlying series of mental disorders – that are somehow independent of this classificatory system, and which differ according to culture only in their presentation. Boyle (1996) suggests that practitioners might benefit more from a more comprehensive knowledge of the diverse ways that people from different cultures tend to make sense of the problems they encounter in their everyday lives.

Somatisation, or presenting with physical problems, appears to be more common in some cultural groups. This may make the detection of mental health problems particularly difficult. Besides being associated with the avoidance of stigma, somatisation may be related to the different ways in which people describe psychological distress, or to their language not having the words to 'describe' psychiatric illnesses (Mihalopoulos *et al.*, 1999).

The undergraduate training offered to medical students does not adequately prepare them for providing holistic mental health care to culturally and linguistically diverse patients. However, postgraduate training is more likely to be designed to address these issues. The postgraduate diploma in Primary Care Mental Health (offered in Western Australia) is regarded as outstanding among the postgraduate training courses available to GPs (Mihalopoulos *et al.*, 1999).

In recognition of the need to better equip GPs to deal with the cultural diversity in the range of potential patients in contemporary Australian society, the Royal Australian College of General Practitioners has developed a series of entry standards to be used for accreditation. The standards that are relevant to the treatment of people with mental health problems from non-English speaking backgrounds deal with several practical concerns. The first of these is the importance of adopting flexible appointment systems. This allows practitioners to accommodate patients with urgent problems, or those patients who need longer consultations. The standards also draw attention to the importance of policies and procedures for communicating with patients who are not proficient in the primary language of the practice medical staff, and the need to adapt referral documents so as to facilitate optimal patient care (Mihalopoulos *et al.*, 1999).

2.11 Culture

Despite the 'multicultural' makeup of Australian society, the systematic investigation of the complex connections between culture and 'abnormal' behaviour is relatively recent (Lin, 1982). In a country like Australia, which has a high migrant population, such investigations are crucial for a number of reasons. Beliefs about the body-mind relationship, emotions, spirituality and views of the cosmic order combine to influence the way people experience mental health and ill health (Parsons, 1990). This in turn has relevance for service provision. The failure of many health professionals to recognise culturally laden ideas about the mind and body may lead them to treat Western notions of physical and mental health as universally applicable, and to impose Western notions of 'mental illness' on their CALD patients. It may be inappropriate for practitioners to determine, on behalf of these patients, what is 'real' and 'unreal', 'rational' and 'irrational' (Parsons, 1990).²

In Australia, the majority of general practitioners have received an exclusively 'Western' medical education. As noted, GPs are generally the first, and sometimes the only, health professionals consulted by people in distress - who may then be diagnosed as mentally ill. People learn ways of being physically and mentally 'upset'. Culture can influence a patient's sense of their mental health and illness in manifold ways, including their explanation of the

² Indeed, criticisms of this kind have been levelled at the discipline and practice of psychiatry more generally (eg. , Szasz, 1994). It is the role of the practitioner (and *not* the patient) to "determine about a patient's mental illness (or behaviour and reported cognition and emotion) what is 'real' and 'unreal', 'rational', and 'irrational'."

origin of their 'illness' and its nature, their experience of 'symptoms', the concepts and vocabulary employed to refer to their experiences, and their preferred form of treatment. Further, people will tend to present with problems in a manner consistent with their cultural orientation (Kleinman, 1980). Consequently, there is great potential for a mismatch in the diagnosis and understanding of, and the treatment options for, ill health between Western trained, mono-lingual medical practitioners and patients from culturally and linguistically diverse backgrounds.

The under-utilisation of mental help support services by Chinese Australians is often associated with cultural differences in defining 'mental illness'.³ Commonly held Chinese understandings of psychological distress vary significantly from Western accounts. This may be due, in part, to the lack of emphasis, in Chinese culture, on the body-mind split that is a hallmark of Western medicine. Chinese people tend to somatise and medicalise psychological distress, and tend to account for its causation with spiritual and religious explanations. The concept of shame, which tends to accompany any diagnosis of 'mental disorder', and a philosophy that encourages endurance may also act as barriers to Chinese migrants seeking professional assistance for emotional problems within the Australian mental health system (Ng, 1997).

Furthermore, Chinese culture does not have a tradition of psychopathology, and there are cultural restrictions against sharing emotional problems outside of the immediate family. Thus the concept of counselling may be anathema to Chinese clients (Tabora *et al.*, 1997; Lin, 1982). There is evidence to suggest that counselling is also an unfamiliar notion for Bosnian migrants (Ethnic Communities Council, 1997). In the light of these observations, the reported 'reluctance' of members of these communities to accept an unfamiliar interpreter into a 'private' counselling situation appears entirely warranted.

A recent needs assessment of survivors of torture and trauma living on the Gold Coast in Queensland suggests that Bosnians may have different or, at least, preferred ways of referring to psychological distress, compared with the Australian born. The researcher, who conducted the interviews in Bosnian, used words meaning the 'heart', 'the soul', 'the psyche' or 'emotional problems' when talking about 'mental illness'.

In addition, the report shows a discrepancy in the perception of the Australian mental health service providers and the survivors in regard to whether the Bosnian clients' needs had been met. The Bosnians' dissatisfaction with the provision of mental health services could signal a mismatch in their respective approaches to making sense of psychological distress. This is reinforced by the survivors' principal complaint that no one understood them (Ethnic Communities Council, 1997).

Immigrants from non-English speaking backgrounds need to be listened to, and understood in the light of their specific cultural and individual perceptions of health and illness. In addition, survivors of torture and trauma may have endured physical and mental distress beyond the experience or comprehension of the majority of health professionals (Parsons, 1990). If medical practitioners are trained to develop cultural competence across a range of cultures,

³Chinese are a very disparate group in Australia. In Australia, there may be five generations to consider ranging from descendants of those who came in the gold rushes in the 1850s to the most recently arrived from China and other countries in the region. These differences mean that among the Chinese speaking population there is a variety of communication issues and markedly different ways of perceiving 'mental illness' (Fugita, 1990). Despite the differences, generally, Chinese have a low utilisation rate of mental illness support services.

these difficulties may be at least recognised, as practitioners become more sensitive to the lived experience, and distress of their clients.

It is important to stress the diversity of understandings of ‘mental illness’ both across and within ethnic communities. For example, despite reporting traditional Chinese beliefs about ‘mental illness’, some Chinese are familiar with Western designations of particular diseases and combine western psychotherapy with traditional Chinese treatments (Fugita, 1990).

The diversity and heterogeneity of belief systems held by Australians about the identification, cause and best treatment of ‘mental illness’ provides a critical impetus for ongoing transcultural research into mental health and cultural diversity. However, whilst culture may be useful in understanding how people from different ethnic groups are likely to interpret, ‘self-diagnose’ and respond to treatment advice and medication, it should not be overemphasised in explaining the under-utilisation of mental health services. Attention to such issues as the lack of community support, social isolation, social class, income, un(der)employment and educational levels is also crucial when looking for positive mental health outcomes (Manderson and Reid, 1994; Eisenbruch, 1991).

2.12 Stigma

In addition to cultural differences in perceptions of mental illness, there is a range of alternative explanations as to why mental health services are under-utilised by people from non-English speaking backgrounds. The stigma consistently attached to mental illness - regardless of ethnicity - must certainly contribute to the ‘reluctance’ of those diagnosed with a mental illness and their carers to seek external assistance. Furthermore, the stigma associated with ‘having a mental illness (in the family)’ is multifaceted and can be exacerbated by other problems, such as unemployment, marital difficulties, and social isolation (Rooney *et al.*, 1998).

There is often a disparity between people from non-English speaking backgrounds and their GPs in their definition of illness in general, and ‘mental illness’ in particular. Thus, when patients present with problems in living there is often a mismatch between the GP and the patients in terms of their understanding of the condition(s) being presented (Kleinman, Kleinman and Lee, 1999; Mihalopoulos *et al.*, 1999).

In Chinese, Indian 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. 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’ (Bentelspacher *et al.*, 1994).

Perhaps in order to avoid the stigma of being diagnosed with a ‘mental illness’, people in distress may report physical symptoms, or “somatise their distress”. This tendency is common amongst those from family centred cultures such as the Chinese, where ‘mental illness’ is particularly stigmatised. This stigma may affect a wide range of people, and have severe repercussions, as it may be attached to the family as a whole.

More positively, the family may also share their relative's problem and develop a collective response to managing their distress (Ng, 1997; Bentelspacher *et al.*, 1994). Chinese families tend to 'put off' seeking external professional help for relatives likely to be diagnosed with a 'mental illness'. Despite the long periods of collective family care that may occur prior to a diagnosis, once 'mental illness' has been identified, families can be swift in their rejection of their 'mentally ill' relative (Lin, 1982). Often, 'mental illness' is blamed on 'bad spirits' or past actions.

When assistance is requested, it is usually for physical problems. By explaining psychological distress in a medical or physiological way, a stigmatising diagnosis of 'mental illness' may be successfully avoided. Practitioners need to be aware of not only the standard warning that physiological symptoms may be 'masking a mental illness', but should also be aware of the potential repercussions of such a diagnosis on the lives of their clients.

One approach to the stigma associated with mental illness is to attempt to 'defuse' it through information and education. A recent study of Victorian carers found that after a period of education about mental illness, Cantonese speaking community members who set up a support group insisted that the term, 'mental illness' be included in the title (van Vliet, 1998). However, it should also be noted that training and information on cultural competency for health and mental health practitioners can also be effective in promoting culturally appropriate, and non-stigmatising ways of talking about psychological distress. Culturally competent strategies for discussing mental health problems may obviate the need for community education about 'mental illness'.

The stigma associated with 'mental illness' contributes to the under-utilisation of mental health support services by carers from many ethnic groups. A survey conducted among Macedonian and Vietnamese background children who were struggling with serious emotional disturbances clearly showed that their parents/carers did not access support services because they viewed the inability to cope within the family as shameful (Luntz, 1998). However, it is important not to attribute the under-utilisation of mental health care services primarily to stigma, as then other relevant socio-cultural and socio-economic issues are unlikely to be given sufficient attention. Such 'practical' issues may have a more direct bearing on how, when and what mental health services are used (Ng, 1997).

Workers in the health care field also associate 'mental illness' with stigma. A study involving six ethnic communities, and carried out to gauge the level of stigma attached to certain health conditions showed that health care workers placed psychiatric illness, mental retardation and AIDS in the 'most stigmatised' category (Ng, 1997). People from German and Anglo backgrounds appeared to be more accepting of psychiatric illness than were people from Italian, Greek, Chinese and Arabic backgrounds (Ng, 1997).

A reduction in the misunderstandings, fear and stigma associated with psychological distress requires changes in both community and employees' attitudes, and in ways of working with distressed CALD clients, as much as in an increase in resources. These changes need to be supported by an appropriate infrastructure. Understanding community workers' attitudes to 'mental illness', and providing them with training in cultural competency is crucial to the provision of acceptable and accessible mental health services.

2.13 Cultural Competence

One of the difficulties faced by providers working in the mental health field is to know when conflicting cultural views will obstruct appropriate health care, when they will contribute to better health care, and when they will prove irrelevant (Parsons, 1990). Although the lack of bilingual and bicultural workers is undoubtedly a major factor in the low level of mental health service utilisation by CALD clients, other health care workers can provide culturally appropriate care if they are provided with training in cultural competence. There are a number of training courses in cultural competency held across Australia, including Western Australian courses run jointly by the Rockingham/Kwinana Psychiatric Service and the Fremantle Division of General Practice. These programs are aimed at improving the knowledge and communication skills of GPs who have patients who are refugees or migrants from non-English speaking backgrounds.

When assessing the appropriateness of a particular service, cross cultural competence is the criterion most commonly applied. Cultural competence involves the ability to interact with, and be accepted by, clients from culturally diverse groups. It also involves the ability to assess problems correctly, to develop trust so that the client will return for further treatment, and to develop treatments that are appropriate to the client's cultural health beliefs, practices and lifestyle. Cultural competence does not imply that the practitioner knows everything there is to know about a culture, but rather that the client is able to regard them as a 'credible problem-solver' (Leafley, 1997).

Plunkett and Quine (1996) conducted interviews with 40 carers, aged from 23 to 80, who were drawn from eight language groups: Arabic, English, Greek, Italian, Macedonian, Portuguese, Spanish and Vietnamese. All carers were resident in New South Wales, where the interviews were carried out. The aim of the study was to further understand the reasons why people from non-English speaking backgrounds made scant use of community based support services. Although not specifically focussed on the mentally ill, the research showed that while many carers had low levels of English language competency, language and other cultural differences could not wholly account for the low use of support services.

Whilst fluency in English may make accessing services considerably easier, a report on newly arrived Bosnian refugees living on the Gold Coast found that it was not sufficient to ensure the effective utilisation of mental health and other services. Being able to use government services effectively requires the user to be familiar with the culture of particular agencies (Ethnic Communities Council, Gold Coast Inc., 1997).

A nation-wide research project arranged by the Carers' Association also found that cultural appropriateness is not limited to language use. Rather, it includes cultural knowledge. This was mentioned specifically in relation to in-house respite care. Carers reported difficulties associated with having someone they did not know in their homes. This highlights the importance of having culturally sensitive health professionals and services. The same research drew attention to the fact that even if there were fully implemented, culturally appropriate programmes available it would be unlikely that less well-established ethnic communities would benefit, as there is a lack of Australian qualified health professionals from those cultures.

Another difficulty which may affect more recently arrived groups of migrants and refugees is the cultural, educational and religious restrictions placed on some women (Fisher, 1996). A

related issue is that of the difficulty that many overseas trained health professionals have in gaining recognition for their qualifications. This difficulty usually has the most direct and dire impact on people from more recently established ethnic communities.

In order to provide culturally and linguistically appropriate services, relevant data needs to be collected. While information on the language needs of the client base is crucial, additional information about the diverse needs of particular groups may be necessary in order to select an appropriate interpreter. The religion, ethnicity, culture and gender of interpreters may need to be taken into consideration, particularly when working with people who have experienced torture and trauma⁴. The employment of interpreters may be fraught with difficulties both for clients and for interpreters. Often, interpreters are not trained in mental health terminology so cannot competently deal with mental health interpreting tasks. Sometimes, there are not the mechanisms in place to debrief interpreters after an emotionally demanding session. In addition, GPs are seldom proficient at working with interpreters. Thus whilst some GPs appear concerned with the 'inappropriate' conduct of interpreters (e.g., crying in the middle of a session), others have themselves been party to the creation of such 'inappropriate situations' (e.g., by asking interpreters to give emotional support to patients, even though an interpreter's job is solely to interpret the spoken word : Mihalopoulos *et al.*, 1999; McGorry, 1995)

The Western orientation of some mental health support agencies is sometimes the cause of carer dissatisfaction. Although the carers interviewed in Plunkett and Quine's (1996) study were generally impressed with the level of service provided by health professionals in Australia, half of them reported feeling misunderstood by service providers and that frequently these misunderstandings were about cultural matters. One point that was highlighted is that in some cultures, adult males have the final say in what services and treatments will be utilised. Female carers from these cultures reported that staff at times did not appreciate the influence and to what extent they were bound by male decision making (Plunkett and Quine, 1996).

Ethnocentrism amongst practitioners has been suggested as a reason for the fact that some Chinese who have been diagnosed with psychiatric illnesses do not return voluntarily for assistance after their diagnosis, let alone involve other family members in the mental health services (Fugita, 1990). A study conducted in the United States of America showed that there are only a small number of Chinese psychiatrists and psychologists working in the mental health area, and that interpreters needed to be used on many occasions. The high utilisation of interpreters and patient's dissatisfaction with them appear to combine to keep utilisation levels low (Liu and Yu, 1985, in Fugita, 1990).

Very little information about Polish care-givers is available, however, a Victorian report on best practice in information provision found that Polish people, both long term residents and recent arrivals, commonly accessed welfare services through mainstream services (Open Mind Research Group, 1997). In contrast, the same report found that Bosnians tended to use ethno-specific or multicultural focused services. Another Victorian research study undertaken to assess 'the needs of CALD carers of the mentally ill' indicated that they did not like using interpreters, and that optimal communication would be achieved by having Polish speakers present at information sessions and during other parts of the research (van Vliet, 1998).

⁴Refer to the Language Services Policy kit which is available from the Office of Citizenship and Multicultural Interests, Perth, Western Australia.

A further reason for the low utilisation of existent mental health services is that many of these services are not age appropriate. Some carers of young people with problems in living reported that they would like more recreational activities to be made available, as they believed that such activities would contribute to their children experiencing a greater sense of worthiness, usefulness and participation in life and their community (Morse and Messimeri-Kianidis, 1997). However, this need does not appear to be a priority for ethno-specific or other community service providers.

Those carers who do use mental health services are often left feeling disappointed with the ways in which they were treated. Sometimes carers are not involved in their family member's care plan and they may feel that the information that they can provide is undervalued or not listened to. Carers have expressed the need to be respected, to have the value of their care acknowledged and to be treated as equal partners in the care team ('Caring for Carers', 1995). However, as medical practitioners need to keep the confidence of their patients, carers may be given little information about the 'mental illness' of their relative. Carers report that some psychiatrists will not even give them information about the medications that they have to administer. Lack of knowledge regarding the diagnosis of the person they are caring for, and not having accurate information about the types of assistance which they could provide, may increase carers' levels of anxiety and psychological distress (Schofielde *et al.*, 1998). These issues have been addressed in the Mental Health Plan for Western Australia (Smith *et al.*, 1996). However, the mere existence of a Health Plan does not guarantee the implementation of the changes that have been suggested.

2.14 Accessibility

To be able to access appropriate services, carers need to know of the existence of these services. The under-utilisation of mental health services is partially due to the lack of awareness amongst GPs as to the existence of services appropriate to the needs of their CALD patients. For example, the Australia-wide study of GPs' delivery of mental health care showed that few knew of the existence of the State based transcultural mental health services, or the Australian Transcultural Mental Health Network (Mihalopoulos *et al.*, 1999). These Australian findings corroborate a United Kingdom report, which found that the major impediment to Asians accessing care occurred at the interface between primary and secondary care (Commander *et al.*, 1997, cited in Mihalopoulos *et al.*, 1999).

Carers report not using the services provided because they either do not know about these services or do not know how to apply for them. For migrants and those who do not speak English well these difficulties are often compounded by a lack of knowledge about how the mental health system functions (van Vliet, 1998). The services that are utilised are generally ethno-specific, or are mainstream services with bilingual workers. Some carers who have used support services have been critical of the lack of assistance they received in applying for particular services (Plunkett and Quine, 1996).

Appropriate intervention can significantly increase utilisation rates. Fugita (1990) found that when mental health centres (in the USA) were publicised in readily accessible places, and when culturally appropriate services were provided, rates of utilisation dramatically increased. Similar results were obtained in Victoria. A community study that addressed the needs of people who had been diagnosed with a mental illness found that amongst the Cantonese speaking people from Hong Kong surveyed, the majority were new to Australia and did not

know how the mental health community based support system worked. However, collaboration between the local Mental Health Service and Chinese community organisations led to greater use of services by Chinese migrants, and the establishment of a support group for carers. (van Vliet, 1998; Bentelspacher *et al.*, 1994). The most effective way to reach non-English speaking background carers appears to be 'word of mouth', although ethnic radio and newspapers have also been mentioned as effective routes for the dissemination of such information (van Vliet, 1998; Open Mind Research Group, 1997; Fisher, 1996).

Apart from the lack of knowledge of available services, and the cultural and linguistic inappropriateness of many existing services, there are a number of other reasons why carers may not utilise the services available to them. Some are associated with the financial costs involved. Others include a lack of private or public transport, the carer's family and personal goals, having children or other dependants to care for, not being able to take time off work, or 'getting the run around' within the health and community services system (Hicks and Lam, 1999; Morse and Messimeri-Kianidis, 1997).

Fear and distrust of mental health institutions presents a major impediment to the use of available services. In many countries, and in recent Australian history, institutions for the 'care' of the 'mentally ill' may offer cruel and inhumane 'treatments' (Luntz, 1998).

In discussing carers' low utilisation of mental health services it is important to recognise that frequently the difficulties that non-English speaking background people have in accessing and using mental health services are defined as a problem located 'within' migrants. That is, this 'problem' is argued to be the result of migrants' inadequate knowledge of English, cultural characteristics, their lack of education about health and medical services, and their difficulties with resettlement, rather than as a structural problem that is pervasive to health care institutions, mental health organizations, services, and the practice of professionals (Minas, 1988). It could be argued that it is the responsibility of mental health care providers to advise people of the services they have available rather than to expect those in need to discover these for themselves.

2.15 Availability

A report arranged through the Carers Association of Australia and based on Australia-wide consultations with carers from 10 ethnic communities (Arabic, Chinese, Croatian, Filipino, Greek, Italian, Polish Spanish, Turkish and Vietnamese) found that the services and support commonly mentioned as being unavailable were respite care, transport, support groups and counselling services (Fisher, 1996). Moreover, GPs reported finding referral difficult because of the limited number of suitable agencies and the relatively few bilingual psychiatrists in private practice. The few practising bilingual mental health professionals in operation usually have long waiting lists (Mihalopoulos *et al.*, 1999). In any case, only the more established ethnic communities are likely to have access to bilingual psychiatrists. There is little likelihood that people from newly emerging communities would have the opportunity to consult a bilingual psychiatrist. For many groups, the situation is exacerbated by the existence of only a small number of trained interpreters.

A needs assessment of the service providers to Bosnian refugees living on the Gold Coast in Queensland highlights some of the ways in which the effects of torture or trauma impact on the lives of sufferers of forms of psychological distress and their carers who live in regional

Australia (Ethnic Communities Council, Gold Coast Inc., 1997). The Gold Coast is a couple of hours drive from Brisbane, the nearest capital city. One problem faced by the Bosnians living on the Gold Coast is that appropriate counselling services for survivors of torture and trauma are not readily available to residents of the Gold Coast. Rather they have to travel to Brisbane for this service. In Victoria, a different problem emerged from a study of the work of the Victorian Foundation for Survivors of Torture. The authors suggested that the focus of present services on newly arrived migrants, particularly those who have experienced torture and trauma, has resulted in a lack of support for more established migrants (McGorry, 1995).

2.16 Conclusion

In accordance with national, international and state mental health policy, this literature review has been concerned to trace the possible reasons for, and the implications of, the general under-utilisation of mental health and support services by people from CALD backgrounds. Specifically, the carers of people who have been diagnosed with a mental illness tend to under-utilise the services available to them. CALD carers are particularly susceptible to a range of health and mental health problems, as a consequence of the demands of a full time caring role. It is thus imperative that carers be encouraged to access the services available to them, in order that they be properly supported. The research reviewed here suggests a number of potential reasons for this under-utilisation. These include the perception that caring is a 'family commitment', or that existing services are culturally inappropriate or inaccessible. The stigma associated with "having a mental illness in the family" may serve, in some communities, as a further disincentive to seek professional assistance, or external support. Further, many of the available services tend not to be recognised by General Practitioners, let alone by carers from culturally and linguistically diverse backgrounds (Mihalopoulos *et al.*, 1999).

The understandings and opinions held by carers, and by CALD community members are of vital importance in disentangling the multitude of factors that contribute to the under-utilisation of services by CALD carers. However, it is also important to consider the opinions of relevant health and mental health practitioners, as they play a vital role in recognising and supporting carers.

There is little research that deals specifically with carers and the Western Australian mental health system, and even less that examines the experience of Bosnian, Chinese, Croatian and Polish carers living in Western Australia. This project will contribute to the body of knowledge on the needs of culturally diverse carers, and on the barriers commonly experienced by carers and mental health practitioners in negotiating successful and ongoing support.

3. METHOD

3.1 Aims

Our most immediate aim was to ascertain the mental health needs of the carers of the mentally ill in CALD communities and to determine whether existing support mechanisms are being utilised by these carers. As previous research is unanimous in finding that such services, on the whole, under-utilised by CALD clients, we expected that the level of utilisation by the communities sampled here would follow a similar pattern.

Our second aim was to document the reasons given by CALD clients, and members of the CALD communities sampled, for the low level of awareness and under-utilisation of support services by members of these communities. Finally, we wanted to identify the measures that may be taken to improve access to existing services.

These issues were explored through:

- 1) Semi-structured interviews with carers who live with 'mentally ill' family members. It is vital to include and encourage the contributions of these people, as they are not often in a position to voice their concerns about mental health support services, or to comment on how they would best be supported in caring for their family members.
- 2) Focus group discussions with members of the CALD communities under investigation. Here, we aimed to collect 'contextual information' about community attitudes to caring responsibilities, and to 'mental illness'. The diversity within each of the ethnic groups was taken into account, and we sought to involve a range of different ethnic organisations from the targeted communities. Those individuals who were advocates for their respective communities through mainstream channels, yet were not affiliated with 'ethnic' organisations, were also included.
- 3) Semi structured interviews with health and mental health practitioners, who had an interest in, and experience with cross-cultural mental health issues. Amongst this group were general practitioners, psychiatrists, psychologists, social workers and counsellors.

3.2 Community and Service Consultations

This project involved intensive community consultation. This interaction between the members of the research team and the communities involved was crucial, as partnerships and trust need a lengthy period of time in order to develop. (Larson et al, 1998). This is a particularly relevant concern when addressing a sensitive issue such as mental health, which people are often reluctant to discuss.

The research team attempted to establish 'a sense of partnership' with the ethnic communities who participated. A number of participants commented that they had been 'the subjects of research' for many different purposes. Understandably they were somewhat sceptical about the ultimate benefits of such research for ethnic communities. In response, we described the intent of the research project, explained that the study would not be intrusive, and stressed

that the information obtained would be used to the ultimate benefit of the migrant communities involved. Through this collaboration, we hope to improve the utilisation of support services by CALD carers.

All of the communities involved in the project were consulted throughout the process of data collection and analysis. The members of the project team were experienced with mental health service provision and research. Further, much of the groundwork for the current project was already laid, in that the team members brought with them a variety of well-developed networks with both ethnic communities and mental health service providers. The research team was able to utilise expertise from academia, the public health sector and the community sector. The project was guided by a Steering Committee, comprising professionals from a wide range of services in the area of mental health.

3.3 Phase One: The Utilisation of Support Services

The first phase of the project involved the collection of ethnicity-related data, in order to analyse the utilisation of support services by the CALD population. This proved to be a difficult task, as existing ethnicity related statistical data were problematic and inaccurate. As a result it was not possible to complete an adequate analysis of the utilisation of support services by CALD communities.

The following is a summary of the data collection procedures, and information obtained, during this phase.

Organisations Sampled

Data were collected from thirteen agencies:

- Association for Relatives and Friends of the Mentally Ill (ARAFMI)
- Carer Respite Centre
- Carers WA
- Crisis Care
- Ethnic Disability Advocacy Centre
- Even Keel
- GROW
- Multicultural Samaritans
- Post Natal Depression Support Group
- Psychiatric Emergency Team
- Saranna
- Schizophrenia Fellowship
- Western Australian Institute of Self Help (WISH)

Many of these agencies are organised to assist people with ‘mental health problems’, rather than carers. These organisations were included in this survey, as it is recognised that this in itself indirectly affects carers, as providing support for people with mental health problems assures some respite for carers.

Summary of Questionnaire Responses

A questionnaire was developed (see Appendix), and was administered as part of a semi-structured interview with each of the organisations identified above.

How are services accessed?

Only one of the thirteen agencies surveyed stated that their service was accessed exclusively through self-referrals. Nine agencies indicated that their service was accessed predominantly through self-referrals, as well as through professional and other services. Two agencies reported that their service was accessed primarily through referrals provided by professionals or other service providers.

At what stage do carers access services?

Most respondents indicated that any stage can be a time of crisis for the families of those with a mental illness. Thus, although most agencies answered “crisis”, the definition of a ‘crisis point’ varied. Some perceived a crisis at the point where a condition was first diagnosed, whereas others indicated that a crisis could occur either much earlier – at the first sign that ‘something may be wrong’, or much later, when public attention may be drawn to the ‘illness’ and to the family. Four of the agencies reported that their services were accessed at all stages. Other responses included “When they (carers/clients) can’t cope” and “when they need time out.”

What percentage of carers accessing services are from CALD backgrounds?

Only ARAFMI and Carers WA had statistics on the ethnicity of their clients.

ARAFMI reported that 15% of the carers accessing their service were from a CALD background, whilst Carers WA reported that 20% of their clients were CALD. However, these clients did not have any communication difficulties, as they were fluent in English language.

What is needed to ensure the utilisation of services by CALD clients?

Responses to this question included “promotion within CALD communities”, “not sure, no time”, “no resources” and “everything”. Although Carers WA reported actively promoting their service amongst CALD communities, the representative interviewed conceded that this needs to be an ongoing strategy and that there was no room for complacency.

Discussion

From the information obtained, it is apparent that services to support those caring for the mentally ill do exist, as does the facility to form specific support groups, if a need is established, and no appropriate group exists to meet that need.¹

However, the utilisation of these services by those from CALD communities, remains low. Overall, it seems that little is being done to promote services amongst CALD communities. Very few of the agencies surveyed had undertaken any specific promotion of their service

¹ This may be achieved through accessing the WISH agency.

among CALD communities or had any specific strategies in place to ensure ease of access for these communities.

Only one umbrella organisation exists specifically to support the carers of people with a mental illness: ARAFMI. This service was under-utilised by culturally and linguistically diverse communities. In the 1998-1999 financial year there were no clients from the target communities (Bosnian, Croatian, Chinese or Polish). Of the carers that accessed this service during this same period, 15% were from a CALD background. However, these clients did not have any communication difficulties, as they were 'second generation' CALD Australians.

Of the agencies sampled, only two – the Ethnic Disability Advocacy Centre (EDAC) and the Multicultural Samaritans – catered specifically for CALD clients. Most of these clients were people with 'mental health problems', rather than carers, and the majority of EDAC's clients had physical, rather than mental, disabilities.

Amongst the services surveyed, Carers WA most actively promoted its services in CALD communities. This service is used mostly by the carers of the elderly, who may be suffering from physical and or mental incapacitation, and only minimally by those caring for people with a mental illness.

Conclusion

Conducting an adequate analysis of the utilisation of support services by CALD communities proved impossible, given the partial and inaccurate nature of the data that we were able to access. However, as previous research is unanimous in finding that such services are, on the whole, under-utilised by CALD clients (e.g., Puls, 2000a, Rooney *et al.*, 1998), and as the incomplete data, and qualitative accounts that were obtained in this initial phase appear to support such findings, the second phase of the project proceeded.

3.4 Phase Two: Interviews and Focus Groups

In this phase, semi-structured interviews were used to collect data from carers, and from mental health practitioners. Focus groups were used in order to obtain information from community members.

3.5 Interviews with Carers²

In depth interviews were used to collect data from carers. Gaining access to carers from the targeted CALD communities was difficult, as carers, as a group, tend to be relatively isolated. In addition, the sensitive nature of the topic under investigation presented difficulties in terms of recruiting carers willing to discuss such 'personal' issues. It was for these reasons that

² The interviews with carers were conducted immediately *after* the focus groups with community members, as this process was designed to enable both the construction of a culturally sensitive interview schedule, and to establish contacts with carers through the community networks of the focus group members. Information on the interviews with carers is reported here *first* as the focus of this report is on the *needs of carers*. Similarly, the results of these interviews precede the results of the focus groups, and of the interviews with health and mental health practitioners.

community members were recruited as interviewers, as it would have been inappropriate to use interviewers lacking in developed links to the carers' communities. This enabled the 'protected' discussion of sensitive issues.

Established partnerships with community settlement services workers were utilised in order to secure their support for the project. These workers provided the research team with useful background information and contacts with potential interviewees.

Characteristics and Role of the Interviewers

Only interviewers who had established contacts with the targeted communities were recruited. This strategy had the benefit of allowing us to establish further contact with carers from these communities. All interviewers had verbal and written fluency in English as well as in a community language. Apart from being fully bilingual, the educational backgrounds, extensive work experience, and community involvement of the selected interviewers facilitated the process of successful data collection. All interviewers were informed about the project details during a training session.

All potential interviewers attended a one day training session conducted by the investigators. This session contained relevant information about the project; information related to the interviewing process and interviewing techniques; the content of the interview; various ethical issues (confidentiality and support); and all other relevant practicalities, such as issues of language and translation; tape-recording and transcribing.

Interviewers were required to translate the questionnaires and consent forms for the carers. They also assisted in recruitment of carers, conducted interviews, transcribed taped interviews and translated the resulting transcriptions into English.

Conducting the Interviews

All carers were offered the option of either being interviewed in their first language or in English. Most carers opted to be interviewed in their first language, or to revert to their first language if they lapsed into English during the interview. An outline of the topics covered during these interviews is contained in Appendix.

The interviews with the carers were mainly conducted in languages other than English (Cantonese, Mandarin, Bosnian, Croatian and Polish). None of the interviewees objected to the tape recorder, so all interviews were tape recorded, transcribed and translated. However one interviewee asked for the tape to be erased after transcription.

The interviewers were in regular contact with members of the research team and assistance was provided during the course of their work. A member of the research team kept in regular contact with each interviewer so as to be able to assess their progress, and to provide support.

Difficulties Encountered

On the completion of the interviews, the interviewers were asked about the process of interviewing, and about any difficulties that they had encountered.

Several interviewers stated that a number of the carers who declined to be interviewed appeared to do so out of 'a sense of guilt' at the very notion of suggesting that caring for a mentally ill family member may be a 'problem' or a difficult task. This following is an example of a situation reported by one of the interviewers, when the carer visited the interviewer's home, at her own request:

She is an old woman, it was quite an effort for her to come to my house and she was quite receptive on the phone about being interviewed. Yet when she came she's had a change of heart. She said she really didn't have a problem.

Carers with existing relationships with the interviewers agreed to the interviews in all cases. The interviewers reported that some carers expressed their gratitude for the opportunity to discuss their own issues, and that these carers were very cooperative indeed. Some interviewers asserted that "it was almost an 'unburdening' for a number of the carers", and that a few carers "went off on a tangent, talking about past experiences unrelated to the caring". As this was seen to be an obvious need, carers were 'allowed' the opportunity to 'talk off topic' during the interview.

Transcription and Analysis

All interviews were tape-recorded and transcribed. The interviews were analysed according to the conventions of thematic analysis (e.g., Plunkett and Quine, 1996). The two principle investigators analysed the data separately and assessed each other's analysis. This process enhanced the reliability of the data. Common themes were summarised and supported with relevant quotes from the original transcripts.

3.6 Focus Groups with Community Members

Recruitment

The researchers' knowledge of, and established contacts with, community organisations facilitated the recruitment of focus group participants. The project Steering Committee was also forthcoming with suggestions about potential participants. Organising the focus groups was a time consuming task. The two major difficulties experienced were arranging a time that suited all participants, and arranging convenient venues. Some community members appeared hesitant to participate in a project on 'mental illness'.

The Pilot Focus Group

A pilot focus group consisting of people from each of the communities under consideration was organised, to identify the main issues relevant for those communities in relation to mental

health. This group was facilitated by a moderator who was experienced with cross-cultural focus groups.

Participants

The group consisted of participants from the Chinese, Polish, Croatian and Bosnian communities. None of the participants had any previous experience with the focus group methodology.

Procedure

The group discussion commenced with the presentation and discussion of a hypothetical vignette. Depersonalising the issue in this way was a strategy intended to make people feel at ease to facilitate discussion of community attitudes to caring and 'mental illness' more openly. However, the pilot group participants felt the vignettes were 'artificial' and not relevant to the experiences of their cultural groups. It was suggested that engaging participants in discussion about their personal experiences (how 'mental illness' may have touched their lives) was more appropriate, would be more culturally realistic and would yield better responses. Thus the first topic was rephrased to initiate a discussion about participants' contact with, or experiences of, someone with mental illness.

The pilot focus group was an extremely valuable exercise and allowed us to refine the focus group process and questions. Many of the suggestions that arose in this pilot focus group were implemented. A discussion outline identifying major issues was developed and used with the remaining groups.

The Primary Focus Groups

Participants

Eleven focus groups were conducted. Each group consisted of between five and nine participants. Focus group members were mainly female. Participants ranged in age from their twenties to their late sixties. The under-representation of men arose because the men who had been invited appeared reluctant to participate, had other commitments or cancelled in the last minute. This may be indicative of the perception that 'caring' is a female domain in the targeted communities.

In nine of the focus groups, participants were recruited on the basis of having established relationships with these communities, or being members of these communities. The remaining two focus groups comprised counsellors from the Association for Services to Torture and Trauma Survivors (ASeTTS). Although some researchers assert that focus group participants should be strangers to one another in order to prevent cliques forming and to encourage openness (Askew, 1989) others recommend homogeneity within each group (Kitzinger, 1995), 'to capitalise on people's shared experiences'. In our research we utilised both approaches in order to explore a variety of perspectives. ASeTTS focus groups drew upon pre-formed groups of people working at the same organisation and proved a useful means of obtaining information relevant to the project. Focus groups consisting of members of the specific communities under examination were more heterogeneous. However, a number of participants knew each other through existing networks.

The focus group participants were recruited through telephone invitations issued by the focus group facilitator, and by one of the researchers. Many participants were initially hesitant and commented that they felt they ‘wouldn’t have much to contribute and do not have anything to do with mental illness’. The researchers reassured participants that it would be a discussion about mental health issues generally, and perceptions in their community in relation to these. This initial hesitation could perhaps be taken as an indication of the level of stigma associated with mental illness in the targeted communities.

Sampling and Group Composition

The focus group participants were selected on the basis of either a) their established links to the selected communities for a significant period of time and/or b) being members of these communities. Some participants were involved in the communities on a professional level and others on a voluntary basis. All were considered key community members with an extensive general knowledge of community issues. It was envisaged that the people chosen would be able to assist the research team to identify key issues pertaining to ‘mental illness’ and caring responsibilities. This was necessary in order to ensure that the other phases of the study – in particular, the interview schedules for carers – were both pertinent and culturally sensitive. More pragmatically, we also hoped that these focus group participants would be able to assist us in the process of recruiting carers through their contacts in the communities under investigation.

Organisations sampled

The organisations from which participants were recruited included:

- Australian Asian Association
- Catholic Migrant Centre
- Chung Wah Association
- Communicare
- Croatian Welfare Association, Croatian Women’s Association
- Ethnic Child Care Resource Unit
- Ethnic Disability Advocacy Centre
- Mental Health Access Team
- Mercy Community Services
- North Perth Migrant Resource Centre
- Northern Suburbs Migrant Resource Centre
- Playgroup Association of WA
- Serbo-Australian Information and Welfare Centre
- South Metropolitan Migrant Resource Centre
- South Perth City Council.
- Swan Mental Health Service
- Translating and Interpreting Service
- Villa Dalmacija Nursing Home
- WA Association of Polish Women

Focus Group Venues

The focus groups were conducted at the Catholic Migrant Centre, The ASeTTS in Perth, Polish House in Maylands, Chung Wah Association in Northbridge, EPPCHU in Perth, Fremantle City Council, the South Metropolitan Migrant Resource Centre in Fremantle, and the Ethnic Disability Advocacy Centre in Perth. Focus groups were conducted in the period between 20 February 2000 and 17 May 2000.

Locations were chosen on the basis of what was most convenient to participants. The venues used were located in the central city and in central Fremantle, as these areas were accessible and proximal to the home or work of the participants.

Procedure

The participants were provided with basic information about the project as part of their telephone recruitment. More substantial information was provided at the start of each focus group. Participants were provided with a letter stating that approval had been given by Murdoch University Ethics Committee, and providing a guarantee of confidentiality (see Appendix B).

The duration of each session was between one hour and thirty minutes and two hours. Focus group discussions were tape-recorded with the permission of the focus group participants, after confidentiality was assured.

A single moderator facilitated the majority of the focus groups. The two focus groups with ASeTTS were facilitated by one of the chief investigators. During these sessions, the two chief investigators observed, made notes about the process, and at times participated in the discussion. On some occasions there was only one observer.

Topics for Discussion

During the discussions a number of key issues were raised and discussed. These were:

- Experience with mental health related problems
- Community attitudes about mental health and illness
- Cultural differences in attitudes towards mental health and illness and caring for people diagnosed with a mental illness
- Migration experiences and mental health and illness
- Community attitudes related to caring for people diagnosed with mental illness
- Caring for people diagnosed with a mental illness
- Community knowledge and information about support services for carers
- Barriers and access to support services
- Suggestions for improvement of access to support services
- Health promotion strategies related to caring for people diagnosed with a mental illness

Often, silence followed the opening topic. To address this problem, the facilitator re-stated the broad definition of 'mental illness' that had been developed in consultation with the pilot focus group. That is, participants were told that for the purposes of this study 'mental illness'

encompassed all of the problems and issues that might endanger a person's emotional and social well-being, including depression, senile dementia, post-natal depression, and post traumatic stress disorder, alongside the more severe mental illnesses. This seemed to 'normalise' or broaden the concept of mental health and illness, and worked to encourage further discussion.

Transcription and Analysis

All focus groups were tape-recorded and transcribed. The quality of transcripts depended on the quality of the recording, including the level of external noise, people talking at once, people speaking too quietly, etc. Some focus groups required more time to transcribe than others due to the difficulties deciphering accents, and to the varying numbers in the groups. Each transcription was checked upon completion by the group facilitator for accuracy.

The transcript of each group was analysed with the same thematic method as was applied to the data from the interviews with carers. The two principle investigators analysed the data separately in order to enhance the reliability of the data. Common themes were summarised and supported with relevant quotes from the original transcripts.

3.7 Interviews with Health and Mental Health Practitioners

Semi structured interviews were conducted with health and mental health practitioners who had an interest in, and experience of, cross-cultural mental health issues.

Participants

Amongst the professional occupations of the practitioners interviewed were: psychiatrists, psychologists, psychiatric nurses, general practitioners, pharmacists, social workers and counsellors.

Some interviewees were from Chinese, Polish, Croatian and Bosnian speaking backgrounds. The others were not members of the targeted communities, but they had extensive experience of working with non-English speaking background clients, patients, and their families.

Recruitment

The mental health practitioners were recruited through the listings in the Transcultural Mental Health Directory (2000), recommendations from Steering Committee members and focus group participants, as well as from the research team's networks. After a list of practitioners for possible interviews was compiled, letters were sent to each member of the list. This letter provided an overview of the project, and aimed to enlist their support. All practitioners received a follow-up phone call in order to arrange an interview. The interviews with health and mental health practitioners were conducted in English.

The Transcultural Mental Health Directory is a vital resource that should ideally be periodically reviewed. Some interviewees commented that a number of professionals who

currently provide culturally appropriate services, and were willing to be included in the Directory had not yet been added, and a number of professionals currently included stated they had not been consulted about their inclusion.

Arranging interviews was a time consuming process. It involved a number of telephone calls to most practitioners – sometimes as many as eight. It was difficult to contact them between their patients or clients. Some practitioners were not interested in being involved with the project for various reasons, from time pressures, to claims they did not see either patients with mental illness, or their carers. One doctor stated that “mentally ill patients change doctors all the time” and it was difficult to get to know them or their carers.

Once contact had been established, however, most practitioners were generous with their time, and were keen to share their knowledge and experience. Thirty-three practitioners were contacted in order to achieve 20 successful interviews. A further two were interviewed but the interviews could not be transcribed due to the malfunctioning of a tape recorder, in one case, and interference on the tape in the other.

Sixteen of the interviews were conducted in person and four by telephone. Telephone interviews were conducted when practitioners had little time available for the interview. It was considered prudent to conduct the interview by phone rather than not at all.

Topics for Discussion

The topics for discussion were formulated collaboratively by the research team in consultation with the Steering Committee.

A number of key issues were raised and discussed. These were:

- Pathways (how do patients find their way to the professionals)
- Stigma and ‘mental illness’
- Communication issues (including interpreter/language difficulties)
- Trust (Confidentiality)
- Contact with carers (whether aware of carers; what role do they see them as having)
- Diversity of experiences (urban-rural, education, generational differences)
- Perception of the impact of migration on mental health
- Cultural awareness and sensitivity in relation to ‘mental illness’
- Awareness of support services for carers
- Perception of the cultural appropriateness of support services
- Suggestions for improved support services

Issues Needing Clarification

Once the interviews were in progress some issues relating to terminology needed to be clarified, for example, there was a lack of clarity in what was meant by ‘carers’. When talking about ‘carers’, practitioners often referred to professional carers, and needed to be reminded that the main focus of the project was on unpaid family members of those diagnosed with mental illness rather than professional, paid carers.

Other issues also needed to be clarified. These included:

- The ‘rigid’ view of mental health problems as mainly encapsulating the severe psychotic disturbances rather than more broadly, ‘problems with living’.
- Mental health problems associated with aging,
- Post traumatic stress
- The difficulty for some in talking about their own culture. There was a perception that some interviewees were ‘affronted’ by the association of their own cultures with mental health issues.
- A few practitioners utilised pathological language and medical terminology when they talked about mental health and reverted to talking about patients and their needs rather than those of carers.

Transcription and Analysis

Data collected from the in-depth interviews with health and mental health practitioners were recorded, transcribed and analysed with the same thematic method as was applied to the data from the focus groups, and the interviews with carers.