

12. INTERVIEWS WITH HEALTH AND MENTAL HEALTH PRACTITIONERS

Pathways

The mental health practitioners interviewed reported that CALD patients and carers often travel diverse pathways before reaching them. In many cases, patients had been referred by their GP. It was emphasised repeatedly that GPs are a main point of contact, since they are trusted, and may have ongoing contact with families. As such, they are often in the best position to detect problems. Even when people 'self refer', this is usually done via a GP. However, referral may also occur via other health care providers or through other mainstream service providers, such as Centrelink, or through more indirect and less formal routes, such as adult education classes. That there are diverse pathways is hardly surprising, since different practitioners have different specialities, serve different catchment areas, offer a varying array of services, and see different client groups who have diverse expectations of the most appropriate first point of contact. There was also widespread agreement among practitioners that problems tend to be picked up at a late stage, due to the process of referral, or to people being reluctant to seek help, perhaps because of the perceived stigma attached to mental illness.

Referrals may come from many sources:

Seventy percent probably come from GPs, but not necessarily from the Fremantle area. They can come from the northern suburbs, because my service is state wide... there are no boundaries. GPs, migrant organisations, Polish Community Centres - Villa Dalmacia for example. And I organise Immigration Department and self-referrals. Patients can ring me and arrange an appointment. They can discuss issues they have on the phone, and when I feel that this is a mental health issue I just arrange an appointment for them - they don't have to have a referral.

- Psychologist

So, as I said, some of our referrals come from Royal Perth Hospital, and some of those referrals at Royal Perth Hospital come from the medical units, for example, and we get asked to see someone on consultation. Sometimes they might be inpatients, or more often than not they might be people that have been discharged and they come to us from a particular direction. Alternatively, we get referrals from general practitioners. We also get referrals from some of the other psychiatric units from time to time. A number of our referrals also come from...well, they're also general practitioners, because they come through the Aboriginal Medical Services. These are probably the main avenues the referrals come from.

- Psychiatrist

AMES [Adult Migrant Education Scheme], community nurses, a lot of mine come from intensive language centres, schools, GPs, other doctors, CRSS [Community Refugee Support Scheme], friends and family or self referrals.

- T&T Counsellor

This psychiatrist described a combination of GP and other health provider referrals, psychiatric hospital discharges, and 'team meetings.'

So when people come to you, how do they come?

They come referred via GPs or other health care providers. A significant number are discharges from psychiatric hospitals.

So you don't have any inpatients here?

No, there is a hospital here that has patients. The referrals come through a duty officer, they might be referred on to other services or agencies which are more appropriate. That is one screening process. The other happens when they are discussed at the team meetings to decide what is the appropriate speciality for them.

- Psychiatrist

In one case, priests were seen to play a role in referral:

The Church is where they go to recover, and I get referrals from the priests. They have a ritual way, a theological way of handling these things, but when the behaviour becomes too much to handle, too dysfunctional, they say, 'See the doctor'.

- Psychiatrist

This counsellor reported that many of her clients were self-referred, or had been referred via indirect or informal means, such as adult education classes:

A lot of them are self referrals, through word of mouth recommendations. This morning I had two women, who came and said, "Oh, you saw my friend, you really helped her. Can you see me?" A lot of them are like that, but a lot are from the Adult Migrant Education Scheme. They get picked up in English classes, if they are not progressing, and they will ring me and say, "Look, we have got somebody from such and such. Could you see them? We think he might have PTSD" (Post traumatic stress disorder). Or, "He is not concentrating", or "She seems to be distracted and depressed". And, knowing the background and where they come from, they presume... Sometimes the referrals are inappropriate and it has nothing to do with PTSD. It could be some family issue, and then I might do some brief counselling or refer them to somewhere more appropriate. They also come from other mainstream service providers such as Centrelink, for example. They might be applying for a disability support pension because of depression... So they might get picked up by the psychologist there because they can't find work or can't look for work because they are depressed. Also from my colleagues, other welfare workers, social and settlement workers, who maybe don't do counselling but take care of other issues, the practical things, and they have noticed that there is a need perhaps for some support in that area.

- T&T Counsellor

Seeking Help as a Final Resort

It seems often the case that clients in psychological distress will tend to seek help from practitioners only after other avenues have been exhausted, or once mental health problems have become unmanageable. As the following practitioners explain:

I would say that as a general rule people would see me relatively late, as opposed to early. And that goes for both Aboriginal patients and people of English speaking backgrounds we see as well.

- Psychiatrist

Almost invariably, when someone ends up seeing me it's...there is either a psychiatric

condition present or there's considerable psychological problems. And that's simply because of the referral process. People don't refer to me unless there are issues like that present...

- Psychologist

They come in various situations of distress of course, where they feel extremely anxious. They don't come when they feel a problem just starting, they come when the problem's very advanced. I think they've just probably exhausted all strategies to deal with the problem...Or they've heard about me and someone told them, "Oh, I had this problem before and I went to see E. and she helped me." They may hear from someone in the community that the problem can be resolved or managed.

- Psychologist

The Role of General Practitioners

As mentioned, given their position at the 'front line', GPs are a key point of referral for many patients:

At what point in the problem do they come to you?

Usually by the time they make their way to my rooms they are quite distressed. I will put it this way - people usually come on the recommendation of their doctors. Doctors say the medication alone is not going to help them. So the doctors are the front line, they are very important. Most people go to the doctors or, if they come on their own, they are looking for a clinical psychologist - usually when they have reached a point where they are really stuck. They would try to get help elsewhere first. They are really stuck, they are really distressed, they feel like they can't function any more, they are so upset. Usually someone has said 'I think you had better go and get help'. That is my experience anyway.

- Psychologist

Even if people 'self-refer', there is often a GP involved:

The biggest percentages are through GPs and through self-referrals, indirectly.

So people are able to self refer?

No, they're not. But that's why I said 'indirectly'...

Okay, can you expand on that?

Yeah. You go to the GP, psychiatric specialist, doctor. That's okay.

So it's really a formality?

So a form of...a form of self referral. But that notwithstanding, there are independent referrals from GPs...

- Psychiatrist

Do people self-refer? Like if someone...

Yes, people can self-refer. Usually they're...somewhere along the line there's usually a GP involved...

- Psychiatrist

A number of practitioners asserted that GPs *should* be involved, because they often possess an in-depth knowledge of families, and may be regarded with a high level of trust. Consequently, GPs are a logical target for further education about mental health issues:

I think probably one of the most crucial people to be involved should be the General Practitioner, because I...because I think the General Practitioner is usually aware of the family, not just the patient. Usually aware over a period of years of what sort of dynamics are happening within the family, and also is a trusted person from the family's point of view....

Well, I guess it's Ok to see a General Practitioner.

It's okay to see a GP. They don't just see people with mental illness, they see lots of different people. So I think raising awareness amongst GPs would be useful. And that could be starting from Medical School, all the way down from Medical School to...as they're training to become GPs, The Royal College of GPs - right through.

- Psychiatrist

Indeed, one GP also made a plea for greater recognition of the role of the general practitioner, noting that emphasis tended to be given to the operations of the tertiary sector, at the expense of the 'front line' role of primary services. This imbalance tends to obscure the 'hidden mass that don't even manage to get here' (to the GPs). Focusing on GPs, in his view, was an issue of accessibility, and of addressing unmet needs:

We need better resources and better referral systems for patients who need other help. Where the resources are really needed are here in primary care. People from CALD communities will always go to their GP. It's the first thing people do, even when they are new to the country. It isn't difficult to access like the other services and policy makers often forget about primary care when they want to change things. I feel really strongly about this, so I hope your research will help to address this issue. Policy makers and researchers talk to the tertiary sector and not the GPs, and they are the ones that see the people involved and know the situation better. The resources are very unequal. It is hard to access the specialist services, and the mainstream services need to be made more aware and sensitive. It is only the tip of the iceberg, the tertiary sector, and that is where people get their figures from. Underneath there is a hidden mass that don't even manage to get here. We need to make the services more accessible. There is a lot of unmet need in this area. You have to have better informed patients and practitioners, and you need to reach more people.

- General Practitioner

It is important, however, to be aware of the cultural differences in people's preparedness to see GPs. Although we did not compare the different groups' patterns of referral, one practitioner suggested that for some Polish people at least, GPs would not be seen as the first logical point of contact:

Sometimes they don't feel it's appropriate to go to a GP. For example, in Poland we didn't have GP referral systems. If you felt you had psychological problems you went straight to a psychologist. So people do not know sometimes that you have to go to a GP to have a referral for a psychological service...

- Psychologist

Stigma

A common theme to emerge from the interviews with practitioners was that mental illness is heavily stigmatised. It was described as being regarded as a 'loss of face', shameful, and indicative of failure as a parent across all cultural groups, but more so in some (eg. Asian groups), than others. Furthermore, stigma was a problem not just for the person diagnosed with a mental illness, but for the family as a whole. This may affect the individual's and the family's interaction in their community. Hence, people may be reluctant to make the issue public within the community. People may try to conceal the problem, or down-play its significance. According to one GP, people "don't seek support as vigorously as they should", and they "try to carry on as if it's just a normal variance". Practitioners believed that stigma was a factor contributing to the late presentation or referral of patients.

Mental illness is shame. It's loss of face in some families. They cannot even tell their neighbours and friends that a son or daughter has mental illness. It's shame. They feel they failed as a parent. They have nobody to tell them, "Listen, it's not your fault". Because there are times, in Polish families, when the mother will ask me, "What have I done wrong, for my son to have schizophrenia?" So they need somebody to tell them, "This is not your fault".

Do you think this issue of stigma is going across cultures....

I think it's going across. I think it's only more intense and less intense, but it's across cultures. In Australia there is also stigma attached to mental illness. But in Asian communities stigma is a great failing...huge...Even the relatives sometimes don't know that there is a person with mental illness in the family...Polish people, they are also quite stigmatised. I've asked people whether they would like to live next door to a mentally ill person and everybody says, "No! What if it's schizophrenia, paranoia or something?" I've said, "Just a mental illness. Would you live next door to that person?" "No," they say...Of course it's ignorance, lack of knowledge...

- Psychologist

Mental disorder is not well accepted or well tolerated in Chinese culture. There is a taboo...almost a taboo. Someone gets a mental disorder and even the family find it difficult to accept ... They don't want to have a family member with a mental disorder. It is really bad. They don't want other people to know that a family member suffers from a mental disorder. They think it is a disgrace to the family. I think it is still considered a disgrace to the family. In Hong Kong, patients present very late, very late. Not until there is a crisis situation do they come to the mental health service...

- Psychologist

People try to down-play or hide it. And often they don't pursue the support or assistance as vigorously as they should, because they try to carry on as if it's just a normal variance. The knowledge of psychiatric illnesses in the community in general isn't all that brilliant. But amongst the Croatian community, in my experience, there are...In the Fremantle area it's poorly understood and often ignored or explained in other ways. Or it's often felt to be a matter for which one should be ashamed or should try to hide ... They feel embarrassed in front of their friends and acquaintances more so than someone who's more distant and seen to be a bit more divorced from their immediate social circle.

- General Practitioner

Many people would not go to their ethnic community for [help for] the reason we said - the fear of stigma. And that it should not be spread around. Apart from the languages I speak, I've had to see many people with interpreters. And I know

particular communities have...this wariness about them. Although the professionalism of the interpreter is beyond doubt, that notwithstanding, people would avoid using them. They would even...Some ask me in their very, very limited English, if they could see me on their own. So we struggle - there's a funny combination between English and Turkish.

So do you think they feel more judged by their own communities than they do by the mainstream...

They're embarrassed. The rumours could be spread.

- Psychiatrist

In some cultures, mental health issues are seldom discussed, and explanations based on 'superstition' or religion may be used to make sense of 'unusual behaviour'. As one practitioner explained, physical illness may be easier for people to understand, since it has an obvious manifestation:

In some cultures, while mental health issues are not discussed, the explanations for things are derived from superstition or the 'evil eye' or religious inclination or description. In other places it's shame on the family that has this illness, and for those other family members who carry the illness into their own families. Aside from this, there's lots of things. I guess every culture has...You see, if you have a physical hurt, a physical illness, then people understand that. And if you break your arm or somebody beats you, they say, "What happened?" You say, "I fell down...at work or at home", or something. And, "How are you going?", "I'm nearly better", "That's fine". But somebody meets you, you say, "I'm depressed", or "I don't care to live any more". That's not easy to say and people don't react well when hearing it. And that's across English speaking society too...To have delusional references or whatever scares everyone, no matter which culture they come from. Because they cannot grasp reality and they see reality as something else, which it really is not, and so there's lots of confusion.

Social worker

Apprehension about Psychiatric Treatment

One practitioner, a mental health nurse working at a mental health clinic, was acutely aware of how 'misconceptions' about psychiatric treatment may affect people's willingness to access services. She explained the strategies she employed for alleviating her clients' concerns:

Well, "You go into a psychiatric hospital, you get locked up and you never come out", or "You get beaten up in the hospital"...If I feel someone may need admission because they are so unwell, and if they are from the CALD group and have the wrong view (in my perception) of what the psychiatric services are about, I tell them when they come to ask for me downstairs. They are quite scared to come into the facility, so I meet them downstairs and I say, "See, this is where it is". And the day patients are there playing with their kids, and the door is open, "Yes we do have a door that is locked, but that is for those people that are a danger to others or themselves. You with your deep depression and trauma issues are unlikely to ever be in there. I am only just across the road, so the nurse can always contact me if you need to come and see me".

- Mental health nurse

Torture and trauma counsellors employ a range of 'de-stigmatising' and 'normalising' strategies to allay their clients' concerns:

We always de-stigmatise by saying, "Everybody we see is not crazy. Everybody we see is in the range of normal for what happens when you've had that kind of trauma in your life". And that's what we always say to people, and people feel much better when you say, "There's a lot of people that feel like you...And this is 'do-able', this is workable. We can help you to live your life better".

So the stigmatisation is coming not only from the client himself or herself, but also from the community, stigmatisation...labelling. They say, "Look at him, he's got such and such..."

The group aspect of early intervention is that it de-stigmatises mental illness or mental health for people. Bosnians, say, are very unfamiliar with that concept of mental health and they immediately think that they are mad. So if you can, with the Early Intervention model, sort of bring it in around stress management and dealing with stress, whatever it happens to be, it de-mystifies and de-stigmatises the whole process. So it makes it easier then to integrate that into accepting or looking for other services that may be able to help them...

...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 and look at it and makes it easier for them to deal with. Because it is a huge hurdle for a lot of those people to overcome initially. It's the initial hurdle of "I need help. I need some assistance with my problem".

- T&T Counsellor

Language Barriers

Language difficulties were seen as a major barrier to clients' use of services, their understanding of information, and their interactions with professionals. This was especially the case with older clients. Language was identified as a factor that could reinforce the reliance of people in psychological distress on their immediate family. Some professionals were aware that they did not have the language skills necessary to successfully 'conduct the therapeutic process' with CALD clients. Although interpreters are commonly used in the practice setting, the quality of interpreting is not always high, which can create problems in therapy. Problems arising from the inappropriate use of interpreters and the difficulties of integrating them into the practice were also mentioned.

And so there's this kind of...isolation the language causes...Because of their experiences, their trust in the system has been damaged. And even though Australia is different, it's hard when you don't speak the language. Part of the therapeutic process is about how people can kind of...put what's happened to them in some kind of larger framework. And that's where I'm...I haven't quite got the language skills to be able to do that, let alone lead in to talk to some people to try and work out some way of making sense of it.

- General Practitioner

The language [issue]... is probably one of the most important ones [problems] really. Because of the language they are not accessing the services very easily, so they tend to rely on the family more and on themselves...

- Mental health nurse

The problem is just the language one. Not being able to access services and understand what's going on because they have difficulty understanding service providers or understanding information sources...There's a difficulty in understanding their GP or they are not able to communicate with their GP and so on...

- General Practitioner

What are some of the factors that may encourage or discourage a Chinese person when using mental health services?

The language. They can't communicate, and if you can't communicate...Quite a high proportion of Chinese patients who come here don't speak very good English. Their communication is appalling, and that can cause misunderstandings, a wrong diagnosis, a misdiagnosis. That is the main problem I think, the communication problem, the language barrier, the cultural barrier. You have to understand their cultural background to understand some of the symptoms, and why the symptoms present as such, and why the relatives and the patients react to the symptoms of mental disorder in a specific way. I think Western psychiatrists find it difficult to understand when they don't know the cultural background. The belief, for instance, that a mental disorder is linked to possession, sort of by evil spirits - a special type of evil possession. It is hard to understand if you do not understand the culture.

- Psychologist

As one practitioner noted, it is easier to communicate about physical problems, which involve 'quite concrete descriptions', than mental problems. They suggested that some clients may not be conversant with mental health issues, let alone able to convey these in English:

It is easier to communicate and talk in a foreign language about bodily functions, about a physical complaint, because there are quite concrete descriptions. But when it comes to talking about your own psychological phenomena, emotions, intellectual functions, cognition, thinking, how you learn ways of coping and so on ... I think there are not even enough of them conversant or educated or even interested in that way of thinking. Therefore, it is very hard for them to convey in English, which is a second or third language for them, because they haven't used these concepts. Therefore they look for doctors who operate in their native tongue, so he can closer decipher their emotional process.

- Clinical psychiatrist

The Use of Interpreters

Many practitioners strongly advocated the use of interpreters. However, a number of interviewees identified the problem of trust that may arise with the use of interpreters. Several practitioners expressed their concern that there is a perception within ethnic communities that confidentiality may be compromised when interpreters are used, thus people may be reluctant to use them in sensitive situations, such as the discussion of mental health problems. This may be exacerbated in smaller communities, when interpreters are well known.

Many practitioners asserted that there is a need for more bilingual workers within the mental health services, as utilising interpreters is often not the most satisfactory way to approach the discussion of sensitive issues:

The first thing is language. It is very important in psychiatric practice. Quite often we can't do a proper assessment by using an interpreter, some of the psychiatric meaning will be lost in the process of the interpretation. We do need more bicultural, bilingual doctors. Here we don't have a system to educate Chinese patients through Chinese speaking doctors. We have quite a few Chinese doctors here, but there is no such system in place.

- Psychiatrist

A number of practitioners noted that the quality of interpreting was very mixed. As one practitioner explained, while some are excellent – ‘you don’t even know that they are there’ – others are so poor they are ‘dangerous’, and an impediment to good practice. She recounted a situation where she had to intervene, because she became aware that the interpretation was ‘wrong’:

You get absolutely excellent interpreters, you don’t even know that they are there. That’s how they are supposed to be, like a conduit for us. You don’t even look at them, you are not supposed to. Other interpreters, you just know ... I had a shocking experience the other day - it was almost a danger to that person who was being interpreted for in a medical situation...I had to say, “Look, I am sorry, I don’t normally do this, but I have to intercede here because it is completely wrong what you are saying here”. For the welfare of my client I had to do this and normally I would just sit back ... I thought that it would be responsible to have the services of an interpreter because I am not an accredited interpreter and in terms of medical terminology there’s a lot of things that I wouldn’t know, so to cover myself in that situation I thought it would be good to have one. Then after a while I realised that I could do it better. It was shocking and it concerned me. - Counsellor

Positive Experiences with Interpreters

However, several counsellors described positive encounters with interpreters and emphasised that well trained professional interpreters can be beneficial to the counselling process, and provide ‘cultural interpretation’, which may be important for the ‘counselling dynamic’.

There are some beliefs which are held without much evidence, that are asserted, that you can’t do relationship-based work, transference counselling, through an interpreter because the energy gets shifted into the interpreter who’s generally a much easier character to identify with for the CALD client. Our experience is different. - T&T Counsellor

I’ve found it wonderful, but you do have to choose the right ones. Once you’ve done that then...maybe it’s not supposed to be that they offer more than the language interpreting, but I think they do provide also some cultural interpreting which I don’t suppose they’re supposed to do. As well as that, it’s sometimes important to have three people there. You know...particularly if I’m working with a guy, it’s helpful for me to have a male interpreter for example. So there’s a balancing process that goes on in the room often...having that third person there which just provides a more trusting environment, I suppose. At it’s best. - T&T Counsellor

No, working with interpreters is not a clinical problem. There’s the occasional pragmatic problems around it, getting them when you want, et cetera. But no...It’s...In fact clinically I really enjoy it now, because I get that time delay and it’s just luxurious. You ask the question, you’ve got time to reflect on it and...I now find working in English quite hard. - T&T Counsellor

Working with Interpreters

Insufficient or inappropriate use of interpreters was a common complaint. This suggests the need for more resources and education, which should include practitioner training. However, the following psychiatrist seemed uncertain as to whether there was any formal training for his registrars:

How do you find working with interpreters in a psychiatric setting?

It is very hard, very difficult for me. And I find that some of my registrars need training in it.

Do they receive any training in working with interpreters?

If they are under me they do. But I don't think there is any formal training, so it adds to the difficulties really. The quality of interpreting varies as well. In worst case scenarios we have actually got into difficulties in therapy because of the interpreting. It varies. I don't think they are used enough and sometimes they are used inappropriately. They are asked to do interpretation, which is beyond their means really.

Do they get any training in working in psychiatric situations?

They don't necessarily. I don't know, it is up to themselves I think. They know that with some difficult cases they have to get help with the situation.

Because they couldn't cope with the distress?

Because they couldn't cope with the distress or they don't know enough about it. I guess if you are interpreting in a closed psychiatric ward in a situation that is potentially life threatening, and you have had no training, then that is difficult for them...

- Psychiatrist

Accessing Interpreters

According to some practitioners, accessing interpreters can be difficult. Further, general practices do not tend to be organised in ways that are conducive to the use of interpreters, especially with the constraints of time and the pressures of the situation (e.g. an accompanying carer who may seek to do the interpretation). As the following GP explained, it is difficult getting interpreters at short notice, and accessing an interpreter via the telephone may be necessary. This can lead to variability in the quality of the service. The pressures of the situation may be such that, paradoxically, the 'more urgent the condition', the less likely it is that an interpreter will be used:

You mentioned language at the point of contact. How important do you think that is? Have you had the experience of working with interpreters?

Yes and no. Yes I have worked with them, and no I haven't worked with them a lot. Again it is an access issue and again the use of interpreters in a general practice setting has some difficulties in terms of organising them around our normal workload, given that accessing them is very difficult. You can use the phone, the quality of the service is variable and sometimes the clients themselves are not all that happy with that approach when they may have a carer who is sitting by their side who is more than prepared to interpret. So, getting them to agree to an interpreter is an issue. Structurally it is a problem for us. It means having hands-free phones, it means organising our practice and the way that general practice is organised in Australia,

unlike the UK, it is a significant disincentive to look after that sort of patient, and they need to look at that at a policy level.

How do you feel about working with interpreters in mental health interviews (mental health in the widest sense) if someone is distressed for example, on the phone or in the room?

Both. It is often the telephone for us, because to get an interpreter down here at short notice...We probably use the phone more than getting someone down, almost exclusively.

How is that?

It is more easily accessible than getting someone down here, especially if they are distressed and you can't leave them in the back room and say, "Just wait until the interpreter gets here". It is often not feasible. So the phone is what we use. In terms of your question about the comfort of using one, I think it goes back to how often you have used interpreters before and how comfortable you are with using them. I think there is a technique and an art to using them that we as GPs are never taught. You learn it on the job. I tend to find that in an acutely stressful situation you tend not to use interpreters. It sounds paradoxical and it is probably the wrong way round, I am sure, but the more urgent the condition is the less likely you use the services that you should be using.

So you would work with the carer or relative?

Yes, I am aware of various problems, but it is often the pressure of the situation which forces you into that, and often the carers are jumping out of their skin to tell you and interpret. Often they want to put their spin on the events, and you find that your consultation is a little hijacked by them, but you let that happen because the pressure is so great.

- General Practitioner

Training for Interpreters

Finally, some practitioners suggested the need for further education for interpreters, particularly mental health interpreters:

I think interpreting is one of those important roles, and maybe they need to clamp down on interpreters with continued education. You can't take it for granted that if this person has been accredited ten years ago they are still good. You have to keep on top of it. We all need our skills to be replenished now and again...

...It is not just the word, saying the word in the other language. It is the nuances. It's what that word might mean in that particular culture. There is the pause, what does that mean? Why are they pausing? In some cultures people will nod and agree with everything that you say because that is the polite thing to do, and they may not agree at all. So there is a whole lot of things that need to be clarified and it requires so much more attention and skill, and we can't afford to have just anybody doing that sort of job. We need to make sure that they are qualified and that they are continuously updated and checked, and we need to make sure that it is top quality.

- Counsellor

Making Information Accessible

It was repeatedly pointed out that most information on mental health is only available in English. This is a problem of access and equity. The production of audio and videotapes in languages other than English was suggested in order to assist people who do not read and write in their own languages. This may be a valuable means by which to offer family support and to provide information.

There will be 'reluctance' at first, if everything is in English. And also the service providers are all English speakers. Also, carers don't trust the Interpreter Service, basically because a number of interpreters, good interpreters, are also involved in other ways with their community. So they can be identified. And they say, "Look, if I talk openly, if the interpreter is also a person at the club or something, will the whole community know about it?" And this is the big question of trust....because people *do* talk over a cup of coffee and discuss, you know, what they did that day, who they interpreted for, and details like that. I mean, if I knew a particular mental health worker who spoke the language and was sensitive to these issues and would keep confidentiality....That would be the ideal situation. That would be ideal for carers, basically...They would prefer support from somebody who, I would say, probably speaks their language and provides confidentiality. That would be the best. But if not, we have to use the interpreter service. Most of the stuff is in English. If you look at any of the pamphlets you will see that about ninety-five percent or ninety-eight percent of it is in English, and maybe two percent or three percent in other languages. And this is largely a point about equity. It's a misdirection of funding, it's a misapplication of people's taxes. Okay, some people don't read well, or write well. Fine, then we can make audio cassettes, so people can listen. Or video cassettes, so they can see. So, basically we need to do more of this family support, through video cassettes in languages other than English, and audio cassettes in languages other than English about different mental health issues and mental health in general.

- Social Worker

Trust

Some practitioners identified trust as a crucial issue in mental health service utilisation. If people don't have trust in a practitioner or interpreter, they are unlikely to approach them. Several practitioners commented that establishing trust may take time, and noted that strategies for building trust are essential. Again, GPs are often seen as especially trusted people, since they have ongoing contact with people and their families. One psychiatrist suggested that trust can be established by sharing concepts and terms:

You see, if you have somebody you can trust, who understands and speaks your language, not necessarily the language of your culture, but someone who uses the same concepts and terms - that would matter.

- Psychiatrist

One practitioner believed that GPs are a crucial contact as they are more likely to understand family dynamics, and are also often trusted by families.

I think that probably one of the crucial people involved should be the general practitioner, because I think the general practitioner is usually aware of the family, not just the patient. Usually aware over a period of years of what sort of dynamics are happening within the family, and also is a trusted person on the family's point of view....

- Psychiatrist

Some practitioners suggested that interpreters were especially mistrusted, because patients believed they would ‘tell stories’:

They would rather work with me and an interpreter for the English, than be seen by someone from their own background. They have this terrible mistrust of interpreters, a fear of them telling stories. “I really can’t do my private business with one of them because they are in the community. I am talking to you because I feel like I am talking to one of my own country.” We laugh at the same jokes.

- Mental health nurse

However, torture and trauma counsellors offered a different experience of working with interpreters.

There's something in our library, basically commenting on how bloody difficult it is to have an interpreter in a group session, and what an interpreter can do to your group session. But most of my experiences with interpreters have been positive in that we employ qualified mental health interpreters where the communities are big enough to have access to those people. And those people are by and large excellent, and are like cultural translators, language translators, and the good ones you barely know they're in the room. But what they add to the room can sometimes be a positive transference.

- T&T Counsellor

Building Trust

One GP explained the strategies he adopts for building trust, which may take years to develop:

I usually try and have a pattern of seeing them on a monthly or whatever basis as a way of establishing a relationship, exploring the medical problems as well as trying to do some sort of counselling type work with them. I try and see them on a regular basis, like once a month or something like that. As a way of them getting to know me, me getting to know them, and hopefully out of a sort of developing relationship we can move forward and try and get things better.

- General Practitioner

The importance of building a relationship of trust for the counselling process was also emphasised by the following torture and trauma counsellor. This process involves acknowledging people’s experiences as a starting point for successful recovery.

For me it's about just going on a journey alongside someone to wherever the journey leads. Understanding the frameworks that we come from, but just walking the journey that they are asking you to go along. The process of building a relationship and building trust, which is the first stage of recovery...

- T&T Counsellor

Practitioners' Contact with Carers

Practitioners reported having varying degrees of contact with carers, from seeing them very often to seeing them infrequently. Different practice situations may provide different opportunities to meet carers. Furthermore, practitioners are likely to differ in their views on the need to see carers and in their efforts to contact carers. According to one practitioner, the involvement of the carer is a crucial part of the diagnosis and management of a 'mental illness'. Because they are often in close contact with the 'patient' they can help identify the nature of the mental health problem, notice early 'warning signals', and can assist with assessing the level of existing support at home.

Sometimes it's very important to see the carer just to establish a diagnosis. And, for example, I might see someone who I see on one occasion, or maybe on two occasions, and I'm still a bit unclear as to what the problem might be. For example, a head injury would come into that particular area. So, someone has a head injury. Sometimes, the signs of the head injury can be very, very subtle. So, the person doesn't actually understand the problem himself, but it's more obvious to the carer...

...I might see the carer if I'm concerned about...even if the diagnosis isn't a problem, but what the severity of the problem is. Or how the person's managing at home, just to get more additional information like that. And, I suppose the other thing too is...sometimes it might be necessary to look at what sort of supports the person might have in the community, when you make a decision about where to send them, in terms of support and even admission. Like, it might be someone who has a lot of carer support...and even though that person may be ill, might not need to be admitted into hospital, because of...simply because of the level of support. There's other times - the person might be ill, but there's no support, [and they] might need to be admitted into an inpatient facility earlier on... If I see someone and I see them with the carer I'll let them know about the early signs of relapse and things like that. So that if the person sees the patient's sleep becomes disturbed or eating becomes a problem, or...those early signs, then they can be picked up.

Psychiatrist

Some practitioners reported that carers sometimes initiated contact, as a result of having first presented with their own problems. A few practitioners acknowledged the difficulty of determining 'what a carer is'. The practitioner may not always be in the best position to assess whether or not the person they identify as the carer is indeed *the* carer or *a* carer, and what their actual contribution is to caring. Consequently, they may over- or under-estimate their contact with carers.

And I guess you can talk about carers in terms of the primary carers, like the mothers and the fathers or the husbands or whatever. And then you can talk about the kind of defacto care that the community actually does, because the community actually carries certain individuals and makes exceptions for them and does lots of things because they know...And so there's two lots of caring going on - there's the caring that people are doing every day, like you read a disability pension form, they're washing them or pushing them or doing all that kind of stuff, or being parents and doing that stuff. But there's other people too who are carrying those individuals in the community in order that they...And they might be the people who are giving them a job in the local factory or dropping around things for them or driving them somewhere. So there's different levels.

- T&T Counsellor

A psychologist, who reported seeing carers 'not very often', recounts an instance where the carer, who was the 'patient' to begin with, later asked whether she could bring in her son for 'treatment':

How often do you see the patients' carers?

Not very often. It doesn't happen very often here... Actually, in one case I started seeing a carer, because the carer felt disturbed. And then after I had worked with her she said, "Actually my son has been diagnosed with a mental illness, and he really doesn't get anything apart from medication, and I think he could benefit from your services. Can I bring him along?" And so the mother who was taking care of her son brought him... She came as a severely depressed person, and I was seeing her maybe a year and then she said, "I feel better but I need to bring my son now".

- Psychologist

Working with Whole Families

Torture and trauma counsellors reported difficulties in 'separating' their 'clients' from 'carers'. They pointed out that whole families can be affected by torture and trauma. Thus, they prefer to work with whole families, when appropriate.

Often the person who is our client is also the carer of the other client. And we get that, for example, at a very practical level when we do Disability Support Pension applications and they invariably put in a double application - one in their own right for a Disability Pension, one as a carer. Because they are both. And we also tend to work with whole families to some extent - at least in terms of assessment and settlement in the beginning, don't we?...

...I think there are issues like, for families when, say members of the family won't express or don't want to talk about or don't recognise that they have issues that they perhaps need to explore. And so then their behaviour affects the whole family. I mean, I've had family members or parents or whatever saying, "What can I do? How can I help my son? I know that there are these..." You know, there's that sort of level of need for carers. Not that they'd actually go and get help, like sickness care. But they'll just come and say, "This is affecting me". "We know that," you know, "We know that he has problems". So what can we do? And there's those sort of issues I think.

- T&T Counsellor

Torture and trauma counsellors also drew attention to the need for practitioners to be aware that children may take on a caring role:

There are so many families caretaking a dad or caretaking a mum, and you've also got to think about that. If that parent doesn't have some kind of respite care, mentor or support...And I've got a lot of kids that are taking on the responsibilities of adults, doing all the things in the family because mum has just lost it. You've also got the fact that a lot of people have got relatives in other countries whom they are missing, and that's prolonging their illness. And if the immigration policies continue as they do we're not getting anybody in a hurry to Australia. So therefore "Until so-and-so comes to Australia, then I'm going to be sick". So the kids are looking after them for maybe five/ten years or whatever, and those children never get to have a childhood, never get to...They have to deal with things they shouldn't be dealing with as children. And children shouldn't have to be carers. And that's not just an issue for CALD communities, that's an issue for people with serious illnesses and disabilities. There's lots of children looking after ill parents, and that shouldn't be the case. And those kids need respite.

- T&T Counsellor

This psychiatrist sees the majority of his 'patients' families, partly as 'a matter of courtesy', but also out of 'interest'. Here, he describes how he approaches the 'very delicate situation' of negotiating contact with carers:

Do you ever have any contact with the carers of the people in the psychiatric...?
Most of the time.

Is that through your own initiative, or do they come with a patient?

I think it is a matter of...If not anything else, of courtesy. To see, let's say the partner, or the husband...or respectively the wife of the person you are seeing. Plus it is...for them is interesting to see you, because they constantly hear about you. And I always make a point to see them. And it's a very delicate situation when you work in the context of trans-cultural psychiatry, because you have to take into consideration how your offer...that they could come and see you. So you don't call them. You simply say they are most welcome to come if they want....That offer, how could it be interpreted?

For example, the husband could say, "Oh, what does that doctor want? Does he think I am the cause of my wife's problem?"...That is not the case. So, there is some defensiveness when they come in the beginning. But overall, in the vast...I probably would say unless specifically declined I would see, either one way or another, seventy to eighty percent of my patient's families.

- Psychiatrist

In the above case, partners are assumed to be primary carers. However, as another practitioner observed, there is a danger in assuming that partners are carers in the sense of actively 'taking care' of another person:

And do you feel that involving the carer actually assists the carer to cope better?
Sometimes the other person is not a 'carer' in the strict sense of the word. Let's say the husband has depression. He manages, goes through life, every day life, angry and subdued, drinking more. Would you call that other person, his wife in other words, a 'carer'?...It's not so. I mean, [it] depends on how you define [a carer]...I would have thought, because 'carer' carries more...defines a certain level of disability in the patient. The person needs to be cared for...If you call the person who is next to the patient, a 'carer' - if that is what we decide to define, fine. Broadly defined, probably, that's alright as a definition. But I know a lot of women who are quite depressed and probably not functional..and we would hardly call the husband a 'carer'. But you can call him a 'support network'...To me, the carer is the one who more actively is taking care of another person.

- Psychiatrist

Community Contacts

This general practitioner reported seeing patients 'reasonably often', both individually and with a partner. They mentioned the supportive role played by a member of the local community, in bringing patients to them:

Do you often see the carers of the patient? Or the partners or whoever might be at home with them?

Reasonably often. Some of them I actually see as couples. They come together. Sometimes they come separately. It just depends. There's also another patient of mine who is Croatian...who has been a great support to local people. Quite a lot of

people come and see him. He's not employed by anyone. But he just does this. I don't quite know how it's come about, but anyway he does it. Which is great. And he's actually brought people in to see me, who had problems and difficulties. And because he speaks English well enough, he can actually help.

-General Practitioner

One practitioner mentioned that he has some occasional contact with carers, particularly through 'outreach programs':

Do you have any contact with carers?

I do. I do. Not much, but clients who come to the Living Skills Program mainly live in the community hostels. Some of them have their own, so to say, 'own' rented apartments, and some of them live with their families. So, every now and then a carer is involved in the treatment process. I would say that we do have an outreach program now, meaning that you would go to places where these people meet, be it hostels, be it in their homes, be it whatever. And in such contacts we certainly speak with carers as well... [We] speak with carers and give them some sort of help and advice on how to deal with patients, how to recognise that things are not going so well...

- Psychiatrist

However, as a number of practitioners noted, some 'patients' live on their own. The following practitioner reported seeing 'marginalised individuals', that is, those who have yet to be identified through income support or community programs:

Most of the folks I see are single. Living on their own. I would imagine that those who have families would have gone through mainstream channels. And the client in question would be placed on a disability pension. Say, for example, if that's what we're doing with them on the recommendation of their treating doctors. So, they wouldn't necessarily need to come through me. I end up seeing more marginalised individuals. Folks that haven't been picked up somewhere along the line and placed on the right sort of income support, and the right sort of community program.

- Psychologist

The Impact of Migration on Mental Health

Many practitioners described migrants as a distinct group of people, if only by the fact of their decision to migrate and leave their own culture and way of life behind. Migrants are exposed to often drastic changes in life circumstances, and various stresses related to these changes. The absence of support in stressful situations within a new culture may, in some cases, exacerbate potential mental health problems. Several practitioners commented that depression appears to be more prevalent in people who migrate, compared with those who remain in their countries of origin.

For a start, the group that migrates singles itself out. By the very act of choosing to migrate they are seen as different to the ones who've stayed behind, in that they are the more adventurous...Or are disgruntled with their lot or don't fit in where they come from. Therefore they tend to select out the people who are a bit different anyway, who'd migrate away. So I think the incidence of psychotic illnesses would probably be higher amongst those who leave their own country of birth. Secondly, when they get to the new country they do have a much more stressful time of it, having to cope with a new culture, a new environment and so on. And the absence of a support system, I think, tends to exacerbate any psychiatric problems. As far as dementia is concerned, I don't think immigrants tend to be worse off in any sense...I don't think the fact they've migrated can be implicated in their dementia. This is another way of putting it - although, moving to another culture does predispose them to psychiatric illnesses, it wouldn't predispose them to dementia.

Are you aware of what sorts of psychiatric illness might be prevalent?

I think things like depression...That is the most important one. But then the others - the more psychotic things - schizophrenia and so on, I'm not sure...I suspect they would tend to have a high incidence amongst immigrants than amongst people residing in their own country. But depression specifically would be. I think depression probably is very much more prevalent in people who migrate to another area.

- General Practitioner

Some of the mental health practitioners interviewed had themselves migrated to Australia, as children, adolescents or adults. In describing their 'first hand experience' of the process, they acknowledged the difficulties related to resettlement and acculturation. Regardless of being relatively 'integrated' professionally and personally into the host environment, these practitioners stressed the complexity of the migration experience.

I think migration is a very complex, a very powerful and a very difficult step in a person's life. I wouldn't do it a second time!! I am not saying that I am not happy and well settled and adjusted in my adopted country. I am raising my child here as well. But many people cannot adapt. They go to another country but would return home if they could. For instance, many professionals from my country went back when the Communist regime collapsed. I didn't do that because there was no need to and secondly I enjoy living here, so I decided to stay.

- Psychiatrist

Several mental health practitioners asserted that migrants often come to Australia with preconceived ideas about 'mental illness' that need to be taken into account if they are to be appropriately treated. If such matters are not taken into consideration, patients may experience additional stress.

Of course I need to ask about their perceptions of mental illness and what would or would not be helpful for them. Through this I learn how I can be of help to them. I have to do that. Otherwise, we couldn't call it therapy. It would simply be putting them through more distress.

- Psychologist

Multiple Losses

Migration was described as a 'risk factor for mental health'. Practitioners commented that this is specifically the case with people exposed to trauma before and during the migration process, as in the case of refugees.

Migration involves ...an indefinite number of losses. We react to a divorce. We react to depression. We react to the loss of someone in the family - reactive depression. So how about multiple losses? And also...most of the time people have already been traumatised in their own country, the people we're working with here...They are already traumatised. Plus they have multiple losses. I read once in the literature that migration magnifies any already existing problems- if someone is anxious already, then he becomes more anxious after migrating here. But it also magnifies strengths. If someone, let's say, had a good marriage...the marriage has become even better here. I have experienced and I have seen people like that. But...imagine the impact of this loss...People get counselling due to divorce....But divorce from one's country of origin, one's culture, friends, prestige, status?

- Psychologist

And, because we are talking here about the mentally ill in CALD communities, there will be a significant proportion, it's got to be at least the same as the host population (my guess is it would be more because of the added stressors) who will be frankly mentally ill.

And just that fact that chronologically we've got a lot of people who are forty/ forty five but who essentially really are not going to be working again in this country, because it requires language acquisition. They have got so many intrusive recollections, so much of that kind of stuff, that they're just never going to...Well they may get the language, but it's not going to be in two years and they may not get it at all. And if they're not learning the language then they've got...And I mean most of our people have the most amazing resilience. They're delivering newspapers and doing every possible thing in the known universe to keep the family going. They try as hard as they can. The whole family does.

- T&T Counsellor

'Mainstream' Mental Health Issues

Migration was not always described as a major precursor for developing a 'mental illness'. A number of practitioners stressed that many of the issues relevant to the migrant community, such as changes in 'family situations', are equally relevant to the mainstream population. They commented that for older women who have spent their adult years in unpaid domestic labour, some degree of 'depression', or 'empty nest syndrome' was likely.

I can give you some examples of older women who have had problems with depression years after having migrated. They have problems with a change in the family situation. Basically, at the beginning they were busy achieving things and they were busy with their family, and when they have achieved all those things then they have more time to think and they develop some sort of depression.

It doesn't happen only to the migrant population. It's the 'empty nest' syndrome, when women can get depressed often years after migration.

- Psychologist

Usually when migrants first arrive they obviously have more stress while adjusting and problems with the language, so after the first honeymoon period they start to find out the problems associated with language and work and all these things. Some of the reasons they are under such pressure is due to their migration, but it is not really clear cut. It is a combination of things - whether they have support, where they live, work etc.

- Mental health nurse

Stresses Related to Migration

The health and mental health practitioners interviewed identified a number of stresses related to migration, which can affect the mental health and general well-being of migrants. These include the mental health of migrants before migration, their family mental health history, and their reasons for migration. Also emphasised were the role of family dynamics, the economic and political situation in migrants' country of origin, and the time of their migration. Upon arrival, migrants may face additional stressors related to their adjustment to a new society, the lack of social and traditional support networks, and the disappearance of cultural identity and familiar values. The experience of being a single person in a new country, and of social isolation is often distressing. All of these factors, alone or in various combinations may produce grounds for anxiety, depression and other mental health problems.

The whole problem is a question of "What was their mental health before they migrated?" and "What were their reasons for migration?" and "What were the family dynamics?" And everything else. Economics, political dynamics, whatever. And then when they leave, there is the fear of the unknown. It is an adventure discovering a new society, a new chance for living. Yes. But also without all the other support you had. For example the cultural identity and values that you are familiar with, which is something new. The stress of migration is so big, as is the adjustment required, and also not having your family of origin with you and not having traditional support and values. Sometimes...some people just...never adapt. And if they are single...for example, they have no partner or family or other relatives or friends...If they don't look after themselves, they go in the direction of alcohol abuse and gambling and so on. Then basically, eventually at the end (it depends on their genetic make-up and the mental health history of their family) there's a chance that they could become isolated, depressed, anxious. And then they have other influences...There's a chance of mental illness. So, isolated from the existing local community, and society, they don't join an organisation, they don't join other people. So they are very much outcast. And this is why they have the chance of becoming mentally ill and suffering.

- Social worker

Migration Varies

A number of practitioners commented that it is impossible to generalise about migrant's experiences, since they are related to the time of migration, the conditions under which migration occurred and individual settlement experiences. Often the only factor that makes migrants a distinct group is the experience of migration. Further, the mental health issues relevant to migrants may differ from those that are pertinent for refugees. They offered a number of variables that should be considered in any discussion of the influence of migration on mental health. These include age, cultural distance from the country of origin, reasons for migration, language, and the availability of social services.

I think migration varies. I know from my own experience too that it is not an easy thing to do. You have to go through a period of transition. There are so many variables and conditions, age, cultural distance from where you came from, what made the migration necessary, language, social services, and so many areas. I guess there are certain groups that have more problems such as victims of torture, refugees.

- Psychiatrist

I think it depends on how they came here. Some people come willingly and settle very well and it is straightforward. But for refugees it is different. Some have come from terrible situations and they may well have problems. They cannot go back, they have lost all their support, and the language is a problem for some new migrants. Then we see problems with alcoholism, drug abuse, violence, depression and anxiety. Migration is not always bad though, and it depends what you mean by mental health. In a wide sense I think it takes a while to readjust and feel at ease in a new place. I wouldn't like to generalise as it is so different if you are a refugee.

- General Practitioner

It's very hard to generalise because Polish people...the older generations, at least, are war refugees. They came from refugee war camps, sometimes from Death Camps in Europe, where they were held during the Second World War. They came from forced labour camps in Germany. They came from Siberia, again forced labour camps, where they had been traumatised as well. After the war they couldn't return to Poland because they heard that Poland wasn't free at all. Instead of German occupation they had Russian occupation. So they are a very traumatised people, but they have lived here thirty years/ forty years...And then they had post Solidarity, so called post Solidarity, Polish immigration. And again these are people who are very often coming from prison - traumatised, persecuted, investigated, interrogated...Plus multiple losses. So, their problems might be similar in the respect that they came as refugees with multiple traumas in their lives, but the difference may be that the younger generation of Polish, the post solidarity generation, are more educated.

- Psychologist

And the other thing is, I think, the big issue is employment. Because once people actually become employed and they start work, they start living a life. Normally you

get up, you go to work, you come home, you earn money, you can support your family. I mean, it solves the problem. You meet people at work, you make friends...But it's so difficult for lots of our client groups to gain employment that's positive for them.

- T&T Counsellor

Pre-migration and the migration experience itself, as well as the settlement process are only a few of the complex interrelated issues that need to be considered when analysing migration as a risk factor in mental health.

As you're aware, the process of migration is a very varied one. There are a number of factors that are important (pre-migration, and then the migration experience, and then post-migration) as to whether they're more or less likely to develop mental health problems...So, I think it's complicated. I don't think you can just say, "Well, you know, migration causes mental health problems". I think it's very much more complicated than that - factors like where the person is coming to, what sort of supports are already in place within this community, issues to do with socio-economic changes, the whole process of trauma, and all those sorts of things would, I think, be important.

The other problem with carers would be that they're probably...I mean, I don't know, but I just get the feeling that there are probably a number of things that they are channelling their energies into. Particularly someone who's come here sort of post-migration, who we're seeing post-migration.

- Psychiatrist

Resettlement

How migrants settle into a new country depends on various factors, including their attitude towards their past and present experiences. The manifestation of mental health problems related to traumatic experiences may be largely dependent on the circumstances that exist *after* migration. A number of practitioners asserted that individual responses vary according to the degree of integration into new life circumstances. If integration is less than successful (due to the inability to find employment, for example, or an inability to satisfy other expectations) people may 'dwell for much longer on their past'.

Obviously if you go somewhere unwillingly you will have more pressures. It depends also on whether you are able to return. Or not return. It's the ultimate question about choice. I mean...survivors of torture and trauma I'm fully aware about. I see a lot of people about these things, but a lot of it depends on their circumstances. If people cannot meaningfully project themselves in life here and now, obviously some of these traumatic experiences will be closer to them, to the surface. It will be more focussed. Obviously many of them had identical problems. But somehow, through availability, people integrate themselves in life through finding a job and even more through determination. For many of them, these things would not represent such a disruptive moment in their life. I don't know what the explanations are for this.

- Psychiatrist

Negotiating a new life through resettlement, managing family relationships and raising children in changed circumstances often leads to further stress and may compound 'traumatic dislocation', which can result in mental health problems. There are, of course, additional problems for people who have experienced physical and emotional abuse in their countries of origin.

Migration is...I expect in most instances, if not all instances, a profound trauma. And...that sense of dislocation. That sense of shock. And all of the other hundred and one hassles and problems that come with setting up a life for yourself and managing your family relationships and raising your kids and whatnot...just adds more stress. It compounds that traumatic dislocation. And I'm...I've come across many people suffering, I guess you could say, mental health problems. You know you can certainly attribute a large part of the problem to the stress of migration and the resettlement process. And we're not even touching upon those individuals who were subjected to physical and emotional abuse in their countries of origin. The sort of torture and trauma victims that we're familiar with.

- Psychologist

Distressing Periods

A number of interviewees alluded to the 'usual time-frame' during which mental health problems related to migration are likely to appear. Often, there is an initial settlement period, during which migrants (particularly refugees) often feel relieved because in Australia they regain a sense of physical safety. However, once this initial settlement period is over they may have to come to terms with the realisation that, in many cases, they cannot return to their country of origin. They may worry about the relatives they have left behind and may feel guilty on account of this. Many cannot find employment related to their qualifications and they may ultimately experience significant downward mobility, and be forced to accept profound life changes. This

may cause additional stress, which in certain cases may result in a mental health problem.

Immigration has been identified as one of the biggest stresses. If people do not crack up in the first or second year they may be all right.

Sometimes it happens with people who are political refugees, that they have lost everything and cannot go back. So they go to a new country, which they believe is heaven. They find themselves here on social security benefits and they do not have to sell books on the road to make a dollar. They can go to the doctor at any time, they can get medication at little cost. They can even find accommodation. So their focus is "This is wonderful. Australia is marvellous," and they have this euphoria about finding themselves here away from the bombs, away from the persecution, and away from scenes of people lying in the road with their throats cut. Things are beautifully clean here and there are trees everywhere. They are absolutely ecstatic. There are beaches everywhere and they are free. So they start their English classes eagerly... What is happening and they do not realise this, is that they are putting a lid on what they have left behind, on their sense of loss. They are not focussing on "I have just lost my mother, my brother, my husband". They are not focussing on that or that they have lost their career. So when the dust settles on their joy at being here they start thinking "I cannot go back to my country. I don't really know if so-and-so is alive or dead. I was doing this job as an executive, driving a big Volvo..." (I remember a Croatian lady telling me this), "...and now I am cleaning houses at \$10 an hour. I used to stay in big hotels and travel the whole of Europe ... Now don't get me wrong, I am grateful for my little flat in Australia...."

Once people get their immediate needs settled (if we think of Maslow's hierarchy of needs - to find food, shelter and protection) they move onto their housing being adequate, having their kids in school and buying what they need to eat. When all their basic needs are settled it is sometimes then that people take a step back and think "Oh my God, what have I been through? What have I had to endure! And yet I am lucky, so why do I feel so bad?" I attribute this to a tremendous sense of loss that a lot of migrants have, significantly refugees, because the ordinary migrant can go back. Refugees can't even if they want to. So if you are dealing with someone who has lost everything and they cannot see an end to it, sometimes it is very difficult to recover from the possibility of fear where they say, "My son got lost in the War. I had to get out because I was being tortured and traumatised by the soldiers. The Red Cross got me out of the country, I grabbed my two daughters and got onto the first plane they could arrange. I was fortunate that I got out with my life..." But the guilt that this person feels because she had to leave behind her eldest son who was missing...Those are the kinds of things which we often have to face in the mental health field. Stress is of course a well known factor in psychiatric illness and the levels of stress that some of these people have gone through as refugees is immense, really immense. They have certificates, their qualifications, and other than that they come out with nothing, absolutely nothing but a small suitcase.

- Mental health nurse

Newly arrived migrants may encounter a series of problems that are quite distinct from those faced by more established migrants. This psychiatrist described two 'critical periods' that may render migrants at particular risk of developing mental health problems. The first is the period of early arrival, and the subsequent time of mourning for their former life, culture, language and tradition. The second is retirement, and the time when the children leave home. This is a particularly vulnerable phase in the lives of many migrants, as many have spent their working lives within their own communities, and thus, upon retirement, lose their social contacts and support. This isolation is compounded by the fact that this is also often the time during which children will leave home.

I think there are two crisis periods - one when they first arrive, after which there seems to be a time lag, perhaps related to the acculturation of their kids (dare I say it?) and retirement. And the kids leaving home seems to be another peak. I think that it is linked to the experience of loss. They come over here with their kids, having lost their culture, their language and their traditions. They have worked within their own communities and when this ends they are lost. And then the kids leave.

- Psychiatrist

Retirement

Older migrants face particular difficulties, which may occasionally be a product of the less tolerant climate towards migrants in Australia that existed at the time of their migration. Whilst they were preoccupied with raising their families and establishing themselves in Australia, many – now elderly - migrants worked and lived within their own communities, and have never mastered the English language. This may be a particular problem for older migrant women, who have spent their working lives caring for their children and running their household. Once their children leave home, these women often face social isolation. However, some communities are mobilising to address these issues by establishing multicultural retirement villages with multilingual employees, to care for retired members of their community.

They managed, but there was a different level of multiculturalism at that time and they had a different background, in that they settled down here OK and looked after their children and now they are retiring. But I have to raise a most interesting point. There is a desire in the Polish community to build up a multicultural retirement village with a nursing home on the side, with staff that speak Polish, Serbian, Croatian, Czech and so on. They came up with this idea and asked me to organise it. They want to sell their houses and retire in villages or nursing homes because their children have adapted to their new country and have grown up, and they feel quite lonely.

- Psychiatrist

Employment Difficulties

In many cases, migrants may accept demanding, yet underpaid work - unrelated to formal qualifications - in order to resolve financial difficulties and to enable their settlement. This may result in there being insufficient time left available to learn the English language. Thus language may remain a barrier for employed migrants.

The practitioners interviewed reported that educated migrants, whose qualifications are not recognised, or who lack English language skills, face the additional stress of being employed below their intellectual level, or outside of their particular field of interest. The loss of status due to unemployment may be particularly stressful for such migrants.

These issues aside, physically demanding work is more likely to result in physical injury than are less demanding positions. Injuries may prevent people from maintaining ongoing employment, and fallen expectations may result in deep dissatisfaction and a 'misplaced disappointment' in Australia.

Homesickness

A number of practitioners described migrants, 'who have settled through choice' as more prone to homesickness and to idealising their country of origin than are refugees, who are forced to reconcile with the fact that they may never return to their country of origin. This was considered to 'give refugees a sense of permanency', as they tend to 'accept their new lives' with less regret than is expressed by voluntary migrants.

Usually our people [Bosnian, Croatian, Serbian] are hard working and they want in a short time to gain more than is possible. And they don't learn English...it's a really big barrier for them. And in order to gain money they undertake some really hard jobs which result in these kind of injuries. So, after that, everyone is saying Australia is...."not a good country". Their experience is very very bad. Because of failed expectations and because of their very poor adjustment in this society.

I have the impression that migrants who came willingly are more homesick. They feel more homesickness than the refugees who didn't have a choice and are more aware that there is a better life for them here than in a country where it's poor.

- Psychologist

And they [recent migrants] have come having lost their qualifications, education, and ways of expressing their knowledge....You can have knowledge, you cross the border of Poland and you still have knowledge in your brain...It doesn't disappear. But you don't have ways and strategies to express what you have been through, to let people know. So they lost prestige, qualifications, educational degrees, and years of work sometimes. Because in post-war Poland there was a trend to get an education. We didn't have possessions, but at least we had an education.

- Psychologist

Voluntary Migrants

However, some interviewees suggested that voluntary migrants have fewer difficulties adapting to life in a new country, as the result of their 'positive attitude' and expectations on arrival.

There are all the usual stresses of migration. I mean everybody, just about, will go through a period of depression. But it is when that depression takes over and they can't actually function and they can't get on with day to day things...So if people are saying that they are just feeling down, we just say, "Well that is pretty much a normal reaction to your circumstances". But if it becomes debilitating then we need to look at how we can help them improve. Also I think it depends who they migrate with, and their reasons for migrating. There is a difference between migrants and refugees. Migrants will get down but they at least had a choice in coming. They chose to come for a better life. Regardless of the initial sadness and missing people and the different culture, they can still see the prospect of a better life ahead of them and there is always the possibility of going back. Whereas for refugees it's like being hurled into a community that they might not even have chosen in normal circumstances. They didn't choose to leave where they lived. They couldn't say goodbye to people. They couldn't dissociate from...They couldn't do it in the proper way that things are done. They couldn't do it in a timely way. It just happened too quickly and they couldn't come to terms with it. So I think those people in the refugee category will be more susceptible to developing mental health problems, rather than those in the migrant category.

- Psychiatrist

A lot of the problems I have seen spring from the fact that they have never actually mastered the English language. Those that have gone out into the community and worked and made friends and established links, seem to cope better. Whereas people who came, maybe post Second World War, and worked in a market garden or in vineyards are very insular in their own communities. They have never actually mastered the language and in those days, of course, we didn't have interpreters or English language classes or any of these services. So there was no way for them to learn English and those people got to a certain age where their kids had grown up and left home, their spouse might have died and suddenly they are very isolated. Most of the ones I am talking about are from Croatia because they are the ones that I have worked with. Though it is the same in any of the communities -people who came thirty or forty years ago still seem to be quite isolated because of the barrier of not having learnt the language, not having had the opportunities.

- T&T Counsellor

Even when it is voluntary, migration is connected with a significant degree of stress. Practitioners described some people as 'resilient to stress', as they have developed 'coping mechanisms'. However, those who are less resilient may be prone to developing mental health problems. Younger migrants generally have fewer difficulties.

There is definitely distress. We see patients of various levels of robustness and integrity and we see the power of resilience and the ones who are exposed to stress. They are less resilient to substance abuse, sleep disorders, anxiety, violence, financial worries, a loss of financial and social status, more depression and anxiety, substance abuse. Changes in stability can cause that, no doubt about it. I would say the younger people are the more power they have in adapting. It looks as if the children of migrants will do much, much better than their parents.

- Psychiatrist

The Settlement Support System

The contemporary settlement support system for newly arrived migrants in Australia was compared favourably with the less developed services of previous years. Practitioners acknowledged the benefits of the formalised social support that is currently available. The importance of taking individual experiences into account was emphasised, as different people may react differently to similar circumstances. Factors such as age, personal expectations and the possibility of realising professional and personal goals affect the settlement process. These may form additional mental health risk factors.

Stress, there is. I don't know about mental illness. They say that in the first two years it's a higher incidence, but then after that it levels out. But there is a lot of stress. It's not an easy thing.

I suppose any new arrivals...any new arrival here goes through the same process. I think that in certain respects, for the newly arrived now, there are more services than there were, let's say, even twenty years ago when I came here. There is more support...on a social level, let alone compared to what it was thirty years ago. Again, how this is lived through by the particular person depends on many factors, like...their expectations, or frustration in different situations. Age. Opportunities for successfully finding at least some niche, some place in life here. All these factors.

- Psychiatrist

Practitioners also identified the need to establish strong support for migrants during the initial settlement period, particularly for those who may have experienced trauma prior to migration.

I mean certainly, these are major stresses. And certainly too, these people need a lot of, what would I say...a lot of help. Particularly at the beginning of their life in the new environment. Many of them come with various types and kinds of traumas and their experiences of things make them a high risk population.

According to research findings migration, particularly at the very beginning of one's life in a new community, introduces many stressors that can increase the proportion of mental illness in such people, be it depression, be it substance abuse, be it... something else.
- Psychiatrist

Several interviewees reported that mental health practitioners tend to only see migrants with 'severe mental health problems', and that many general mental health issues in the migrant population remain unaddressed. Factors influencing general mental health that are related to migration include changes in social status (particularly for men), profound changes in lifestyle, and the loss of support networks.

Migration does have quite a big impact on mental well being. We just see the minority of the migrants who have a major mental problem. Those who come here suffer from major mental disorders .There are minor psychological disturbances that are common amongst migrants as a whole, yes. The change of status to the man, the total change of life style, the lack of support outside the support networks...A lot of problems.
- Social worker

Cultural Awareness and Sensitivity

The practitioners described significant cross-cultural differences in perceptions of mental health amongst the 'mentally ill' and their carers. A number of interviewees drew attention to the need for a culturally appropriate approach in mental health provision and argued that 'cultural beliefs' as well as individual and family values need to be considered. An awareness of the diverse ways that people make sense of psychological distress and of the culturally bound symptoms of 'mental illness' was identified as a prerequisite for the 'proper diagnosis and management' of 'mental illness' in CALD communities.

Like...family structure. Who is the head of the family? Is there partnership in the family? Individualisation...In Chinese culture there is no separate self, there is a family self. People are not considered as separate individuals - they are part of the whole family. So when you see a Chinese person you have to realise you have the whole family there. You should not say anything that would upset the father or the mother, even if you are talking to the person as an individual, say a child in the family for instance. There's no clear boundary between self and family. And in China they live for the well-being of the family. They don't live for themselves. They didn't migrate here for individual goals, they came for family goals. So we have to be careful how to advise and how to conduct therapy, and sometimes therapy values are not consistent with those of cultural values. Like, "opening up" is inappropriate in many cultures. Talking about problems does not exist in many cultures, because they have an avoidance strategy to deal with the problem - not mentioning it, not talking about it, forgetting. That's how they deal with the problem. So when you say, "Talk about your problem," or, "Tell me about your problem," you have already put him or her in conflict because that's not what the culture allows.
- Psychologist

These sentiments were reinforced by other mental health practitioners.

I think people are not clear about what it is we do here. There are two traps people fall into. One is to think that we won't deal with things or that we are going to do the opposite and over explore something they want left alone. That brings us back to the cultural sensitivity issue. It is a very Western thing to want to get things off your chest. I have seen people who feel they have adequately dealt with things and they want to move on and get on with things. It is a cultural thing; we are converting them, by implication, from survivor to victim, which goes against the grain. It is an incredibly delicate area and we don't really see enough here to develop any real expertise. Possibly the nature of the problem, too, is that we replay, especially for someone who has been interrogated, we replay that situation in our work. Getting back, I guess, to the question of perceptions about mental health - even if you introduce it in undergraduate and postgraduate courses, people are going back to a more anthropological view in transcultural psychiatry.

- Psychiatrist

I think what is necessary is first to define, to provide, to produce culturally sensitive definitions of mental health problems and mental disorders in different people. For example, in Aboriginal people...they may speak of mental health, but they don't speak of schizophrenia, depression, and similar diagnostic, Western diagnostic, categories. What they say is 'grief', 'loss', 'fatal despair', 'anger', and similar things...All of which need to be defined to enable mental health professionals to assess, diagnose and manage such problems. The same is true of people coming from culturally and linguistically diverse communities. There are a number of culture-specific syndromes, disorders and conditions that require quite elaborate assessment in terms of these disorders, and if they are assessed properly then management can be more appropriate.

- Psychiatrist

It's just that assessments are developed by English speaking middle class white, you know, whatever. And they don't necessarily fit the cultural groups that they're mapped on to. We might say, these are the features of traumatic stress, but you need to reframe that for the culture. And what she in fact said to the Cambodians was, "Have you lost your spirit?" Because a lot of Cambodians will identify as being possessed by someone's ghost or... they will talk about mental illness in those terms. And so by talking in their terms about it they could then explain it to her. Whereas, if she'd said to them, "Look, do you have intrusive recollections?", "No, I've been possessed by a ghost, you idiot". And it's that kind of stuff that we need to be aware of.

- T&T Counsellor

Culturally Insensitive Practices

Most mental health practitioners identified the need for cultural sensitivity when dealing with 'patients'. When this is not practised, medical practitioners may impose their viewpoints and cultural values on patients and their carers. Insensitivity of this kind may jeopardise treatment as well as the relationship between the carer and the mental health practitioner. Appropriate language and an understanding of various cultural practices in relation to 'mental illness' and caring responsibilities are vital for successful 'therapeutic relationships'.

Many practitioners also noted that various therapies, such as psychotherapy, are based on the experiences of Western educated, white, middle class professionals - whose understanding of 'mental illness' is not necessarily applicable to people from different cultures. Both the existing literature (eg. Littlewood & Lipsedge, 1989), and the

interviewees acknowledge that this may lead to misdiagnosis. Most of the practitioners interviewed were aware of the need to address mental health problems in culturally appropriate ways, and were well informed about the body of literature dealing with these issues. These attitudes appeared to be influenced by the migrant backgrounds of many of the practitioners, their partly non-Western training, and their interest in cross-cultural issues in health care.

We have to be very careful because I remember a Greek mother with her son. She said, "Can you explain to me symbiot....what is symbiotic mother? Because the psychiatrist told me that my son is in a symbiotic relationship with me, because he is still living at home. But, in Greek culture, if I have a big house and my son is living in it and if he has an illness, I am his mother and I am taking care of him. Even...if he had cancer, if he had pneumonia, if he had I don't know what else...a mental illness. It's my obligation to take care of him, like with any other illness. And I was told that I'm not letting him go. I'm not letting him individuate". So, that advice of course caused a lot of personal distress to that poor lady who was taking care of her thirty year old son, who was unmarried and suffered from a mental illness. So we have to be careful, even when offering services to CALD communities, not to let them think we are saying, "We are going to take care of your son, not you". No, we need to say, "We're going to help you take care of your son". Because they are not going to resign from this role. It's a cultural thing, to take care of your son with any kind of illness. So we can't say, "You have a rest and we...we're going to take care of your son forever and..." We have to be diplomatic - "Yes, we appreciate you taking care of your son, but we would like to offer something that would help you relax sometime...Or have more stress management, to deal better with the hard work you put in".

Psycho-therapies are also designed to for middle-class Western people. So...I cannot use them with the Chinese or Polish or Bulgarians or Croatians, because they are for middle class Western people. They do not work, they're not universally applicable of course.

So you think that there is a need for specifically different strategies for...?

Absolutely. Yes. There is a little bit of literature already. There wasn't much, say, fifteen years ago. It's more available now. What works, let's say, with Chinese instead of 'anxiety'? Or what would work with this kind of problem in this particular culture? And again, who diagnosed the problem? A Westerner with a Western diagnostic manual...

- Psychologist

Avoiding Assumptions

Although there was a general consensus amongst mental health practitioners that people diagnosed with a mental illness need to be treated in a culturally appropriate manner, a number of practitioners asserted that treatment should be 'individualised', so as to avoid unwarranted assumptions and generalisations. Examples of the 'positive practices' described by practitioners include making referrals to services identified as culturally sensitive, and collaborating with people familiar with the given culture. However, some of the interviewees argued that there are certain mental health disorders that are 'very biological', and that the symptoms and manifestations of these are not culturally bound, thus 'culturally specific services are not really necessary'. For other, 'culturally bound' disorders, a culturally sensitive approach was still regarded as crucial.

It's on a case to case basis. It's not that we have got a program - don't get the wrong impression. But as soon as we see a problem, we deal with it. Sometimes we refer them. Sometimes we, what could I say, invite somebody who knows the culture to our centre. So there are many ways of trying to help. But we always try to address this cultural issue. Always.

If you have somebody with a mental disorder such as schizophrenia, then I don't think that a culturally appropriate service is so very necessary. If available and possible - so much the better. But you see there are many psychiatric disorders that are very 'biological', in quotation marks. It does not matter, so very much whether you've got a mainstream or culturally sensitive psychiatric service. There are many other psychiatric disorders - such as depression, anxiety, substance abuse...The culturally appropriate approach is more important than what is done by a psychiatrist.

- Psychiatrist

I don't think I need to adapt my understanding of psychological functioning but I need to always be aware of the culture. My style has got to change in that way. I have to understand their cultural background to understand some of the symptoms and why the symptoms present as such and why the relatives and the patients react to the symptoms of mental disorder in a specific way. I think Western psychiatrists find it difficult to understand when they don't know the cultural background, the belief that mental disorder is linked to possession, sort of by evil spirits - a special type of evil possession. It is hard to understand if you do not understand the culture.

- Psychologist

A number of practitioners asserted that mental health service providers need to 'start from scratch', and listen to their clients' own accounts of their problems, in order to address their particular needs.

It's good to assume that each person is new to you and you don't know anything about them. Even if you have a referral letter. At least, I'm working that way. I will get a referral letter from, let's say a GP, which contains his diagnosis....I pretend, acting as if I don't know anything about this person and am starting from scratch. I start with the belief that I know nothing about the structure of the family. I don't know the person's biography, I don't know their values, I don't know their pattern of behaviour, I don't know their concept of illness ... The patient is going to tell me. I will learn from him. I ask him if there's no literature or research available .. then he will tell me, and be quite willing to tell me.

- Psychologist

Most of them don't really know the whole concept of mental health or counselling. So I'm not even sure that most of the people I work with have a concept of madness, actually. So, it's like having to get all the frameworks we've got and somehow listen to where they're coming from, and structure what we think we're doing into something that matters for them.

- T&T Counsellor

I think they need to assess each patient or each client as an individual, and tailor their services accordingly. They need to have a mix of services available, and at the point of assessment it needs to be planned out and managed accordingly. I think the key would be in using almost a general practice or primary care approach when dealing with these matters. When people first turn up, whoever is assessing their needs must be aware of the multiple dimensions that will affect their management of that person's condition, and have at his disposal a mix of services he can organise and deliver.

- General Practitioner

Differences within Cultures

Several practitioners commented that it is impossible to generalise about 'ethnic responses' to 'mental illness' as there are a number of subcultures within each cultural group. Some cultural subgroups may be more inclined to maintain their traditional beliefs, and may prefer traditional forms of medicine for their health problems. This psychologist indicated that the use of traditional and/or Western medicine within his client group was not always related to educational background or social status.

It differs, depending on the subculture. We can't generalise. The Chinese are all different, depending on their subculture. Some will go the extreme that they don't accept the diagnosis of mental disorder at all and they turn to more traditional practices, a spiritual cure in the Chinese way. It is not quite related to their education or their social class, but more a sort of cultural behaviour. Some Chinese people are more into Chinese culture, some well educated people behave in a superstitious way...As I said, it is hard to generalise
- Psychologist

Chinese, yeah. They take a very philosophical, karmic approach to it. It's something that they have done maybe in the past and so therefore they have to endure it. And they...their endurance is a way of dealing with it and generally it is quite effective. Cambodians are very similar. Burmese are very similar once again. Bosnians and Serbs - there's a huge difference in them. How they perceive what the problem is, and their methods of dealing with it. Serbs tend to be a lot more macho, machismo. They puff out their chests and try and push on. Bosnians on the whole tend to withdraw and try and get more support within family or within the community. Afghanis tend to...like the Middle East is a completely different one again. They tend to...just to push it down. A lot of them use religious thoughts to deal with it. Religion comes into it quite a lot as a way of trying to explain and trying to deal with it, I find. Whereas in Western culture they wouldn't use that concept as a foundation to try and understand what's going on with them.
- T&T Counsellor

Some practitioners pointed out that different concepts related to health in general, and mental health in particular, are not only specific to certain cultures but also vary within cultures.

There are some conditions which have more a biological basis. Let's say someone has suffered a stroke, for example. Even in this situation I find that the perceptions people have of the situation, their conceptualisation of it varies, whether or not they are from a CALD community. Theoretical models people have to explain what has happened to them vary, but it especially becomes an issue in psychiatry because you can't see the problem in the way you'd see a broken leg. You can 'see' but you can't visualise so easily and it becomes an issue, a problem. Attempts to fit diagnostic categories, I find, sometimes just don't work, for a variety of reasons. It is the issue about hot and cold with the South East Asian groups for example, very different ways of looking at things. It goes right through the range to torture and trauma, which interestingly we don't see too many of.
- Psychiatrist

Alternative Explanations

In some cultures, people do not talk about 'mental illness', and everyday explanations of unusual behaviour may involve 'evil spirits', rather than psychiatric constructs.

In some cultures mental health issues are not discussed. Other explanations are given - superstitious beliefs, the 'evil eye', or religious ideas and descriptions.

- Social Worker

It depends on their reaction and their understanding. We have to be flexible, but an understanding of the cultural background would be helpful. We realise that some Chinese people will react this way - it is not a mental disorder for them. It is related to possession by the devil, it is a spiritual problem... That is a typical, traditional reaction.

- Psychologist

This nurse described a patient treated with 'traditional methods'.

This person, who had been here for 30 years, had a niece who was mentally unwell. He wanted to go and see a special man in Thailand to exorcise the girl. And in fact they did go and do this, and then they came back.

- Mental health nurse

A number of practitioners described their encounters with various culturally bound explanations of emotional experiences, and of mental health and illness.

You mentioned that some people will always agree with you. Do you find that people from different cultures have different perceptions of mental health?

Definitely. I spoke to a young woman from Ethiopia about this (and she is educated, mind you, a bright young woman) and she said that it is from the Devil. It is seen as people having done something wrong. They talk about exorcism, and really see the problem as something from beyond. They don't see it as an internal thing at all, but a manifestation of some wickedness in the family, maybe from generations ago. And, of course, it is going to be looked upon unfavourably.

- T&T Counsellor

Well actually I was just sharing some stuff I heard with E (name of psychologist) last week on differing ways of grieving in different religious frameworks and that was really interesting. I mean, I guess we'd all sort of know about it, but we hadn't actually articulated it or thought about it. It started with what you were talking about - the different ways Asians perceive things. I found it very interesting and the detail I would hesitate to put on tape just without going back and thinking about it clearly, but just the whole loss and grief process is really different. The way you have funerals and how often...you know, how long you honour...It's just so different. And I suppose the whole 'loss' framework is something that is really relevant.

- T&T Counsellor

Culture, Caring and Families

Culture also exerts an influence on family relationships, and it is common amongst migrant families for carers to be drawn from within the immediate family. Parents may feel a special responsibility for children with mental health problems, an obligation to care for them, and frustration and fear about the future of their child once they are no longer able to look after them.

I have several people, from both Croatian and Italian backgrounds, whose children have schizophrenia. And only when I broach the question about gut fear...they're absolutely petrified of what will happen to their children. The children are also petrified. Okay, one is sixty five. How long will she be able...you know. Or maybe she will live to a hundred and sixty five, but we know that life is not like this.

- Psychiatrist

The following counsellor also gave an account of care as a 'natural part of family life'.

An illustration that we've had is a client of mine was given a Carer's Pension for looking after her elderly mother. And she walked out of Centrelink howling with laughter just saying, "They're going to pay me to look after my mum?" She just thought it was hilarious. "Why would they do that? What else would I do?" So this whole notion of being a carer...I mean it's just a natural part of family life. For some people it is.

- T&T Counsellor

This psychologist simultaneously acknowledged the importance of 'mental status' in the Chinese community and the high level of stigma attached to 'mental illness'. He explained that people often depend on their 'family networks':

I think one thing that really stands out about Chinese patients is that they need me to tell them that they are not going mad.

They need that reassurance?

To see a psychologist is like going mad. Usually they depend on their family network to help them resolve their problems. One's mental status, in Chinese culture, is very important.

- Psychologist

Describing Distress

A psychologist explained that his patients prefer to describe their symptoms with physical terminology, and that they also prefer that any diagnosis is explained using these terms. However, once some agreement about the nature of the illness is reached, these patients usually accept medication and medical advice, as health professionals are highly regarded and respected.

Have you encountered any difficulties that are specific to working with people of a different culture other than the main Australian culture?

My Chinese patients seem to have a different understanding of what mental disorder is and also a different acceptance of psychiatric treatment as such. They tend not to accept the diagnosis of a mental disorder, preferring a physical diagnosis. So it is quite often difficult to convince Chinese patients that they need to take medication for their mental disorder, but once you have explained it to them, they will quite often take the medication. Chinese people - they will do what the doctor tells them to do.

- Psychologist

Cultural Proximity

Having the same cultural background, or at least an ability to communicate in the same language, can improve the understanding between clients and mental health professionals.

Does being Chinese help when you see a Chinese client?

Yes, I think it is help for them. They feel more comfortable; they feel that I can understand what they are talking about.

- Psychologist

Sometimes people will have confidence in me because although I happen to be from a different country, at least I speak their language.

- Mental health nurse

Cultural proximity, or the ability to use and understand the same concepts and terms in explaining problems, was considered a vital component for establishing a relationship of trust between the mental health practitioner, patient and carer. The following mental health practitioners stress the positive effects of a close cultural proximity between patient and practitioner.

They handle emotional isolation badly, they don't want to be alone. They want someone who can understand them or who has a certain match with their beliefs and emotional, cultural factors.

Psychiatrist

You see, if you have somebody you can trust, and who can understand and speak your language, not necessarily the language of your culture but, you know, use the same concepts and terms - that would matter.

- Psychiatrist

Ethno-Specific Professionals

However, some interviewees believed that it was unrealistic to expect all cultural groups to be able to yield sufficient numbers of mental health practitioners to cater for CALD clients from similar ethnic backgrounds. This lack in ethno-specific human resources reinforces the need to increase cultural sensitivity and competency amongst all mental health service providers.

If the system can't accommodate cultural diversity in our society, we simply have to be more sensitive to the cultural differences.

- Psychologist

Culturally Competent Mainstream Services

The following mental health nurse, who specialises in cross-cultural mental health, asserted that mental health service provision for CALD communities needs to be completely incorporated within mainstream mental health services. He argued further that there is no need for ethno-specific workers in mental health provision.

Do you mean ethno specific workers, or bicultural and bilingual workers?

No, we can't have ethno specific workers because that would be creating problems. No, not ethno specific - multicultural workers are what we need.

What about specialist services?

Services without any focus of specialisation, working for everyone in that sense, diluted into the mainstream. You see, I consider even the English speaking person to be part of the multicultural community. When we say 'multicultural' why do we have to exclude the English speaking people? We are all in the same boat.

- Mental health nurse

Opinions were divided on the issue as to whether having a similar ethnic background to one's clients is necessary for successful communication and cultural understanding.

I don't necessarily think that you have to be from the same culture to be culturally sensitive.

- Psychiatrist

It's not that we decline ethnospecific workers, it's that we are looking for people who can work across a number of cultures and there's even some advantage in offering people a counsellor or worker who is manifestly not of their culture. We have probably more clients who say what they don't want, than who say what they do. We have Afghans who only want Iranian interpreters, we have Arabic speakers from, say Iraq, who wouldn't want an Iraqi interpreter, and presumably not an Iraqi case worker because they want somebody who speaks their language but is not part of that group. They don't trust each other, and with good reason, given their experiences and so forth. So, the advantage of having, say, an interpreter who is not actually a member of the group as we did recently - I mean, we had a Hungarian-born interpreter who is accepted by Serbs, Croatians and Bosnians because she is none of those things, but she speaks the language fluently. And the same can be true with workers. So I wouldn't want to say that's our main reason for doing it, but it's actually an advantage rather than a disadvantage.

- T&T Counsellor

Barriers

Language barriers have been identified as a major source of problems related to the treatment of CALD people diagnosed with a mental illness, and as primary barrier to utilising support services. For a complete discussion of the role of language barriers, please see the section on language and communication issues (p 120).

Social Isolation

This clinician commented that migrants generally do not have well-developed social support networks, and that this may become more pronounced when there is a 'mental illness in the family'. Social isolation may increase as the result of difficulties in acculturation, broken social networks, and the stigma attached to mental illness.

As a rule they don't have a supportive network. Even if they did, they would try to minimise their contacts because of the stigma which we were talking about earlier. Because of embarrassment they withdraw.

The other thing is, interestingly, in the organisation of life, which many people from European and Asian cultures find so different here. Namely - because life is organised in this way, there isn't a mixing up, a spontaneous mixing up with people. Like, walking in the street. You're there, in the market. You're in touch with people. Be that from Italy, be that from Thailand...

- Psychiatrist

The following torture and trauma counsellor supports this view.

Tremendous pressure in the family because a lot of different cultures are very family, extended family oriented, and to see that they can't even support each other in the difficulties that they're going through, and having to get someone else in, is a failure of themselves. They take it very personally, as if they are not coping and they should be responsible for, you know, the elderly parents or whoever, or the extended family. So, I think a lot of the problem would be, why they're not accessing services is because culturally it's not...they don't see it as...it's a failure on their part personally. And as a family if they do. So they're caught in a Catch-22. There's a tremendous amount of pressure, and many clients I work with would gladly accept some sort of help, or they might feel compelled to bring elderly parents over, knowing at the same time when they do that it's going to be incredibly difficult for them. But at the same time there's that guilt or whatever. The internal dilemma, to do that. So they do it knowing that it's going to...keeping up the cultural expectations about what they should do, and the family expectations. But as far as themselves and their families, it can put a huge amount of pressure on their lives.

- T&T Counsellor

An Unfamiliar Health System

This GP emphasised communication difficulties and a lack of information about the Australian health system as the two main barriers faced by people from non-English backgrounds. Further, he argued that primary care in mental health requires a greater emphasis and more resources, of the kind currently allocated primarily to tertiary care.

I think what frustrates them most is communication. That really is a problem for non-English speakers. They give up before they start. Also, they don't have enough knowledge to find their way through a system that needs improvement - they might be unhappy with a situation in the mental health services, but they don't know how to change it. It's different for the second generation, of course. They also tend to get lumped together, which is a bad thing. My main gripe, though, is the concentration on tertiary care to the neglect of primary care in this area.

- General Practitioner

Limited Support Options

The practitioners agreed that there is currently insufficient support available for people from non-English speaking backgrounds. This lack, in addition to the limited social and family support networks of CALD carers and their charges may result in further isolation. The lack of extended family support for migrants was identified as a problem by a number of practitioners as well as by carers and community members. As caring for the mentally ill tends to be treated as a family responsibility, this lack of wider family support may place considerable stress on both carers and 'mentally ill' family members.

There is not much available here. They seek support but the trouble is they don't get much. There is social support and there are social resources. However, these are quite limited. Unless they have their family or relatives in Perth, loneliness is quite likely. Many of them have few, if any, relatives here. Some are here by themselves, having come from mainland China or Malaysia and they don't have many friends. They feel lonely and there are not many resources available where they can meet people and talk to them in their own language.

- General Practitioner

The regionalisation of available services may also be a problem, as this often results in a situation where people are not getting the assistance they might prefer if given the option.

Judging by the way in which the system works, regionalisation and so on might cause some problems with looking after people in the appropriate way. You know what I mean - one patient lives here and they want to see someone in one area but he or she cannot do it because they are in the wrong area.

- Mental health nurse

Treatment

One GP stated that a number of his patients with mental health problems were not willing or able to accept a diagnosis of 'mental illness', and that this 'inevitably affected their treatment'. His patients tend to present with physical complaints and after a period of time, once trust has been established, may be willing to discuss mental health problems. Where possible, he refrains from referring his patients on to other mental health services.

How do people's views of mental illness affect the benefits they get from treatment?

Well it depends. Some people are reluctant to accept a diagnosis of mental illness or they see it in a different way. We try to manage most things here, unless it is really serious. So the main thing is that they know me and I know them so I work with what I have got in terms of how they see it. They often come with physical problems, for example, and only after a few visits do we find out what is really wrong. Usually they find it difficult to accept they have a mental health problem.

- General Practitioner

When mental illness is diagnosed, patients and carers often react with disbelief.

So what are their reactions when you tell them that the patient has a mental disorder?

They deny it.

That's the patient, with the carer...?

They do have difficulty.

- Psychologist

Medication

The following mental health practitioner asserted that most of his patients would accept a medical professional's recommendation related to medication, once their diagnosis had been accepted. This is due to the fact that medical professionals are seen as authority figures, thus their decisions are not questioned. He argues that such attitudes appear to be changing, but are still present amongst the Chinese population, regardless of the cultural differences between various subcultures.

So when you get the point across that they need to take their medication, most Chinese would diligently take it?

Yes, of course. Some patients, no matter what you do, won't take their medication. Chinese people as a whole do what an authority figure tells them to do. They view doctors as a sort of authority, even in Hong Kong. Things are changing, but in the old days the patients didn't ask many questions. They just did what the doctor told them

to do. It is the same here - Chinese people don't ask too many questions. Local people do, they ask a lot of questions. They think it is their right. Chinese people just see doctors as the authority.

So does it make it hard to actually generalise across the board ?

It is hard, if you understand the cultural background. It depends more on where the patient comes from too, a rural background or urban. I see several patterns; one is the rural or urban background, and another is related to education. Less educated people are more in favour of authority, more traditional I should say. More educated people don't follow what an authority figure tells them to do. They are more individual, they do what they want.

- Psychologist

Several psychiatrists reported that their CALD patients appear more inclined to 'select' medication as a treatment option than are Anglo-Australian 'consumers'.

What about medication? Do you think that people from non-English speaking backgrounds would less readily accept medication?

No.

Do you think that's across the board?

Across the board is my experience. But I would say nowadays many young people who grow up in Western cultures with a Western understanding - Australian, American, European. They're probably more reluctant to take medication than some of the so-called 'ethnic' people. I think it is more age-wise, age differences.

- Psychiatrist

Side Effects

This was identified as an age issue, as well as an issue of informed preference. However, it was also argued that occasionally, this could be related to CALD patients having misunderstood information about the negative side effects of specific medications.

Young people are more reluctant to take tablets actually, to take medication.

What do you attribute that to?

To many factors - wrongly understood propaganda, let's say, wrongly understood advertisements, for example. At one stage there were advertisements against Benzo-Diazapines - ten years ago, picturing a woman in a bottle struggling to get out. If you remember, they were on television. I used to hate them because all my patients, for the next two weeks, would come and ask me, "Am I on these tablets?" And they weren't. But it unsettled them. Somehow people, because of the complexity of their psychological problems, feel it's a sign of weakness if they have to take, let's say, an antidepressant.

- Psychiatrist

It should be noted that there is very little publicly available information on the negative side effects of psycho-active medications (Breggin, 1991). This may be a particular problem for people from CALD backgrounds, who may encounter difficulties in obtaining this information in languages other than English.

Another practitioner pointed out that certain CALD community members find medication to be more appropriate than other available treatment options. It was noted in the focus groups that, in some Asian cultures, counselling, for example, is not the most culturally appropriate or acceptable treatment.

They just don't believe in this sort of curing. Probably they have more faith in medication. But, many of these medications have side effects, which are very uncomfortable. And when we refer them to psychiatrists it is another problem and they return to us again. Our people are very different from Australian people in this way. They really don't need help from psychologists and psychiatrists if they have enough support from family and community. They could cope with their depression, and anxieties just with support from the community and from friends.

- Psychologist

The Need for Flexible Services

Health practitioners recognise that ethnic groups are not homogenous and that preferred methods of care are not entirely dependent on ethnic and cultural identification. Problems may arise in mental health services should people from the same ethnic background be treated as a homogeneous group. For the first generation of migrants, language is the main barrier to the utilisation of services, but with the process of acculturation, and for subsequent generations, health care issues may become less of a problem. A suggestion repeatedly made was that mental health services need to be flexible and adaptable:

I think it depends on the client. These days you can't classify an ethnic group as homogeneous. I think there are different levels...certainly language is a barrier for recently arrived migrants. Matching up is probably important but for second generation and those who have lived here for a while the mainstream services are often more appropriate than ethno specific ones. I guess that the challenge for the mental health services is how they can be adaptable and flexible in catering for the varying needs of these groups.

- General Practitioner

Another mental health practitioner, whose clients are predominantly ethnic Chinese, supports this view.

There is the issue of communication. There are Chinese associations here, but they can't provide a lot of service, given their limited resources. It would be better if services in general were more responsive, both culturally and linguistically.

- Psychologist

This GP argued that decisions on policy need to encourage flexibility and adaptability in the health system, and should not necessarily be focused on ethno specific services, which may not be able to address all the needs of particular communities. Mainstream health providers need to be able to adapt to changes in the population level, and not rely on under-resourced and often understaffed ethno specific services to meet the needs of 'ethnic communities'.

I get annoyed when people say, "Well, you are from the Italian group. You should go to this service because you are Italian." I think it is more complex than that and I think policy makers are falling into a trap. These days, in a needs focussed system, you have to be very flexible and adaptable. Often, the services available are not appropriate for them [people from CALD communities].

- General Practitioner

This was supported by a number of other interviewees.

Generally I think there are services out there, but it is just a question of making them appropriate for this specific client group.

- T&T Counsellor

However, the following practitioner, who provides cross-cultural mental health services, asserted that there are accessible and appropriate services available, and that it is a matter of personal choice for carers, once they are informed about services, as to whether they utilise them.

They are used to some extent. I mean the help is there, in a way, but whether these people are using it is a different matter. Because really they do it themselves within the family. Sometimes they deal very well with the situation within the family. We can provide them with information and say these services are there for them if they want to use them. What else can we do? If they feel they do not want them, then fine.

- Mental health nurse

Talking About Migration

A number of interviewees emphasised the importance of acknowledging peoples' experiences and working with the positive aspects of these. He argued further that it is important to give migrants the opportunity to talk to health practitioners about the circumstances that prompted them to migrate to Australia.

Part of the therapeutic process is about how people can kind of...put what's happened to them in some kind of larger framework. So I'm sort of working with people and trying to move forward, because people can't do this alone and you can't just give it to them. I mean it's actually an evolutionary process....Of trying to move forward. I mean one of the things I've suggested to one or two people is that, as awful as the experience is, by coming to Australia they can actually help make Australians more aware of the importance of a good society, a society that works properly. Sometimes people who have seen things done badly, can actually help keep this society working better.

- General Practitioner

Some practitioners reported that giving 'patients from other cultures' the opportunity to 'express themselves' often led to positive outcomes.

"Tell me a bit more about what happened and what was it like?" And do they understand that these awful things actually leave an imprint on the body? And that that imprint is manifested as symptoms, but it's not a disease. It's actually the things that are wrong coming out of their system. And they sort of seem to understand that.

- General Practitioner

Cross-Cultural Awareness

The following psychiatrist finds it useful to contact ethno-specific organisations or religious institutions in order to secure assistance in cultural matters, and when seeking additional information about culturally bound perceptions of mental illness. He reported that communication difficulties may influence treatment. The lack of English language skills amongst migrant service users is not an insurmountable barrier to effective communication.

We certainly take into account culture as a factor. Not only that - many of these people have a poor knowledge of English. So we organise a little English course for them and help them master basic English language skills. So that would be one thing. Once you can develop more appropriate verbal communication it's certainly easier to help them. Another example would be we approach various Churches, or the Vietnamese Cultural Centre, say. So if we had a client, and we couldn't understand his problems, we would approach these people and ask for help. -

- Psychiatrist

A number of interviewees acknowledged the importance of their training in cross-cultural awareness, which had assisted them to comprehend the complexity of the experiences of their clients.

Basically from our training and experience we try to look beyond the medication, to the social aspects, settlement, immigration. We try not to use the medical model and instead use the language that people use themselves.

- Psychologist

This is how one counsellor approaches the issue when she works with newly emerging communities, and has insufficient information about these cultures.

You mentioned the Ethiopian woman. How do you respond when someone comes with a different view of mental illness?

You have to be respectful of their views. It is difficult sometimes, but in terms of responding to different cultural views...Sometimes I would get, perhaps, a Burmese man coming in and I would be worrying, thinking about my own ignorance -"I don't know anything about Burmese culture or the situation in Burma". I would look in the library and sometimes I could not find anything. In the end I thought, "No, I am going to admit that I don't know anything". I have found it to be an absolutely marvellous tool to empower the person. It makes them feel they are giving me something and I am giving them something back, and it is a nice transaction. That is basically how I work with the cultural differences and I have learnt a lot through that, rather than plodding on pretending I know. I learn more by being honest and telling them that I don't!

- T&T Counsellor

Longer Consultation Times

The need for mental health practitioners to allocate more time for their CALD patients was discussed as a strategy to increase mutual understanding.

It is the style, the way you talk. You have got to be *more* with them - with every client actually. So you look at every client as a unique individual and you don't transpose your own values and culture on them. I treat everyone as unique, each coming from a particular culture, with a unique value system.

- General Practitioner

Awareness of Support Services for Carers.

When discussing carers' awareness of support services, a number of issues were raised. These include the obvious difficulties related to language barriers and social isolation, which were reported to exacerbate the difficulties of caring for someone with a mental health problem. A "general lack of energy" on the part of carers, and the issues of shame and stigma were also raised. There was a general concern that the prioritising of spending in health care generally, due to inadequate resources overall, has resulted in the inability of services to adequately meet the needs of people with mental health problems and their carers.

The usual feedback is that, just in terms of the basics, there is insufficient support, information and accommodation available in the community, so carers are worrying about that. It is a resource issue. What people are seeking is not related to what is available and what they know about. It is difficult. There are some conflicts, generally we are concerned that we might not be able to respond properly to what they need. We have to prioritise and it can be difficult.

- Psychiatrist

Care in Social Context

A number of interviewees asserted that mental health is not solely the responsibility of health and mental health service providers. The following practitioner argued that the care of the 'mentally ill' needs to be placed in a much broader social context. He stated that many services are not culturally sensitive towards the diverse needs of their clients, and this may cause people considerable distress. He further reported that a lack of social support is a problem for people diagnosed with a 'mental illness' across all cultural groups. Further, support services are seldom well publicised. Even when people are referred to these services, they may not be offered adequate care.

The same problem applies across all cultural groups - be that the indigenous groups here, the Australian background groups, or the migrant groups. There isn't very much support available, or there isn't support that is well publicised, you know? Even when people want to know about it, they can't find out about it. Some recent cases immediately come to mind. You give them addresses. They go there, they're fobbed off here, fobbed off there. Some of this carer support should be more through organisations which are competent and knowledgeable about the system.

- Psychiatrist

Access and Equity

Some identified issues of access and equity as problems for most cultural groups, including the mainstream Australian population. These problems are concentrated around the lack of support and the lack of information about existing support. Information is not readily available and people in need of support are often 'pushed' from one service to another, without anyone 'taking responsibility'. Some suggested that the support system should be more holistic, and that it should address practical aspects of everyday existence, as well as 'mental health issues'. A number of practitioners pointed out that familiar situations that appear 'straightforward' to people who belong to a particular culture may be experienced as complex and stressful by persons who are new to that culture. If this stress is prolonged and

language and cultural barriers remain for extended periods of time, 'mental health may be at risk'.

But sometimes coping goes beyond seeing the doctor, because I *am* a doctor and...my role is particularly defined. Often people need support on other levels...Social support.

Are you aware of any support services that carers might be accessing?

As I told you before, I know that you are interviewing me within a particular cultural context. I have to tell you that that is...The same problem applies across all cultural groups - be that the indigenous groups here, the Australian background groups, or the migrant groups. There isn't very much support available, or there isn't the support that is well publicised. Even when people want to know about it, they can't find it. Immediately there comes to mind several cases recently. You know, I'll give them some addresses. They go there, they're fobbed off here, fobbed off there...Some of this carer support should be more through organisations which are competent and knowledgeable about the system. The system - not only the medical, but the mental health system. The whole support system, ranging from social security through to electricity bills, especially for people from non-English speaking backgrounds. You'd be surprised, you'd be surprised to hear what 'problems', inverted comas, sometimes present themselves as enormously stressogenic - generating stress - to people. Let's say, a cheque has to be written and to be sent, because they have never had any experience with cheques before.

...We've had several organisations springing up and then...yes ARAFMI carers is one organisation but I want to know how many people from non-English speaking backgrounds they have on their books. - Psychiatrist

Carers do not Know About Support Services

There was a general consensus amongst the practitioners that CALD carers are not informed about support services.

They are not aware at all. They don't know about support. Recently [name of the person from support organisation] came to introduce herself and to tell me what she is doing...And not one of the people I know caring for mentally ill people has ever heard of this [name of organisation]. And if they had they wouldn't understand what the organisation is doing. There is nothing in the language, there's nothing.

- Psychologist

It was emphasised by a number of interviewees that carers do not access services because of this lack of information, and because caring for family members is often regarded as a family responsibility.

I think that...certainly within the ethnic groups that I mix with, you keep your problems in house, rather than looking for help outside. And it's quite scary, and when you think there are a lot of people who are immigrating and who aren't aware of the services. They possibly don't have the services in their own country, but they are available here, and they aren't aware. It's a shame.

- Pharmacists

A lot of them aren't aware of what services exist. A lot of them, the ones that do know that the services exist, still feel it is a family responsibility and that it is not proper or right to seek help outside the home. If they needed some support in terms of talking to someone then they may, but in terms of practical assistance such as respite care, or any kind of break for themselves, then it might be seen as a bit of a luxury. It's almost like, in seeking assistance, they are foregoing their duty. Also they don't see

themselves as carers, these people, it is just an extension of their role as a mother or as a wife or a sister. Notice I am using all the feminine? Usually it is the women in these communities who are carers.

- T&T Counsellor

Peer Support

Practitioners described the importance of the informal peer support that newly arrived migrants may provide for one another. This tends to occur because new arrivals often settle in the same low socio-economic areas. In the absence of extended family, without their own transport and with inadequate public transport and other necessary infrastructure, people tend to depend on each other.

They've got links with one another, because I think there's a reasonable number of them in the Lockridge area. So, they have links with one another. Some of them have trouble with transport, getting to me. I saw a woman who was brought in by a friend who is a single mum, whose husband, I think, was killed in the war. The girlfriend is not a 'carer', but she's certainly a support person.

- General Practitioner

This GP also reported that people from CALD communities prefer to depend on themselves and on the support of family and friends, when available. Otherwise they may 'struggle on their own'. He suggests the following explanation, which again emphasises the need for education for carers:

People need to recognise what they need before they can go out and get it. So they have to have a lot of knowledge and awareness that they usually don't have. There is a need for a lot more education really. What happens is that they just opt out struggle on their own. They often resort to their own community support or nothing. So if they do not have family support, if they are here on their own, they are in trouble. There is a strong sense of obligation in caring for people. The services that are there are often not appropriate for them.

- General Practitioner

Migrant Resource Centres

A number of migrants with mental health problems are supported through migrant resource centres, and through religious institutions. Practitioners remarked that people tend to seek assistance from others "who won't judge but will help and give confidence".

People mostly turn to the Migrant Resource Centre in Fremantle, North Perth, Mirrabooka. Places like that. This is where they get lots of support. They also get support in clinics, but if they need an interpreter service...It depends how much interpreters are used in clinics. That's the whole question.

- Social worker

A number of practitioners asserted that new migrants receive 'superior support' to more established migrants, including support in the area of mental health, from migrant resource centres where they can access ethnospecific workers. Seeking support from other services often results in communication difficulties, as it is not always possible to access appropriate interpreting services.

A number of mental health practitioners have been approached by ethnospecific service providers to assist them in information provision related to mental health for their client groups.

Basically there is a good will to help these people. I was asked by the [name of the ethnospecific service provider] to give an information sessions for clients. They are recognising problems with the younger migrants.

- Psychiatrist

It was also suggested that services for torture and trauma are accessed more frequently than are other mental health services. The reasons, as suggested by one GP, are as follows:

Part of the reason that people access services better who have been exposed to say torture and so on, is that they tend to be younger...they tend to be better educated. Recent immigrants who are a bit more sophisticated in their awareness of these issues and the resources and available. Therefore they are more aware of seeking assistance and more aware of what resources are available or should be available.

- General Practitioner

Stigma and Social Networks

Practitioners recognised that stigma attached to 'mental illness' contributes to the under utilisation of existing services by CALD communities.

As a rule you wouldn't have a supportive network as a migrant. Even if you did, you would try to minimise your contacts really because of the stigma. Because of the embarrassment. Withdraw.

- Psychiatrist

This was supported by a number of other interviewees.

It's something that's seen to be a bit of a stigma. People try to down play or to hide it. Therefore they often don't pursue the support or assistance as vigorously as they should, because they...they try to carry on as if it's just a normal variant.

- General Practitioner

The following GP suggests that a lack of understanding about 'mental illness', an unwillingness to accept a diagnosis of 'mental illness', language barriers, and a lack of understanding as to how the health system functions, prevents CALD people from obtaining appropriate mental health care.

I find that there is a lack of understanding of mental illness... what it's all about. Often it's ignored or explained by other reasons and not looked upon as an organic brain problem, and often it is denied altogether by the family. So that's one problem, which is lack of appreciation of what the disease process involves. The problem is the language one. Not being able to access services and understand what's going on because they have difficulty understanding service providers or understanding information sources...There's a difficulty in understanding their GP or not being able to communicate with their GP and so on...

- General Practitioner

Lack of Follow Up

Some of the interviewees admitted that they were not well informed about support services themselves, and did not know whether their clients were accessing these services.

I'm not broadly aware of the services that they're accessing....I don't, it's probably been a slip on my part, not actually asking those questions.

- General Practitioner

Of those practitioners who were informed about support services, most provided relevant information, but rarely followed up on whether their clients' carers were accessing support services. Although some mental health practitioners were aware of support organisations, they expressed the concern that these services are not used by people from culturally and linguistically diverse backgrounds. Lack of information and language difficulties were described as the main barriers. Carers need more information about support services.

I think the whole problem for carers could be - where are the services? So, knowledge of services...Language problems perhaps too. I don't know how much carers are accessing those services. And in my experience, the people I see...I haven't been all that convinced that they're accessing any carer support services. Probably a number of different strategies are required for different people, but....I think sometimes issues of education are very important.

- Psychiatrist

We put them in touch with various voluntary organisations for mentally ill people and their carers, I don't know if they use them really.

- Psychiatrist

We've had several organisations springing up and then...yes [name of organisation] is one organisation, but I want to know how many people from non-English speaking backgrounds they have on their books.

- Psychiatrist

The following GP was 'well informed' about available support services in his area for clients from various cultural groups. However, he did not have any information as to whether these services were being utilised.

In this area, as you are probably aware, for the Croatians there is Villa Dalmacija, which is a nursing home specifically catering for people of Southern European origin, but particularly for those of Croatian, Dalmatian backgrounds. It acts as a source of information for people and a source of support in that...apart from providing care for people who require nursing home care, they also have a Day Centre. Now, that place is a resource which is under utilised.. I think three days a week they take these people in for Day Centre activities, lunches and so on, giving carers respite. It also acts as a focal area where people can exchange information and get information back from other carers and from the staff as to how to manage their relatives or whoever they are looking after. That's the Croatian side of things. The Italians have the Italian Village down in White Gum Valley, which is a hostel, which again is a combination...but acts as a focus or a source of information for families or the carer. The Migrant Resource Centre in Fremantle does provide some assistance.

I make them aware of the presence of these services, and they sometimes access it themselves and sometimes not. It depends.

- General Practitioner

Linking Carers

One practitioner asserted that in order for peoples' experiences to be validated, they need to meet with others who have had similar experiences. He suggested that it would be useful to provide opportunities for carers to meet, share experiences, and support one another.

In a sense they need people who can just listen...Genuinely listen....So that their experience of providing support can be validated....I don't know whether [name of organisation] and [name of organisation] have a useful place and whether there's something along that sort of line that might be able to be set up for....the various ethnic groups and the kinds of things that they've been through.

- General Practitioner

Religious Institutions

A number of interviewees noted that people from CALD backgrounds - particularly the older generation of migrants - turn to religious institutions for spiritual and emotional support when faced with difficulties in their lives.

The older generation turns there and they carry their denominations quite proudly. I have no problem with any church really. We share the main moral concepts. The Church is where they go to recover. I get referrals from the church. The priests... they have a ritual way, a theological way of handling these things, but when the behaviour becomes too much to handle, too dysfunctional, then they say "See the doctor."

- Psychiatrist

This GP reported that many of his patients had sought and obtained help through their religious practice.

A lot of our Christian patients use the Church a lot and pray for healing. Some of them are very fervent about their religious practices. Sometimes other religions, too, will get spiritual guidance go back to their countries to seek a cure. I think that is interesting in terms of mental illness and how they see it.

General Practitioner

I think, from my perspective I'm quite reluctant to attribute sort of comprehension and mourning and healing processes to different groups...A lot of what I find is that clients have to question humanity and...So there are certainly cultural and religious aspects to how you reintegrate and understand what on earth has happened. It's such massive life questions that are raised that...Yeah, religion does seem to come into it a lot. And then of course there's different notions of religion within religions in this cultural aspect.

- T&T Counsellor

Religious institutions may be an important source of support:

Do you find that people from CALD communities are getting support from other sources such as the ones you have mentioned?

I think they do. I have families that go to their church meetings every Sunday and get a lot of encouragement. And they get a lot of hope for the future, that things are going to be better. That is so important, as well, for people to continue...if they do not have that hope then they just crumple up I suppose.

- Mental health nurse

I think the Church has a pretty powerful role in these things, or it potentially has. So far I don't think that it's done very much. I think the Church could play a very positive role in this.

I think what's under used, and we've touched on this, is as I said, the clubs - very much so, and the Church to some extent.

- General Practitioner

Suggestions for Improved Support Services

A number of interviewees acknowledged that there are no easy solutions for the improvement of the quality of mental health care, and social support for CALD communities, and no 'quick fixes' for access and equity issues.

I don't see easy solutions. We need more training for professionals but of the right sort. In my experience leaflets aren't much use, nor are short courses. How can you encapsulate someone's whole culture in three pages? "This is what you would expect from an Albanian." It is impossible!

- Psychiatrist

Some interviewees were concerned that, despite the volume of research identifying problematic areas in mental health provision for the diverse Australian population, very little has been done to address these identified needs or to encourage positive institutional change.

Research is good but I have a feeling about research. How is it going to change things and hasn't it been done before? We have been asking these sorts of questions for such a long time and we still haven't come up with the answers to improve things.

- Psychiatrist

Organisational Change

Some suggested that change needs to occur at an organisational level, within the health system, and that the diversity of the population and their health needs should be recognised on all levels of policy-making and service delivery. Furthermore access and equity policies need to be enacted.

There have to be transparent multi-cultural policies in organisations. There has to be signage - multicultural, multilingual signage, multicultural pamphlets, videos and cassettes. It needs to be visible, so that people will approach those community services.

I think that we need to ask Government – why is mental health information for non-English speaking communities the last on the resource list?

If people are citizens, they pay taxes, and they deserve all the information and help and support...Like, every Australian, who speaks English. They deserve this.

We are negligent. The whole Health Department, everybody around. And they have a professional duty/obligation to do it. And the funding to do it. It's needed.

- Social worker

Familiarise Migrants with the Australian Health System

Practitioners suggested that familiarising migrants from various backgrounds with the Australian health system would greatly reduce the stresses associated with dealing with an unfamiliar mental health system.

If somebody comes from a different culture, had a different language and maybe had different expectations, most of this is unknown. There is fear.

Information on the radio, newspaper, bulletins boards. And we could meet and talk about issues on a weekly basis. Let people bring others from the community or their own family and then start to build that kind of support with information and education. I think this is the way to do it. - Social Worker

Ethnic Media

Opinions varied in relation to the value of ethnic media as an avenue for mental health promotion. Some felt this was not a particularly useful means of disseminating mental health related information. However, ethnic media was strongly advocated by other practitioners and in most focus groups, as a useful avenue for mental health promotion, and as a means to disseminate information for carers.

I don't think the radio, or newspapers and those kinds of things will provide a great improvement in the educational way. I don't think that really they are all that widely utilised by the people who are most at risk.

- General Practitioner

Maybe more topics on ethnic radio, more things in [ethnic] newspapers. And maybe some lecturers in the community. 'Let's talk about general mental health'... you know?

If you combine maybe physical and mental health and one evening talk about physical health, and the next evening about mental health - more people will listen. It would be like a follow-up. - Social Worker

Some suggested that the mainstream media should have a more pronounced role in providing information.

The media could really play a big part by using different languages. By having text written on the screen, maybe they could have it in Spanish one week, Italian the next, Croatian the next. - Mental health nurse

Information Sessions

The need for education, information and mental health promotion for carers was strongly advocated. Information sessions were suggested in the form of seminars and lectures to address mental health issues. Well-informed and supported carers were described as potentially important partners in the 'early identification of mental health

problems' and in timely intervention. They could also assist with community mental health promotion.

I think it would be useful to organise educational sessions for carers. I think that it would be useful if one could explain to them what a mental illness is. And the signs of mental illness. How to recognise that somebody in their family is at risk of committing suicide, or is disintegrating.

So that carers become partners in monitoring the mental state of our clients - their family members, I would go for a series of public seminars which would address symptoms and signs of mental illness, taking into account culture, migration and all that they experienced. And also promoting mental health generally.

- Psychiatrist

I think it comes back to what I said before, more education at the places where these people congregate. That means saying to them, in an informal way, "These could be the signs of a mental illness, the early signs and symptoms of something, such as schizophrenia".

- Mental health nurse

Ethnic Clubs and Organisations

Interviewees who had a number of clients from various CALD backgrounds suggested that ethnic clubs and other ethnic organisations should have a more pronounced role in addressing specific community needs. Activities could be organised to support people - including those caring for family members with mental health problems. Information and education could be incorporated into the programs of these organisations.

Any kind of education of these people would be of benefit. Unfortunately, the main sorts of activities these people participate in tend to be social ones, where they are inter-relating with other people, mainly socialising on a superficial level. I'm referring particularly to the various clubs that exist around the place. These clubs don't make any effort to educate or provide support for anything...for the physical or mental health related problems. They tend to be mainly oriented towards providing entertainment, supporting social and sporting activities.

They are grossly under used...mechanisms for providing information and services to these communities are under utilised. The clubs are such powerful influential bodies that are very well attended, very well patronised, and have great links in the community. I think very little has been done to utilise those organisations. The same applies to the Church.

Very little is done, or nothing is done, by the clubs in that regard. And I think that it would be the logical venue through which to do it.

- General Practitioner

Ethno-Specific Workers

A number of interviewees acknowledged the substantial contribution to mental health promotion made by ethno-specific workers from migrant resource centres, as they tend to be 'trusted' and to speak the same language as their clients. Migrant resource centres also provide a less stigmatising support service, as migrants turn to those organisations for general settlement support and not specifically for mental health related problems.

People are going to the same people where they go for general practical issues in Migrant Resource Centres....That's where they go for everything, and they will talk about those issues there. Because they know the workers, they have built up a trust, and they identify with those agencies closer than any other agencies.

- Social worker

However, others noted that migrant resource centres are not always accessible. Community-based professionals, from a range of ethnic backgrounds, may be best placed to provide education, information and support.

It would be nice to have people with expertise in these areas, such as welfare workers or social workers or something, of that ethnic background based in the various communities.

Occasionally they tend to be based in places where the community doesn't really have much access to them...For instance, as much as I have a high regard for the [name of the migrant resource centre] as an example, the average Croatian person living in say, Spearwood, would never go there. They would never think about going there.

- General Practitioner

Accessing Carers

Accessing carers in order to provide any sort of information about support services was considered to be a major difficulty. A number of suggestions were made:

We have got to get into their four walls, so the electronic media is a way to do it, especially Community Radio programs because it is in their own language. They listen to it, they look forward to it. It is the only time they hear their language, they hear the music they are used to, they hear the news from home, and they will listen. So that is the avenue we should utilise for information provision. It is getting into their homes in their own language.

Another suggestion I heard from a pharmacist recently was that if someone is coming in to pick up medication and the pharmacist knows, of course, what it is for. So they already know if it is schizophrenia or bipolar disorder or whatever, they could put a pamphlet into the package with the medication and let them take the information away with them. It is a practical suggestion, it doesn't need heaps of funding. You don't have to have 50,000 brochures on a counter in the hope that one person who needs it picks it up. You target them, and often the carers are the ones that pick up the medication.

- T&T Counsellor

Sensitivity in dealing with mental health related issues is a crucial component of the successful implementation of any strategy to encourage carers to utilise support.

My feeling would be that they would be keen to get any assistance they could, if it was done in a diplomatic and sensitive way.

- General Practitioner

Some practitioners suggested that more information should be provided in languages other than English, and that government and non government sectors should become more involved in mental health information provision.

We need to do more of this family support, through video cassettes in other languages as well as English, and audio cassettes in other languages as well as English about health in general and mental health. This is what's needed, promotion and involvement by the city councils, involvement of Migrant Resource Centres, involvement of the Health Department.

- Social worker

Bilingual Professionals

A number of practitioners argued that there is a need for more bilingual mental health professionals within the mental health system, and that this issue needs to be addressed through employment practices within the wider health system. Some interviewees strongly emphasised that bilingual mental health professionals who work with particular communities, and have adequate cultural knowledge, are highly valuable in the mental health care of CALD communities.

We need to train more doctors, more nurses, more social workers, psychologists from non-English speaking backgrounds. That's not done.

- Social worker

Identifying the interested people to work through is a way of getting access - through the link worker like [name of the person]. We do have Dr. [the name] for example, who has the language and works with a particular community. These individuals are important.

- Psychiatrist

Well the language thing is very important, that needs to be addressed. I think you need more training in the mainstream for professionals about cultural awareness and more professionals from different cultural backgrounds are needed, that helps too.

- General Practitioner

Language skills, on the part of practitioners, are crucial in providing culturally appropriate support. However, belonging to the same ethnic community as one's clients can sometimes present a barrier. Practitioners described a number of occasions where carers had been reluctant to interact with professionals from the same, close knit community. This was asserted to be due to confidentiality issues and stigma. It was suggested that carers might feel more comfortable sharing the care with someone who is professionally trained, with appropriate language and cultural knowledge, but who is not closely connected with their community.

It would be difficult to accept someone from their own community, if it's someone who they know reasonably well. If it's someone who speaks the language, but is not in that immediate community, I think they would accept them more so than someone who they are intimately interacting with in the community.

It would have to be someone who would take on a more distant, but professional approach. You know, they feel embarrassed in front of their friends and acquaintances more so than someone who's more distant and is seen to be a bit more divorced from their immediate social circle.

- General Practitioner

General Practitioners

The vital role general practitioners play in the care of people in distress and their carers was emphasised throughout many of the interviews - as it was in the focus groups and in the interviews with carers themselves. Some practitioners felt that this is often overlooked, and under-resourced. A number of tertiary mental health service providers described the importance of GPs in the treatment of people diagnosed with mental illness and the role they can play in providing information and referrals for carers.

Everyone concentrates on the tertiary [sector] and the specialist services in particular, it really gets me down. We see far more mental health problems here in general practice than they see, and without all those resources.

- General Practitioner

It's "okay" to see a GP. They don't just see people with mental illness, they see lots of different people. So I think that raising the awareness amongst GPs about mental health issues and services, would be useful.

- Psychiatrist

Other interviewees agreed that general practitioners have a vital role in mental health care but recognised there is a lack of culturally and linguistically appropriate information available in most general practices.

You know they have other priorities. Other things in their waiting rooms. If they had more of the relevant pamphlets, maybe while people were waiting they would read something...I know this would cost money, but how do you educate people? They could put a video on that people could watch while they are waiting or...they could read.

- Social worker

Family and Friends

It was suggested that migrants from CALD backgrounds generally prefer to rely on networks of family and friends, rather than on institutionalised support. With the support of family and friends, people may be better equipped to deal with mental health related difficulties in their families. In the absence of this support - as is the case with many migrants - they may have to 'look further afield' or cope alone.

Our people [from what was Yugoslavia] are very different from Australian people in this way. They really don't need the help of psychologists and psychiatrists if they have enough support from family and community. They could cope with their depression, anxieties and they could recover...just with support from the community, from friends.

- Psychologist

However, some practitioners reported that family dynamics are changing as the result of the varying rates of acculturation of the younger generation of migrants and their parents. This may affect people's attitudes towards family caring responsibilities.

I will tell you about a very disturbing phenomenon within the Asian Community - Vietnamese for example. Their children have adopted the Western way of living very, very fast. They attend high school, they speak English very well and they are articulate and enjoying the Western way of living to the fullest. If one of their parents had a mental illness they would discriminate against them and they would virtually ostracise them. I hear about it from the other carers - "Oh so and so, they reject their parent because he is loopy" or whatever. When this happens it is important that they see that I convey my respect for the parent - for their sense of humanity and dignity despite their mental illness. This is something denied to them by their own children, that is something which has really struck me. It is really interesting isn't it?

- Psychiatrist

Volunteers

Social isolation among carers was recognised as a problem by a number of interviewees. This further emphasises the need for external support. The following practitioners suggested that carers could be supported through a network of trained volunteers:

Very often I think about the mentally ill lonely and isolated people here. They come to services, they come to groups, and they have either psychotherapy or also psychiatric treatment. But they have absolutely nobody. It would be a good idea to have a host family scheme or volunteers with high personal ethics, to invite these people sometimes for two hours, somewhere, if not to their own place. For a picnic, or for a cup of coffee for two hours to break this isolation, to interrupt this isolation.

The volunteer needs to be prepared...how to deal with these kind of people with the illness.

- Psychologist

Because we're not looking out of the proper framework, but the idea that there is need of support from volunteers, for example, is something that we do discuss and recognise as very important. My best image is that every family would automatically have a volunteer to support them, to provide support. And so that may be a better model than the sort of mental carer type model.

It's about linking, linking families with...say Australian families. So to bridge that gap, because not only...Not only have people sort of been traumatised and been through terrible things, but they are now in this country and they find it very difficult to actually make contact with people that live in this country. So then they are feeling more isolated. They're here, they're isolated, they have more time to think about all the things that they've been through and they're bored. "How can I move forward? How can I make a life here? I can't even get to know people that live in my street..." So we're trying to do some, look at some ways that we can try and bridge that gap somehow and get the communication flowing both ways. Often matching their needs with an Australian family, an Australian family and...

Not so much focussed on the medical traumatic issues...

No it's more than that...

It's the cultural connection.

- T&T Counsellor

However, opinions about the use of volunteers to support carers:

The volunteer could seem to be intruding.

You know, there's an embarrassment about it...

We have a lot volunteers at [name of organisation] And they are prepared to work in a place like a nursing home, but they'd be very reluctant to go out into homes and so on.

- General Practitioner

I think it's actually about building up informal networks.

They need people who can just listen...Genuinely listen.

- General Practitioner

Respite

Respite was identified as a valuable form of support, particularly needed for carers from older age groups. However services need to be tailored according to individual needs.

A day off. Respite. Especially for elderly people.

The services are limited. It is difficult. You have to establish individual contact. We don't have this. We have to have somebody to go and pick them up, not leave them to their own devices. We don't have these services.

- Psychiatrist

I think in the first instance it would be better to get the carers out. I think there would be some resistance to getting the actual patients themselves into one of those facilities.

I think initially one should aim for the carers, and then once they became established in that particular club...if the club was used, then one could introduce the patients afterwards. I would start with the carers first of all.

- General Practitioner

The practitioners identified a number of barriers that could prevent CALD carers of people diagnosed with mental illness from accepting respite. Again, of these are related to expectations within some communities that caring should be a family responsibility.

It is really difficult. It's a cultural expectation to look after old parents and family members, and they believe this is best for them. Religiously, from a Christian perspective, "sometimes we need to suffer in life". So they find it very difficult to ask somebody to help. I think if they knew of services, if they were familiar with them, they would ask. So why not have half a day in a week or one day in a week free from caring?

- Social worker

Language Specific Support Groups

The usefulness of establishing a series of language specific support groups within existing support organisations was emphasised.

You know specific sections, a Polish section in ARAFMI, a Polish section ...or a Chinese section or a Croatian section, or any other ethnic group. And the presentation or workshops or discussion in their languages.

- Psychologist

Cross-cultural Training

The need for more comprehensive cross-cultural training in primary and tertiary health sectors was strongly advocated, as was the need for change in the organisational cultures of service providers.

I would say training and more training, various forms and not just in the tertiary sector, more work with GPs and out in the field, more education and training!

Really you need to change the whole environment, but it is easier to take short cuts. Training is needed about cultural bias, culture is complicated. There is a culture of nurses, for example, which is different from doctors. There is a culture, which comes from the establishment.

- Psychiatrist

It was suggested that cross-cultural training could serve to reduce the incidence of cultural stereotyping and racism in mainstream service providers.

The trouble is stereotyping, assumptions are made, sometimes it is just that about certain groups. I could bring up a lot, there is so much there, particularly against Aboriginal people. It is dealt with separately - there are the Aboriginal people's services. Even at conferences it is dealt with separately, yet there is so much to share about this topic. It is such a huge area and kept separate from multicultural work.

- Psychiatrist

Service Evaluation

A number of practitioners strongly advocated for provisions to be made to enable clients from CALD backgrounds to have some input into the evaluation of services.

We wanted an evaluation form in different languages for everyone using our services. The hospital has produced an evaluation leaflet...."This is what we do. What can we improve? What do you expect? What would you like to see done better?" If we weren't so overwhelmed with the clinical work we would do that. I can't do everything, so I concentrate on the priority that is the clinical work, but there is so much which can be improved.

- Mental health nurse

Straightforward Strategies

Even relatively straightforward strategies, such as having an accessible, and anonymous telephone 'counselling' or 'advice' service, could provide crucial assistance for isolated CALD carers, and may be an initial step towards building a support network of people in similar situations.

I think that what a lot of people need is just someone talk to. I have found in my own work that some people ring up regularly and they just need someone to talk to. Unfortunately we just don't have the time. It always feels like you are rushing things or whatever. I think it would be a good idea to have some sort of 24 hour telephone line, for people to ring. It could be a roster of volunteers, so there is always someone there. It doesn't have to be talk about the mental illness, it could be talk about something totally unrelated to that. People can get rid of their frustration, they can share their sadness, or talk about how things used to be and what hopes they have

for the future. Or they might need advice about where they can turn to for other help. Volunteers could be provided with a list of contact numbers for easy reference. Really I think people just need that human contact even if it is on the phone, just a voice on the other end. And the phone call can be made in their own time - when the person they are caring for is asleep. It is safe and anonymous and it can be done in a variety of languages. Maybe that building up of trust with that other person can develop and give people the strength to enable them to go elsewhere, or even build up a support group bringing together people with the same sort of problem.

- T&T Counsellor

Services are Improving

Despite the concerns raised by many of the practitioners, a number of interviewees took care to stress that, overall, the services available to CALD people in distress, and their carers, have improved dramatically.

Awareness has gone up. We have these new developments with access workers (Mental Health Access Team) and so on. When I arrived here in the 80s we didn't have had many resources on the ground to look at these issues. Now we have greater numbers and more qualified people who work in the services, and they have migrant access workers to look for people who are missed by the services.

-Psychiatrist