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ABSTRACT

Each issue in the 2001 edition of the Australian Transcultural Mental Health Network (ATMHN) newsletter represents a theme critical to mental health practitioners. The Spring/Summer 2001 issue features articles on building communities of support for refugees, providing support to these families in cultural transitions, and studying depression among refugees. The Autumn 2001 issue presents articles on gender, culture, and child mental health in South Africa, as well as mental health care giving in immigrant communities. The Winter 2001 issue focuses on the mental health of young people and contains a critical exploration of cultural diversity and infant care, and a description of a health project for youth from culturally and linguistically diverse backgrounds. The issues contain reports on current ATMHN-funded projects and lists of additional mental health resources. (Contains 65 references.) (GCP)

Synergy
Australian Transcultural Mental Health
Network Newsletter

Sandee Baldwin, Editor

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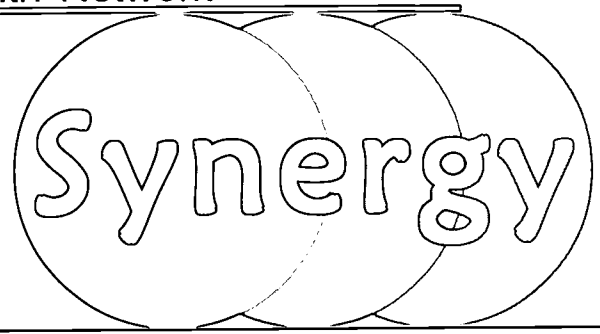
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Spring/Summer 2001

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Australia Day Honour

ATMHN Director receives honour for service to multicultural health services

The ATMHN is pleased to announce that Abd Malak, Director of the ATMHN received a Member in the Order of Australia (AM) "for service to multicultural health services, particularly through the Australian Transcultural Mental Health Network and NSW Transcultural Mental Health Centre", in the Australia Day Honours List 2002.



Abd Malak has worked in the field of health and social welfare for the past 25 years. He has led the development of innovative state and national services that address the difficulties faced by minority and disadvantaged groups when accessing mainstream services. He was instrumental in the establishment of the NSW Transcultural Mental Health Centre where he is the Director. He is also the National Director of the Australian Transcultural Mental Health Network, Director of Multicultural Health for Western Sydney Area Health Service and Chair of the Federation of Ethnic Communities Councils of Australia (FECCA).

Better Communication → Stronger Communities

An ATMHN workshop on Reporting on Mental Health Issues in Ethnic Communities

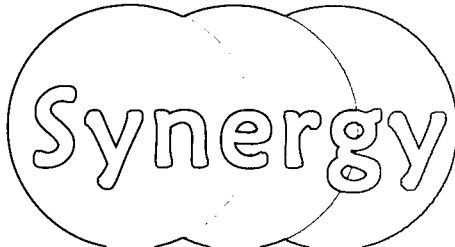
The Australian Transcultural Mental Health Network, in association with the Qld Transcultural Mental Health Centre held an interactive media workshop designed to educate multicultural health workers and members of Queensland's ethnic media on effectively communicating the mental health issues within Queensland's diverse communities.



The two day workshop was held in Brisbane in November 2001. Day 1 was for service providers only and aimed to provide participants with the essential skills, knowledge and confidence to develop successful media promotions and campaigns.

Day 2 brought together service providers and members of the ethnic media. Radio Station 4EB gave us the use of one of their studios where interviews were recorded, with the aim to be played on air in the future.





SYNERGY is the quarterly newsletter of the Australian Transcultural Mental Health Network (ATMHN).

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Contributions to this newsletter do not necessarily reflect the views of the ATMHN.

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Anyone interested in contributing to future issues of Synergy please contact the editor at:
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Building Social Capital with a Refugee Community – a Case Study of Partnership

By Kim Tomlinson and Susan Lee

The Association for Services to Torture and Trauma Survivors (ASeTTS)
Western Australia

The Association for Services to Torture and Trauma Survivors (ASeTTS) works with refugee individuals, families and communities who have been subjected to torture and trauma. In May 1998, staff at ASeTTS held a community consultation with one of the new emerging refugee communities in Perth. Members of the community had requested the meeting, the purpose being to discuss the community's needs. ASeTTS had already identified this community as being one with high needs related to the recovery from experiences of torture and armed conflict.

This small community numbered approximately 350 individuals with new refugees continuing to arrive. The community is not identified in this article, as they are a small emerging community slowly joining together as a cohesive group. Their experiences in rebuilding community cohesion are not unique to their ethnicity, language or religion but rather shared amongst many communities that have endured armed conflict and organised violence. Unlike some more established refugee communities, this community had no formalised infrastructure. For example, there was no active management committee, radio station or newsletter to support the building of the community's identity.

Like most other refugees, when people from this community were forced to flee their country, their extended family and community networks were largely destroyed, as was their identity as a people. This occurred not only through a physical loss of place and separation of families and communities but also through the loss of identity and the effects of the trauma and/ or torture endured prior to and during flight.

Originally members of this community had social networks that were based on birth, marriage and friendship. However, those that ended up in Perth, Western Australia while being of the same cultural background, in most cases had not known each other previously. Some people, who identified themselves with this group, did not even share the same language or script as the majority of the group. In addition, those people who ended up in Perth came from a wide range of social classes and educational backgrounds. Differences and issues arising from class and educational background did not simply dissolve on arrival in Australia. In Australia, as in the home country, these were factors that often significantly determined the degree to which people chose to connect with each other. Hence, while we will refer to this new emerging group as a 'community' in this article, the term 'pre-community' is probably a more accurate description.

In the consultation with ASeTTS, community members articulated their desire to re-build a sense of community and establish a community identity in Australia. They also clearly articulated their need for support in order to accomplish this. People said, "even though we've been terrorised we want to be together as a community" and "we can contribute to help build this community".

The mandate for the work was clearly to help rebuild a sense of community but the question was, 'How do we effectively support this group in rebuilding a structure that would survive in the Australian environment?'

Continued Overleaf

Synergy Spring/Summer 2001

SOCIAL CAPITAL

Just as the destruction of this community's social capital, the relationship bonds between individuals, families, and community (Winter, 2000), was deliberate, the re-creation of social capital needed to be just as deliberate. Through our work with other communities, staff at ASeTTS have identified key components of social capital that are essential in rebuilding lives and communities shattered by torture and armed conflict (Elliott, 1996). These components have also been identified in both the social capital and trauma literature (McCann & Pearlman, 1989; Latham, 1997; Maynard, 1999; Sarason & Sarason, 1995). We have found that the following components of social capital are the most relevant when working with refugee communities:

- the meeting of basic needs such as food and shelter
- the rebuilding of trust
- the re-building of a sense of identity and esteem
- the establishment of new social networks
- the re-establishment of hope or a sense of purpose in life

By assisting in meeting the needs the community had identified, the key components of social capital would be enhanced. These activities would form the basis of ASeTTS community work program with this community. All of these activities would also help re-establish a sense of hope or purpose, a particularly important component of social capital. If people have no sense of hope or future, they will see little or no point in building capacity for future programs within their group or community.

IDENTIFIED NEEDS

In the consultation with this new community, members identified specific needs and concerns. These were (in order of importance):

The need for a community venue in which to meet.

The community had been trying unsuccessfully for five years to find a venue so that "the whole community can work together"

Lack of recognition

The community felt they were invisible, not recognised as a group by service providers or by the Australian Government. Not having any radio time was one example given. Community members had previously applied to get their own radio program and were unsuccessful.

Lack of information / misinformation

There was a lot of confusion around health and employment issues. Community members also identified lack of information by service providers about the

particular health and social problems experienced by refugees as a concern. For example, the community expressed their frustration about the lack of understanding from doctors and the Australian public about their issues. Support from ASeTTS in consciousness raising was requested

The effects of past torture and trauma experiences

It was stated that "Governments have spent millions of dollars ruining our brains" and that community members now suffered as a result of past torture and trauma. People grieving over the deaths and disappearances of family members were a common example of this.

A family camp/ retreat

There was a stated need for practical and immediate support, for example, in organising a camp for families. Many families had not been away on a holiday since their arrival in Australia.

Lack of safety / trust

This was a concern particularly because supporters of Governments that had inflicted torture were living in Perth, many having also come here as refugees.

In September 1998, four months after the consultation, an ASeTTS worker was allocated time to work with the community to help them address their expressed needs. In August 2000, the beginning of the two-year phase of work with this community had come to completion. In each stage the work has been informed and directed by the community as well as by the worker's understanding of the theoretical constructs behind social capital, community development and trauma recovery.

In the two-year period many community projects were undertaken. Each of these projects has addressed the community's needs articulated at the consultation. The following is a brief account of the learnings gained from two of the projects: the establishment of a community house and the community radio project.

THE COMMUNITY HOUSE

The establishment of the community house was the first identified priority at the consultation and hence the first joint ASeTTS / community project. ASeTTS had a lease on a residential style house that was allocated for community use in a separate suburb from the main agency. This house was a short walk from the train station. It was conveniently located within the one town council in which approximately 90% of this community lived. At this time there was a group of men who were acting as the community's steering committee. The steering committee's 'Chairperson' was given the key to this house with the authority to use it when needed. The house and

its location seemed perfect to both the community and ASeTTS.

There was a big opening party for the house in which about 80 men, women and children from the community attended. At this time there was much excitement and planning around the venue, for example, about how community members would paint the house (ASeTTS would organise free paint) and how wonderful it was to have a place at last. However, after the initial party, the community's use of the house never became a regular or frequent event. Three successive women's groups from this community did use the house, but the ASeTTS' worker facilitated all these groups. This lack of community engagement with the house provided ASeTTS' workers and community members with the first concrete indication of how little social capital existed within the community.

In the meantime due to vandalism and related financial reasons, ASeTTS lost the lease on this house, hence the community was once again without a 'home'. It was a sad event, though not as sad as it initially may have seemed. Both ASeTTS staff and several community members acknowledged that, when they had finally got their house, there actually had not been much commitment to it as a community. There were several possible reasons for this; one being that there was effectively no community association at the time. There was a feeling that while previously lack of material objects (a building) had been seen as the obstacle to getting a regular community meeting happening, it was now recognised, by some community members at least, that something more intangible was needed.

The "intangible" was the social capital of the community. At that time the social capital of this community was not sufficient to enable a resource, the house, to be sustained, a not uncommon situation for communities shattered by organised violence (Maynard, 1999). There was in effect less of a 'community' than originally thought rather only a group of individual people available to work on and use the house. Moreover, as relatively newly arrived refugees, this was a group of individuals and families whose energies were already largely consumed by the myriad of more immediate individual demands and problems related to settlement in a new country and coping with past traumas. Community members were for the most part asking the community worker to assist with individual issues regarding more immediate basic needs such as food and shelter. Broader community development projects were still seen as important but not as urgent as having adequate housing and food on the table.

THE RADIO PROGRAM

Whilst the community house project was postponed, the work continued on a number of other community projects addressing each of the needs raised at the consultation. These specific projects were all developed using the same theoretical framework of social capital, community development and trauma recovery. One of these projects, the development of the community radio program began in May 1999, eight months after ASeTTS community work with this group had been started. This eight-month period was a crucial time of trust building between ASeTTS and community members and contributed heavily to the very successful outcome of this project.

Three of the community members who had worked with ASeTTS on other projects undertaken in this eight month period approached staff at ASeTTS for assistance in getting their own community radio program. There was still no official community association at the time, but two of the members were part of an unofficial 'association' steering committee.

Staff met with this group fortnightly for a period of four months. The group had two core members and fluctuated from three to seven people over the meeting period. Two ASeTTS workers were involved in facilitating the establishment of the radio committee. This included modelling the running of the meetings Australian style (having formalised minutes, for example, is important to establish credibility with sponsors and funding bodies), assisting with approaches to sponsors and general advocacy with the radio station. Two months into the work, the community was successful in getting a once weekly, one hour program slot with the local ethnic radio station 6EBA FM.

The committee then called a public meeting for community members to discuss what the community might want to hear on the program and also how they as a community would raise the \$120 monthly studio fees. Very few community members attended the meeting. The radio committee started to despair about, not only how they could consistently raise the funds, but also whether they as a very small group of people, could sustain the work and commitment required to keep the radio program going.

The radio committee members expressed resentment toward members of their wider community that their own unpaid work with the radio was not being adequately recognised or appreciated. These individuals' feelings of not being recognised by their own community paralleled the process of this refugee group not being recognised by service providers and the Australian government, a sentiment expressed at the initial community consultation.

Continued Overleaf

During this difficult period some of the community members started to actively encourage and support those that had become dispirited. These people effectively took on the supportive role that the ASeTTS workers had been playing. These small behavioural changes indicated a real breakthrough in the building of the social capital of this small group, and in turn the whole community. The key components of trust building and establishment of new social networks between the committee members began to become evident at this point. An example of this was that in the beginning of the radio program meetings the men involved did not communicate or socialise with each other at all outside the ASeTTS meeting space. This changed subtly as time went on in that after a few months people continued to meet and to talk after they had left ASeTTS.

Shortly after this turning point of spirit came a financial turning point. A small international telecommunications company, which the committee had earlier approached for sponsorship, agreed to provide funds for the first 6 months of the program. The community's radio program was born.

This once weekly radio program continued successfully for some time by the community members themselves with very little assistance from ASeTTS. The radio program provided an excellent opportunity for continuing to build social capital and capacity in the community. This was not just in the dissemination of information to isolated community members but also in a myriad of other ways. These included the strengthening of the community's sense of cultural identity and esteem and the development of radio production presentation and project management skills for those directly involved in the program. The radio program helped to create a sense of hope for the future so important to the continued strengthening of social capital.

This first two-year period of work with this community is just the beginning of the rebuilding of social capital for these people. Working together with the community members we have deliberately targeted the components of social capital for rebuilding just as they were deliberately targeted for destruction. The destruction of these components had occurred over a period of many years hence the re-creation of social capital and the healing involved in that, cannot be expected to occur instantly. This is slow, sometimes painstakingly slow work, often with the sense of two steps forward, one step back. However, our own experience in working with traumatised community's has repeatedly shown that addressing the key components of social capital and incorporating them into projects does result in successful and sustainable outcomes.

Because this is slow work with a particularly damaged community, it is important to be realistic about the measurements of success and sustainability. It is unrealistic and usually inappropriate for all projects to eventually become self-sustaining (Green & Barker, 1988). Many projects undertaken in this type of work are vehicles to rebuild trust, esteem, identity and social relationships and are not necessarily meant to be more than that. For example, the learn to swim group we ran will not continue forever as a program, but some of the relationships built between its members will continue beyond the last lesson, as will the sense of accomplishment and esteem gained by participants.

What is important is that the capacity to create supportive social structures, such as a community association, is built. It is the building of this capacity (the skills, knowledge and their transfer to other community members) which will ensure the continuation of the growth of social capital within a community. The flow on effect of this will be an increase in the overall health status of the community, especially in the long term (Commonwealth Department of Health and Aged Care, 2000).

THE WORKER'S ROLE

The worker's role in this work is multifaceted. A first step is to establish trust with the community members, then to bring people together in one's and two's and threes in a supportive neutral environment. For this community this was done, for example, with the radio group, a children's holiday program, and on a larger scale with the community retreat. With the women's groups this involved creating the space and opportunity for working on an activity of mutual interest, such as gardening, in a small supportive group. When a women's group, for example, has finished, one or two relationships are sustained between the women. These may be tenuous relationships at first but enough of a link that a woman later feels she can initiate contact with the another woman for support and friendship.

These were the interactions and links we observed developing as result of the groups, the kinds of interactions that break down social isolation and allow sharing of information, resources and the transfer of knowledge and skills. These interactions have the seeds of all the components of social capital; the rebuilding of trust; the rebuilding of a sense of identity and esteem, the establishment of new social networks and the meeting of basic needs.

A key role for the worker is to support emerging leaders in the community. This often includes an educational component, passing on vital information about how Australian society works or how education and employment systems and networks operate, so that the

people learn how to access the systems. It is the workers' role to model more formal structures of Australian society such as meeting facilitation and grant writing. This is done in the process of supporting community projects such as in the setting up of this community's association and the radio program.

The existing level of social capital within a community can be measured to some extent by benchmarks such as the existence or non-existence of a community association or newsletter. When community programs are planned and funds allocated, this information needs to be ascertained with reference to and in collaboration with the community in questions. To put programs in place without consulting with the community and determining the existing level of social capital is to be outside the feedback loop of essential information and hence to ignore the basic foundation for the success of the work. It is in effect like pouring water into a cup with no bottom. If there is little or no container of social capital to hold and sustain a resource put into the community, then that resource will be only short term at best.

Another of the worker's roles then must always be to actively feed this information, the practice, back into policy development and to those responsible for allocation of resources. The role of the policy makers and funding bodies is to listen and act accordingly. In this way the feedback loop of action research is completed and the best environment is created for the continued success and sustainability of the work. □

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Nostalgia

1.

Home. The unfamiliar word
hums in my throat.
I try again. Home.....Home.
The teacher says: Repeat after me,
This is your home now.

This is my home now?

A disconnected part of me
is lit and warmed by scenes
like photographs on riffled pages.
Places I once knew; people
crowd my dreams until
I'm not sure which is real.
Home. A time when I was happy.
Was there ever such a time?
Pain vibrates into my chest
and settles there. Home.

11.

Put it from your mind, they say
as if a thought, when banished
disappears.
Don't they know, the yearning
to be elsewhere
is not just in the mind?

The stamp of gravity and latitude
is on my flesh and bone.
My body feels the difference
to its marrow
and instinct, thwarted
in its rush for home
aches like the phantom pain
of a missing limb.

Louise Gilmore

Consumer Perspectives

Salem Jaouhara

Consumer Advocate NSW Transcultural Mental Health Centre

What is your cultural background?

I'm second generation Lebanese/Syrian Australian. While my blood is and always will be Lebanese/Syrian, I also see things through Australian eyes.

Do you feel more Lebanese/Syrian than Australian?

At times I crave Lebanese food. I grew up eating Lebanese food. I am used to certain parts of my upbringing because of by Lebanese/Syrian culture. There are other times when I love to have the meat and three veg that makes me feel Australian.

You've been to your homeland, how was it?

Lebanon was such a beautiful place, especially the snow on the cedar trees. Most things were close by unlike Australia where you need to travel long distances. Syria is more desert-like and there are many villages.

How long have you been a consumer advocate and what drew you to becoming one?

I have been a consumer advocate for six months. It was offered to me by a mental health counsellor. I feel very empowered by my experience in this job. My opportunities to help others have grown.

What do you hope to achieve in this position?

I feel I am a consumer advocate, a voice on behalf of mentally ill people. I wish to bring hope to those who are in despair.

What are some of the issues of CALD consumers you're currently working with?

Everything from suicide prevention to stigma reduction, to consultations on area mental health service plans.

If you were in charge of the mental health system for a day, what would you change/do?

I would take clowns into the mental health hospital and give the sick an opportunity to laugh. The patients are so unhappy. All they need is the incentive to laugh and be happy which reduces a lot of stress, anxiety and depression.

Consumers also need activities that give them something to do, such as some form of diversional therapy, such as music, art and gardening. Some consumers are in hospital for nearly one month, that is a long time to be doing nothing. Patients get frustrated and can get violent. It is a waste of time if there is no therapy happening in that period.

Do you think a person's culture is important in nurturing their mental health? Why/why not? Do you have any examples to illustrate your point?

There are good points about being Lebanese/Syrian – Australian, the food, the belly dancing, but it was destructive to my mental health. I felt confused between the two cultures. When I was growing up between the two cultures I had conflicting ideas on how to live my life. Yet, being independent in Australia has given me a much desired freedom to be myself.

If you are a consumer and would like to contribute to this page, please contact the editor of Synergy, Sandee Baldwin on 02 9840 3381.

The Utilisation of a Specialist Mental Health Service by Refugees

Teresa Petric
Team Leader, Clinical Services
NSW Transcultural Mental Health Centre

Residents of New South Wales who are refugees have been a significant client group utilising the Clinical Service of the Transcultural Mental Health Centre. The total number of refugees who received clinical intervention through the Clinical Service between June 1994 and December 2000 was 679. This number represents 27.4% of all clients seen by the Service during that time period.

Further analysis of the group of clients identified as refugees shows that a total of 42 languages are represented within this group. The most common languages spoken at home by this group were Serbian (27%), Bosnian (16%), Farsi (12.5%), Vietnamese (11.2%), Croatian (8.6%) and Arabic (7.5%). The remainder of the group spoke a range of other languages including Spanish, English, Russian, Tamil, Turkish, Armenian, Assyrian and Burmese.

Data collected on the country of birth for refugee clients indicates that 30.8% were born in Bosnia and Hercegovina, 11.3% in Vietnam, 9.6% in Iran, 7.7% in Croatia, 6.3% in Iraq, 4.8% in Yugoslavia, 4.4% in Afghanistan and 3.2% in Turkey.

The client data collected by the Service further shows that 54% of all refugee clients were male and 46% were female. The year of arrival data indicates that 86.5% of this group arrived in Australia between 1990 and 2000 (with 52 percent having arrived between 1995 and 1997) and 13.5% arrived between 1970 and 1989.

The place of residence of refugee clients was mainly distributed throughout the Sydney metropolitan area and included a total of 51 local government areas. Most resided in the western (29.3%) and south western Sydney (23.6%) areas, whilst the south eastern (12.5%) and central Sydney (7.7%) were also significant areas of residence.

The most significant source of referral for this group was through self referral or referral through a friend or relative (21%). Other significant sources of referral included non-government organisations (20%), General Practitioners (17%), mental health services (13%), specialist refugee services (8%) and schools (4.5%). Other sources of referral included community health services, general hospitals and women's refuges.

The reasons for referral to the Clinical Service provide insight into the mental health problems experienced by refugees. Most refugee clients were referred due to war related trauma (28.8%), followed by depression and suicidal ideation (26.2%), anxiety (16.5%) and psychotic symptoms (5.5%). Other significant mental health problems recorded for this group of clients includes sleep disorder, adjustment problems, somatic symptoms and bereavement.

The main type of clinical intervention provided to this group of clients by the Clinical Service was assessment (88%). This included psychosocial, psychological, cultural or family assessments. Other types of clinical intervention provided were psychoeducation and short term therapy. The amount of time provided for clinical work ranged between 4 and 10 hours, with 5.3 hours being the average time spent with each client.

The outcome of clinical intervention with refugee clients involves the formulation of recommendations for their future care and treatment. The recommendations most often made for refugee clients included the need for ongoing counseling or psychotherapy (33.2%), referral to mental health services (13.7%), cognitive behavior therapy (13%), group therapy (12.5%), psychoeducation (10%) and further assessment (9.6%).

All refugee clients seen by the Clinical Service were referred to the most appropriate service following the completion of clinical work. As noted in the recommendations above, these services include community based mental health teams for further assessment and psychoeducation. Refugee clients needing ongoing therapeutic treatment were referred to the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS).

**For further information contact the NSW
Transcultural Mental Health Centre on
Tel: 02 9840 3800**

NATIONAL NOTICE

Tasmanian Transcultural Forum

The Australian Transcultural Mental Health Network and Mental Health Services, Tasmania are co-hosting a forum on mental health services for culturally and linguistically diverse people within Australian society.

The Forum will be held on 21 March 2002 at the Hobart Function and Convention Centre, Hobart.

Key note speakers are: Emeritus Professor Beverley Raphael, Jorge Aroche and Associate Professor Harry Minas.

Issues to be explored are:

- Changing trends in mental health service provision in Australia
- Torture and trauma services and their relationship to mainstream mental health services
- The availability and usefulness of cross cultural tools

The forum promises to be highly relevant to mental health workers, consumers and carers, people from culturally and linguistically diverse backgrounds, and representatives from key organisations.

All enquiries please contact Claudia Duenow on 03 6233 5087

SA NESBWEB

The Multicultural Mental Health Access Program has been active in undertaking education and staff development for both non clinical mental health support workers and mental health clinicians.

Highlights have included training with the Centre of Personnel Education (COPE), various TAFE's and a Graduate Nursing Course (Community Mental Health) within the University of South Australia.

Information about McMHAP's involvement in worker training can be found in its most recent newsletter at www.arcom.com.au/~mcmhap

For any other information about the NESBWEB: SA Transcultural Mental Health Network Convenor Mark Loughhead (08 82435613).

Carers and Consumers Issues

Following numerous requests Lorraine Stokes, the ATMHN librarian, is collating all material pertaining to carers and consumers into one easy section on the ATMHN website.

The Carers and Consumers section of the ATMHN website will be a comprehensive information area where people will be able to access information about relevant national, state and local agencies that covers issues for carers and consumers within a culturally and linguistically diverse society.

Of course the section cannot contain everything, but will provide extensive material to those who have an interest in this field. There will also be an opportunity for you to contribute material for this section providing it is relevant.

The material will be available in many formats; books, journal articles, reports, research in progress and audio visual material, some of which will be available in languages other than English.

If you know of any research or reports that are relevant to carers and consumers from a culturally diverse background and would like it added to the site please phone; **Lorraine Stokes on 03 9411 0310 or email**

l.stokes@unimelb.edu.au

ACT Transcultural Network

The ACT Network continues to meet following the completion of the Commonwealth funded transcultural mental health project in the ACT. An important outcome of that project was the reinvigoration of the Network that now includes service providers, policy makers and ethnic community representatives. The commitment of individuals and agencies across Canberra to continuing the work of the Network is a testament to the project officer Salva Crusca's community development focus.

The key achievement of the project is an increased awareness of the difficulties experienced by CALD communities in accessing mental health services. As found in other states, this is the result of both service barriers and stigma. Initiatives of the project that will continue to address both these issues are:

- Improved collection of data at point of entry to mental health services that identifies cultural and linguistic background
- Maintenance of directories of bilingual GPs and services for CALD consumers and carers
- Development of a proposal to seek funding for a transcultural mental health liaison officer
- Development of education and awareness-raising activities in ethnic communities

For further information please contact Susan Heylar, ACT Mental Health and Corrections Health on 02 6207 5994

Reciprocity in Education

The Reciprocity in Education Project evaluation has been completed by the South Australian Community Health Research Unit (SACHRU) and will be available from SACHRU by the end of November 2001.

The project met all of its objectives - in some cases exceeding expectations set by the Local Advisory Committee. A draft version of the final project report entitled, 'Speaking of sadness and the heart of acceptance. A model of interactive learning between migrant communities and mainstream mental health services' has been developed and a final version will be launched in the new year.

The model continues to be used to educate post graduate mental health professionals at two South Australian Universities and is part of the New South Wales Institute of Psychiatry Training Program for Psychiatrists. During November 2001 it was showcased as an example of best practice at the Promotion, Prevention and Early Intervention for Mental Health Workshops run across South Australia by the Department of Human Services.

Contact A/Prof Nicholas Procter (08 8302 2148) for more information about the interactive learning model.

Studies in Transcultural Mental Health

The NSW Transcultural Mental Health Centre in collaboration with the Faculty of Nursing, Midwifery and Health of the University of Technology, Sydney has jointly developed a Graduate Certificate/ Graduate Diploma in Transcultural Mental Health.

The course will begin in March 2002 and subjects are offered in mixed modes; by distance education, intensive and/or block teaching mode. Students are required to complete:

4 subjects for the Graduate Certificate (Year 1 subjects) or 8 subjects for the Graduate Diploma (Year 1 and 2 subjects).

Subjects include:

Year 1

- Transcultural mental health assessment and treatment
- Ethnicity, culture and migration
- Counselling and group skills
- Models of transcultural mental health practice

Year 2

- Issues in transcultural mental health
- Advanced clinical practice in transcultural mental health
- Research Subject
- Elective Subject

For further information contact:

Christine Senediak, NSW TMHC on Tel: 02 9840 3897 or e-mail: Christine_Senediak@wsahs.nsw.gov.au

Kevin Kelleher, University of Technology, Sydney on Tel: 02 9514 5050 or e-mail: Kevin.Kelleher@uts.edu.au

Establishment of 24 Hour Counselling Service

The NSW Transcultural Mental Health Centre has established a 24-Hour Counselling Service on 12 September 2001 for members of the community who are of non-English speaking background and who have been adversely affected by the aftermath of the American crisis.

The utilisation of the 24 Hour Service shows that some groups in the community have been singled out for vilification or abuse due to their religious or ethnic backgrounds. A recent phone contact with the Service concerned a taxi driver who was verbally abused and threatened by two male passengers. The abuse was aimed at the driver due to his appearance and perceived ethnic background.

Other calls have also concerned men and women who have been the targets of verbal abuse due to their manner of dress or their appearance. For example a number of women wearing the 'hijab' have been verbally abused.

Utilisation of the 24 Hour Service has been growing steadily since it was established. The Service has been primarily used by people of Arabic, Hindi, Croatian, Bosnian and Farsi speaking background.

The 24 Hour Service thus provides counselling, support and debriefing over the telephone. Short term face to face counselling can be arranged if needed, and will be provided through the TMHC bilingual sessional workers who speak 50 different community languages. The Service is accessible through **1800 648 911**.

Further information about the Service can be obtained from Teresa Petric on 02 9840 3943.

Refugee Websites

U.S. COMMITTEE FOR REFUGEES

www.refugees.org

USCR was founded in 1958 to coordinate the United States' participation in the United Nations' International Refugee Year (1959). In the forty years since, USCR has worked for refugee protection and assistance in all regions of the world.

REFUGEE COUNCIL OF AUSTRALIAN

www.refugeecouncil.org.au

The Council's work is centred around 5 key areas: policy, support for refugees, support for it's Members, community education and administration. In addition, the Council seeks funding for specific projects that directly relate to our objectives and enhance our capacity to serve the refugee community.

The aim of the Refugee Council of Australia is to promote the adoption of flexible, humane and constructive policies towards refugees, asylum seekers and displaced persons by the Australian and other Governments and their communities.

REFUGEES INTERNATIONAL

www.refintl.org

Refugees International is a non-government organisation serving refugees, displaced persons, and other dispossessed people around the world.

WORLD REFUGEE

www.worldrefugee.com

A website that brings together all the latest international news on refugees. It is an excellent site to keep up to date on the latest events around the world.

UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES

www.unhcr.ch

The United Nations High Commissioner for Refugees was established by the U.N. General Assembly in 1950, one of several attempts by the international community during the 20th century to provide protection and assistance to refugees.

The League of Nations, the forerunner of the U.N. had named Norwegian scientist and explorer Fridtjof Nansen to the post of High Commissioner as early as 1921. World War II provided the impetus for several new organizations, the United Nations Relief and Rehabilitation Agency, the International Refugee Organization and subsequently UNHCR.

The new agency was given a limited three-year mandate to help resettle 1.2 million European refugees left homeless by the global conflict. But as refugee crises mushroomed around the globe, its mandate was extended every five years.

Today, the UNHCR is one of the world's principal humanitarian agencies, its staff of more than 5,000 personnel helping 22.3 million people in more than 120 countries. During its half century of work, the agency has provided assistance to at least 50 million people.

REFUGEE STUDIES CENTRE

www.qeh.ox.ac.uk/rcp

The Refugee Studies Centre is part of the University of Oxford's International Development Centre at Queen Elizabeth House. Its objectives are to carry out multi-disciplinary research and teaching on the causes and consequences of forced migration: to disseminate the results of that research to policy makers and practitioners, as well as within the academic community; and to understand the experience of forced migration from the point of view of the affected populations.

ATMHN Website

www.atmhn.unimelb.edu.au

Families in Cultural Transitions: Strengthening Refugee Families and their Communities

Monica Lamelas
Families In Cultural Transitions Coordinator
NSW STARTTS

Refugees face any number of complex challenges when settling into Australia, ranging from meeting basic needs such as communication, food, accommodation and education, through to the physical and mental sequelae of their often extremely traumatic experiences. And the issues are not only played out at the individual level- the structure of refugee families as a whole must often also go through significant adjustment in order for family members to 'find their place' in this new country.

The issues of normal family life, the process of migration, and the impact of trauma are intricately linked. For example, a refugee teenager's normal (but often difficult) process of individuation from his/her parents (a normal 'family life-cycle' issue), is exacerbated by the parent's physical illness and traumatic losses back home which causes them to be more dependent on, and hang on more tightly to, their children in Australia (both 'trauma' issues). This is then further exacerbated by, say, the parent's lack of income, and reliance on the adolescent's English language skills in order to find a job ('migration/ settlement' issues), which in turn puts more pressure on the relationship between the adolescent and their parents (back to a 'family life-cycle' issue). This all-too-common scenario is so complicated, that it can seem impossible to even figure out where to start unraveling the issues.

STARTTS has been dealing with issues like these since its foundation 13 years ago. One of the many creative- and highly successful- solutions the organisation has developed, based on the experience of staff working with families, providing them with information and linking them into services, is the Families in Cultural Transition (FICT) program.

Basically, FICT is a group program designed to assist migrant and refugee families with information, psychoeducation and support around the issues and family processes associated in making the transition from their country of origin to Australia.

The Program centers around a Resource Kit, which provides group facilitators with a comprehensive package of materials to run the 9 x 3hr sessions in the complete program, as well as information on running groups in general.

Each session, or module, in the program covers a topic area of particular relevance to families trying to settle here. The topics are as follows:

Module 1 Introduction and Settlement

Getting to know each other, the concept of settlement, and differences between migrants and refugees.

Module 2 Support Services

What's out there, as well as how to use basic tools like the phone book and street directory to find the services you need.

Module 3 Money

Covering everything from budgeting to getting a safety deposit box to buying in bulk at the markets.

Module 4 Trauma and Healing

Psychoeducation about the process of trauma, loss and grief and things that individuals and families can do to feel better.

Module 5 Families

The issues faced by families moving between cultures-how things change and how they can stay the same.

Module 6 Children

How children are affected by migration and trauma, common responses of children, how to communicate with children, Child Protection issues.

Module 7 Gender

The dynamics between men and women in Australia in comparison to the country of origin, legal issues (including equal opportunity and Domestic Violence issues).

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Module 8 Youth

The impact of migration and trauma on teenagers, the cross-cultural conflict, issues impacting on youth in Australia e.g. unemployment.

Module 9 Enjoying the new environment

Finding the time to take care of yourself and your family.

When you put them all these sessions together, it's like putting together the pieces of a puzzle, which, through the course of the group, covers most of the key areas of concern. The FICT modules help migrant and refugee families by:

- Normalizing responses, both to trauma and to migration, and validating feelings of cultural dissonance.
- Empowering people by providing information about the new country as well as a safe space in which to practice using this information.
- Strengthening family relationships, by providing relationship, communication, and parenting skills.
- Reducing feelings of isolation and alienation, by strengthening the social supports and links both within the refugee community, and with the wider community and its services.
- Early Intervention and identification of problems within the families, as well as more individual psychological problems that need to be addressed.

The group sessions are run by trained bicultural/bilingual facilitators. STARTTS has been very successful in recruiting and training these facilitators from many of the refugee communities currently residing in Sydney, and these facilitators have access to STARTTS' staff for information, assessment and support throughout the length of each group.

Recruiting people from the refugee communities to run groups has the effect not only of providing a contact person for group participants who has been through it and 'made it' here, so to speak, but also of strengthening the skill base within the refugee communities.

Facilitators who have been through our training increase their chances of employment (through gaining local work experience) and their ability to find information for themselves and their loved ones, and have often gone on to become community leaders.

As a flexible and adaptable program, FICT has been highly successful with groups of nationalities as varied as

Somali, Laotian, Former Yugoslavian, Assyrian, and Vietnamese. It has also been adopted by the Department of School Education within a number of its primary and secondary schools as part of its approach to assisting the parents of students at those schools. This ongoing partnership between STARTTS and DET has been particularly satisfying in terms of the success stories that have come out of those groups, including large groups of refugee mothers turning up at schools to volunteer in the canteen, and coming to participate in P&C meetings through an interpreter.

Returning to the family in the example at the beginning of this article, let's say a worker identified these issues and referred them to the FICT program. In the first session, they met others who were in the same situation, and who had gone through similar experiences to theirs. Then, in the first two modules, they were given information about English classes, Centrelink services, job-seeking assistance, and the telephone interpreter service.

In the 'Trauma and Healing' module, they learned to identify and normalize some of their own symptoms and reactions to their traumatic experiences, and see how this is impacting on their current family relationships. And in the 'Youth' module, they learned about 'normal' adolescent behaviour, and how the traumatic experiences, and the current experiences of settlement, were impacting on their adolescent. All this in an environment which was understanding and supportive, and where they felt comfortable asking questions and working through issues. They made a number of friends in the group, and no longer felt so alone in this strange country. And they now felt more comfortable about being referred on to a counsellor, because they now understood that their symptoms were not signs of being 'crazy'.

What we have here, like in so many families who have gone through the FICT program, is an excellent outcome- and a family that is well on its way to finding and using its own strengths to make a new life for themselves in Australia.

The FICT kit is available for purchase by groups and centres, and training can be arranged for anyone who wants to run these groups. To get further information, get involved in the FICT program, or refer someone to the program, please contact the FICT Coordinator at STARTTS, ph: (02) 9646 6666; fax: (02) 9646 6610.

Listening to diverse voices: Studying depression among refugees

Farida Tilbury, Renata Kokanovic, Mark Rapley and Ilse O'Ferrall
Murdoch University and the Eastern Perth Public and Community Health Unit,
Western Australia.

Depression is increasingly recognised as a global health problem, being a highly disabling mental health condition. It involves substantial social, economic, and personal costs. According to the World Health Organisations (Murray & Lopez, 1996) depression will be the second leading cause of disability in the world by 2020. Each year at least 100 million people around the world develop a depressive illness. This number is likely to increase due to global economic and cultural changes, which expose more people to prolonged psychosocial stress (Douki & Tabbane, 1996). Yet there has been little conclusive research into the most appropriate strategies to use in the prevention of depression.

Likewise, while there is even less research about the understandings that people of culturally and linguistically diverse (CALD) backgrounds have of the conditions encompassed by the term depression, and of the ways in which these conditions may be managed or prevented, researchers have recently begun paying attention to the relationship between culture and the perception and presentation of mental health related problems (Kleinman and Good, 1985; Wolpert, 1999; Zang, 1995). Understanding the different modes by which people express depression, and establishing appropriate forms of communication with depressed people, is important in mental health promotion and/or counselling (Jenkins, Kleinman & Good, 1991; Sartorius, 1987), especially since verbal expressions of emotions in some languages are still predominantly somatically-oriented. For example, in Chinese languages, even though there are written Chinese characters designating states of depression (as defined by a Western medical model), there are no equivalent expressions in the spoken language. Hence, multiple physical complaints serve as a culturally sanctioned avenue for expressing depressive reactions (Zang, 1995:230).

At a more fundamental level, understanding cultural differences in the "definition of human suffering" (Obeyesekere, 1985:149) leads to a rethinking of what we should consider normal and abnormal states of unhappiness. Consider Obeyesekere's query:

"How is the Western diagnostic term 'depression' expressed in a society whose predominant ideology of Buddhism states that life is suffering and sorrow, that the cause of sorrow is attachment or desire or craving, that there is a way (generally through meditation) of understanding and overcoming suffering and achieving the final goal of cessation from suffering or nirvana?" (1985:135)

Cultural variation is thus not an epiphenomenon that simply affects superficial aspects of illness such as the way symptoms are described. It affects the experience of illness at a fundamental level. Groups vary in the specificity of their medical complaints, their style of medical complaints, their anxiety about the meaning of symptoms, their focus on particular organ systems and their response to therapeutic strategies (Good and Delvecchio-Good, 1981). It is therefore necessary to develop a meaning centred approach which focuses on emic, or 'lay', conceptions of the condition.

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While each individual will have their own unique experiences of suffering and have developed their own mechanisms for coping with that suffering, it is likely that depression may be a significant issue for those who have come to Australia as refugees. By definition, refugees are those who are outside their country of origin and unable to return due to "a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social or political opinion..." (United Nations Convention, 1951). They have therefore experienced significant trauma in their own country and/or in leaving it. Recent events in Australia have highlighted the entrenched racism of some Australians, which is likely to heighten levels of discrimination towards, and feelings of unwelcome among, refugees. These factors simply exacerbate the psychosocial stressors encountered by refugees.

As well as the usual hurdles faced by migrants, refugees face further challenges which may predispose them to mental health issues. These may include:

- Traumatic experiences, including torture, rape, imprisonment, destruction or appropriation of property, war or other forms of oppression, or prolonged stress before or during immigration
- Extended stays in refugee camps
- For those who have come as asylum seekers, the liminality of life in detention centres, and second class status when released
- Low socioeconomic status, or drop in socioeconomic status following migration
- Significant culture shock
- Inability to speak the language of the host country
- Loss of or separation from one's family and extended kin
- Prejudice and discrimination in the host society
- Isolation from others of a similar cultural background

It has been shown that refugees suffer from mental health problems, such as major depressive disorders, schizophrenia, anxiety disorders and neurotic conditions, which are far more severe than those of voluntary migrants (Gold, 1992). Refugee populations also suffer high rates of post-traumatic stress disorder, with around half of the members of some populations showing symptoms (Marsella et al, 1996). Refugee children whose families have been subject to persecution often develop symptoms

including social withdrawal, chronic fears, depression, dependent behaviour, sleep disturbances and social problems (Canadian Task Force, 1988). However, Jayasuriya et al (1992) warn against assuming refugees are more vulnerable to developing psychiatric conditions since no reliable epidemiological data are available, and since internal differences in refugee experiences result in variable outcomes.

Australian policy makers have recognised the importance of providing mental health promotion information resources that are accessible and sensitive to differences of culture and language (Commonwealth Department of Human Services and Health, 1999: 31; Minas et al 1993; Burdekin, 1993). The Commonwealth Mental Health Promotion and Prevention National Action Plan (1999) has highlighted the crucial importance of addressing the mental health needs of newly arrived immigrants. Several recent State initiatives (Seah et al, 2001; Victorian Foundation for the Survivors of Trauma, 2000; NSW STARTTS et al, 2000) have produced resources for mental health professionals to improve service delivery to migrant and refugee communities. Likewise there is increasing recognition that if mental disorders are to be recognised early, the level of mental health literacy among Australia's diverse population needs to be raised (Jorm, et al., 1997).

The authors have recently begun a Healthway funded project in Western Australia, entitled "Listening to Diverse Voices", which investigates understandings of depression among a number of migrant and ethnic communities, including several who have migrated as refugees. Bosnians, Croatians, Somalis, Sudanese, Ethiopians, Eritreans, and Chinese, as well as indigenous Australians, will participate in focus groups and interviews designed to elucidate how different cultures understand and deal with the symptoms commonly regarded as 'depression'. These groups display demographic characteristics that place them at a social and health disadvantage relative to the rest of the community (Commonwealth Department of Human Services and Health, 1999). According to the DIMA Settlement Database (1999), the number of people migrating to Australia from the Horn of Africa under the refugee category is increasing. These communities are relatively isolated and have been exposed to traumatic events prior to their arrival in Australia. It is necessary to address their mental health needs in a culturally-appropriate manner.

The communities will also be asked about the perceived relevance and comprehensibility of current mental health promotion information, in the form of media coverage (ethnic radio, televisions and newspaper publicity) and information leaflets, which attempt to target these communities. The question of the content and form of

information presented in the media has important implications for strategies of mental health promotion. Australian and international research shows that there are significant ethnic differences in terms of attitudes towards mental illness, and knowledge of mental health services (e.g. Baker et al, 1993; Brodie, et al, 1999; Lay, 1998; Vargas and de Pyssler, 1999). Migrants who speak a language other than English at home possess less knowledge about existing services and are less inclined to rely on written information (Fan, 1999). This suggests the need for more culturally appropriate mental health information. Unfortunately, relatively little is known about what culturally specific information about mental health is presently available in the diverse media, and about the salience of information about mental health services for potential user populations. If mental health promotion is to be improved, it is important to identify ways of improving communication.

The study begins from the premise that contemporary mental health promotion efforts designed to assist CALD communities to deal with emotional and/or psychological distress may not be readily comprehensible to these communities. This may be so because they are couched in a discourse framed in terms of western, medical understandings of psychological/psychiatric disorder. By revealing the extent of congruence or mismatch between expert messages and lay understanding, the project will assist in the effort to develop culturally appropriate practice by mental health services and improve the uptake of such services by the communities under study.

The study aims to establish a rich descriptive understanding of the ways in which emotional/psychological distress is understood in these communities, recognising the diversity within the communities. Using discourse analysis (Potter & Wetherell, 1987; van Dijk, 1997) media data, focus groups and interviews will be closely scrutinised in order to identify and describe the interpretative repertoires of psychological 'health' and 'distress' employed in the material. Note will be made of commonalities and divergences in the discursive presentation of 'mental health' and 'ill-health', the nature of 'symptoms' and 'depression', and of recommendations made in terms of treatment options across the different media and community groups.

The key questions to be answered by the research include: to what extent are public health communications noticed in CALD and indigenous communities? To what extent, and how, are such messages comprehended in these communities? To what extent are public health messages incorporated into everyday 'common-sense' and behavioural practices? After consultations with each of the communities, recommendations about culturally

appropriate mental health messages will be made to the state government.

The project began in July, and will run for two and a half years. Findings will be widely distributed at conferences and in papers, as well as regular updates in Synergy. For further information please contact Farida Tilbury, 0421 360 820, or Renata Kokanovic, (08) 9224 1347 □

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New publication available from the ATMHN

Mental Health Shared Care for Ethnic Communities - a handbook Brisbane Inner South Division of General Practice

This handbook contains practical strategies for the establishment of ethnic mental health shared care programs and arrangements, and offers insights into the issues affecting shared care for ethnic communities. Some of the issues that affect shared care service delivery to people of non-English speaking background (NESB) are similar to those for the community at large, however there are also distinct issues involved.

The general purpose of the handbook is to assist those planning to set up ethnic mental health shared care programs. The handbook guides the reader through the main issues that should be considered before setting up an ethnic shared care program and then provides practical information that may assist the implementation phase. More specifically the purpose of the handbook is to assist divisions of general practice and others to:

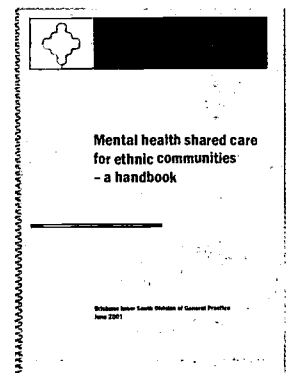
1. Plan and implement programs in shared-care that can meet the specific needs of clients of NESB;
2. Incorporate the needs of clients of NESB into existing shared care programs.

Much of the information in the handbook is based on experience gained from an ethnic mental health shared care demonstration project in Brisbane. This project piloted a shared care approach between the Brisbane Inner South Division of General Practice and key services working with people of NESB with mental disorders.

The aim of the project was to enhance general practitioners' (GPs) skills and knowledge in an early intervention model where people of NESB exhibiting early signs and symptoms of mental disorder could be identified, assessed and treated.

The project provided resources and support to GPs with assessment and diagnosis and ongoing support of their patients in a general practice setting. The project had a strong evaluation focus.

The report costs \$11 (including GST) plus postage and handling. To obtain a copy please contact the ATMHN on 02 9840 3333.



Events Calendar

2002

February

20-22

Holistic and Creative Choices
National Home and Community Care
Conference
Adelaide Convention Centre

Tel: 08 8379 8222
Website: www.plevin.on.net/HACC2002/

23

Blind to Betrayal:
Forgetting, Unawareness and
Interpersonal trauma
Bardon Conference Centre, QLD

Tel: 07 3398 0201
Email: holhills@powerup.com.au

April

13-14

**Boundaries - Boundary Issues for
health professionals**
Cannan Research Institute
Brisbane

Tel: 07 3398 0201
Email: holhills@powerup.com.au

28-5 May

**5th WONCA World Conference on
Rural Health**
Melbourne

Tel: 03 9417 0888
Website: www.ruralhealth2002.net

May

13-15

**3rd International Conference on
Drugs and Young People**
Australian Drug Foundation, Centre for
Youth Drug Studies and Ted Noffs
Foundation
Sydney

Email: events@adf.org.au
Website: www.adf.org.au

June

11-15

**Third International Conference on
Child and Adolescent Mental Health**
Brisbane

Email: t.collier@elsevier.co.uk
www.iccamh.com

July

11-14

**Changing Climates: Future Priorities
in Psychiatry, Psychology and Law**
Australian and NZ Association of
Psychiatry, Psychology and Law
Darwin, NT

Tel: 08 8363 1307
Email: fcceaton@ozemail.com.au

August

19-22

Annual THEMHS Conference
Sydney Convention Centre, Sydney

Tel: 02 9926 6057
Website: www.themhs.org

2003

February

23-28

**The 27th World Congress of the
World Federation for Mental Health**
Melbourne Convention Centre

Tel: 03 9682 0244
Email: wfmh2003@icms.com.au
www.icms.com.au/wfmh2003

March

1-4

7th National Rural Health Conference
Hobart, Tasmania

Tel: 02 6285 4660
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WINTER 2001

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For information on transcultural mental health issues contact the ATMHN or your local transcultural mental health service. For those living in the Northern Territory or Tasmania contact your local Department of Health.

Australian Transcultural Mental Health Network

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Transcultural Mental Health Services

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NSW Transcultural Mental Health Centre	02 9840 3800
QLD Transcultural Mental Health Centre	07 3240 2833
SA Transcultural Mental Health Network	08 8243 5613
Victorian Transcultural Psychiatry Unit	03 9417 4300
WA Transcultural Psychiatry Unit	08 9224 1760

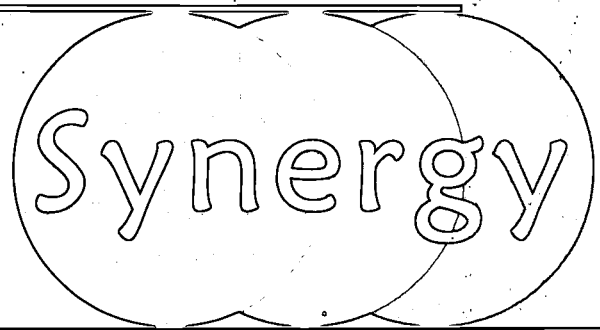
Other Contacts

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Carers Association of Australia	02 6282 7886
Federation of Ethnic Communities	
Councils of Australia	02 6282 5755
Mental Health Council of Australia	02 6285 3100
National Ethnic Disability Alliance	02 9891 6400
National Forum for STARTTS	02 9794 1900

Government Mental Health Services

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ACT Dept. of Health and Community Care	02 6205 5111
NSW Health	02 9391 9000
Territory Health Services, NT	08 8999 2400
QLD Health	07 3234 0111
Dept. of Human Services, SA	08 8226 8800
Dept. of Health & Human Services, TAS	03 6233 3185
Dept. of Human Services, VIC	03 9616 7777
Health Department of WA	08 9222 4222





Autumn 2001

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7 Trungs Story 3rd Prize in NSW TMHC Young Writers' Competition 2000

9 Evaluation of the ATMHN

11 On having a mental illness in the family - care-giving in immigrant communities

Southern African delegation attending Diversity in Health: Sharing Global Perspectives

The ATMHN is pleased to announce that AusAID International Seminar Support Scheme is funding a delegation of Africans to attend Diversity in Health: Sharing Global Perspectives. The six delegates will present a symposia outlined below and a 'Meet the Experts' lunch.

A critical look at cultural diversity in infant studies

Mark Tomlinson is a clinical psychologist and director of the only mother-infant intervention randomised controlled trial study in southern Africa providing support for mothers affected by deprivation and amongst the highest recorded rates of postnatal depression internationally.



Depression in developing countries: Lessons from Zimbabwe

Vikram Patel is a psychiatrist with extensive experience in the culture and mental health field in Asia, Africa and Europe. His ground breaking work on mental health in Zimbabwe has great relevance for how we think about and deal with mental health problems in a changing world.

A schistosomiasis intervention among rural Malawian schoolchildren: Lessons learned

Chiwoza Bandawe is Malawi's only clinical psychologist, and therefore has a unique perspective on mental health policy and intervention issues in the context of scarce resources. He will also bring a breadth of experience in dealing with the social consequences of HIV/AIDS and refugee issues.



African traditional beliefs and some western medical practices: An uneasy meeting point

Kgamadi Kometsi is a South African clinical psychologist of rural origins. His research into culture and psychotherapy, and the cultural politics of organ transplantation positions him to raise important questions about the ethics and experience of health systems in a multicultural world.

Racial integration of formerly 'white' schools: beyond mental health problems

Esther Price is the Spencer Fellow, University of Cape Town and will present research focusing on key questions of transformation in a post-conflict society, with relevance to similar situations throughout the world.



Critical perspectives in culture and health: southern African voices

Leslie Swartz is recognised as a world authority in the field of culture and mental health. In 2000, he worked for the South African Truth and Reconciliation Commission and has drawn together work relevant to rebuilding traumatised societies.



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Disclaimer

Contributions to this newsletter
do not necessarily reflect the
views of the ATMHN.

Forthcoming Issues:

Young people and adolescents

All contributions must be with the editor by June 15, 2001

Refugees

All contribution must be with the editor by August 15, 2001

*Anyone interested in contributing articles or correspondence for future
issues please contact the editor, on 02 9840 3381 or*

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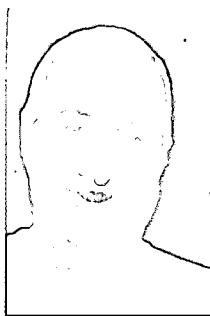


*The ATMHN is an initiative
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Department of Health and
Aged Care.*

Gender, culture and child mental health: a view from South Africa

Professor Leslie Swartz
Department of Psychology
University of Stellenbosch
South Africa

In 1994, South African had its first democratic election, and after centuries of colonisation and, latterly, apartheid, the country now has what is recognised as one of the most liberal constitutions in the world. In every aspect of South African life, there are attempts to build a human rights culture, in which each person is valued, and through which every group is granted respect and dignity. Archbishop Desmond Tutu, Nobel Laureate and formerly chair of the South African Truth and Reconciliation Commission, speaks of celebrating diversity in the South African 'rainbow nation', and the State President, Mr Thabo Mbeki sees South Africa as spearheading what has been termed the 'African Renaissance'.



Professor Leslie Swartz

Professor Swartz has been appointed international evaluator of the Australian Transcultural Mental Health Network

Legislation promoting and protecting diversity and minority group rights has been promulgated. For example, there are now 11 official languages in South Africa, whereas under apartheid only the home languages of the majority of whites (English and Afrikaans) were officially recognised. In keeping with the new focus on human rights, in public discourse in South Africa, there is special concern with the rights and wellbeing of children and those who look after them.

As the euphoria following South Africa's relatively peaceful transition to democracy has subsided, and especially in the post-Mandela era, there has come to be a more sober assessment of what is actually possible in the new 'rainbow nation'. Crime statistics are amongst the worst in the world, and there is a tension between the desire to build human rights and the wish to act forcefully against crime (and especially crime against women and children). The economy is not nearly as strong as had been hoped for, and the sheer cost of providing for diversity makes many plans unrealisable at present. This means, for example, that, if anything, English has come to be more dominant as a language in South Africa than it ever was before; indigenous language rights in all aspects of public life, including health care, social services and education, are commonly paper commitments with no real substance. Added to this is the tremendous and frightening burden of the AIDS epidemic - for example, in KwaZulu/Natal Province in 1997, 26.9% of women attending antenatal clinics were HIV-positive. Women are at particular risk for HIV infection for a host of social and cultural reasons, as well as because male-to-female transmission of the virus is more biologically efficient than female-to-male transmission. Even in the Western Cape, the province having the lowest HIV prevalence rate, anecdotal evidence suggests that there is scarcely a public health facility which is not burdened with HIV, AIDS and their consequences. All of this holds implications for mental health services and resourcing of such services.

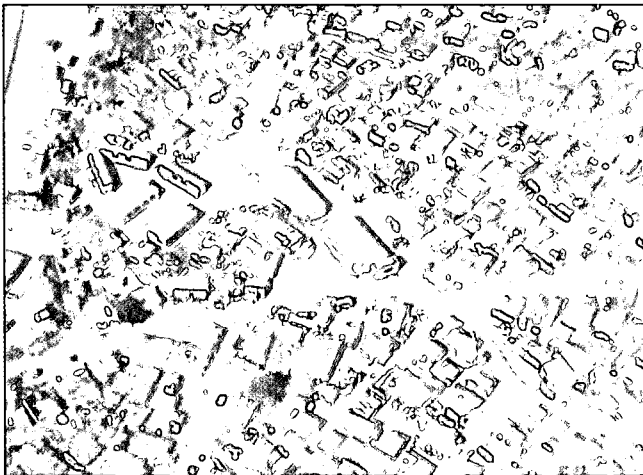
Given the combination of enormous changes in South Africa and the continuing challenges the country faces, the ways people live their lives are changing. As in other developing and low-income countries, South Africa is a rapidly-urbanising society, and every large town or city in the country has its share of informal settlements and shanty towns. The absence of social security of any kind for the unemployed contributes to a spiral of crime. Work in which colleagues and I are engaged in Khayelitsha, a peri-urban settlement near Cape Town, has found the rate of postpartum depression to be 35% - approximately

Continued Overleaf

Synergy Summer 2000

three times the usual rate internationally. These women are commonly far away from their own mothers, who remain in rural areas, and many women in Khayelitsha do not have male partners. This is reflective of general trends: more than half of South Africa's children are born out of wedlock, commonly to women not in any ongoing relationship with male partners. There are, furthermore, many AIDS orphans in South Africa, and as the illness spreads there will be more and more such orphans, with minimal public funding available to take care of them. The burden on communities and on informal helping networks is likely to increase. More women than men will die of AIDS, and there will therefore be a pool of children in urban areas often far away from the traditional supports of grandmothers, who will be in need of care, usually from other women in the community.

All these changes cut across an existing diversity of understandings of whom children belong to and what parenthood means. Many South Africans practise a system of bridewealth (lobola) whereby the groom's family will pay the bride's family (traditionally in livestock) on marriage, and the bride will join the groom's homestead. This practice, like many other customary practices, was appropriated and corrupted in 'customary' legal regulations imposed from above by colonial and apartheid governments in collaboration with 'traditional' leaders who at times had little credibility with the people whose 'traditions' they supposedly upheld. When a woman has had a child out of wedlock, this may affect her prospects for securing bridewealth for the family. In such cases, damages may be claimed from the father of the child, if the father is known and accepts paternity. As South Africa



Khayelitsha is a peri-urban settlement of over half a million residents on the outskirts of Cape Town. Many residents regularly return to their birth place, rural Eastern Cape 1600 km away, in search of employment and services and key life moments, such as funerals and circumcision school for initiation purposes for young men.



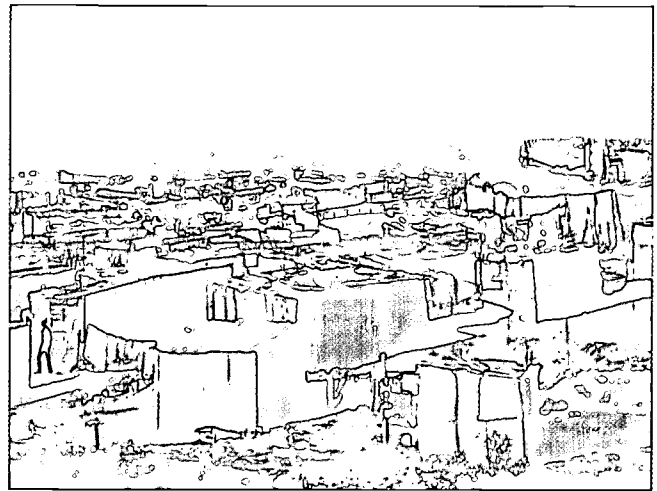
The majority of Khayelitsha residents are unemployed and there is no social security. Living in poverty leads to overcrowding and networks are often formed across traditional boundaries simply so people can survive. Situations arise where family and friends are forced to cooperate financially and functionally in order to survive.

changes, however, and especially in the context of strong moves towards gender equality in the country, there is considerable debate about bridewealth and other practices which are labelled 'customary'. A complicating factor with all such practices is that the apartheid regime in particular relied upon notions of 'custom', 'tradition' and 'culture' to divide and rule disenfranchised South Africans. Some African people, self-styled, styled by the apartheid regime, or true hereditary traditional leaders, were co-opted into the divide and rule system. For obvious reasons, such persons may well have a continuing interest in claiming special status when it comes to determining the parameters of family life in South Africa.

Where then does this leave South Africa's children and those who provide mental services for them and those who look after them? The reality is that the old pattern of the male-dominated household with men and women fulfilling traditional gender roles no longer holds in many cases. It is also the case though that the idea of 'African tradition', in all its complex and contradictory meanings, holds tremendous sway for at least two interrelated reasons. First, in a frightening and rapidly changing world it is hardly surprising that people hanker after an image of the past in which roles are depicted as having been clear, and society well-ordered. Second, the systematic vilification of black people over generations in South Africa has led responsible black South Africans to wish to redefine their heritage and identity as something to be proud of and, indeed, to be celebrated. There is a gap, though, between the image of seamless cultural continuity and the reality of a confusing world where roles are changing and have to be rapidly redefined and renegotiated under straitened circumstances. This gap is probably growing all the time.

Not surprisingly, it is precisely at this point of disjuncture where mental health workers often work: with people who are stressed and struggling both economically and with a bewildering confusion of role expectations. In this context, being 'culturally sensitive' as a mental health practitioner can never mean simply accepting one fixed view of what is culturally appropriate to a particular context. On the contrary, it means being constantly engaged in raising questions about and debating issues of culture, and being alert to ways in which notions of 'tradition' may be used both to assist people and to legitimate the abuse of power. Gender violence and child abuse, for example, are commonly defended with reference to 'traditional African values'. It is clear that the notion of tradition can be appropriated and abused, and clinicians in South Africa, whether they share a linguistic or supposed cultural background with their clients or not, must be aware of this.

Issues of this type affect not only poor people and not only black people. Changing gender roles in middle class households (regardless of race) lead to a situation in which some men are playing far more of an active role in childrearing than did their fathers, a trend which reflects similar changes throughout the Western world. When relationships break down, courts cannot and should not simply assume (as they did, by and large, in the past) that mothers are 'naturally' the best custodial parents for children. Mental health professionals who advise the courts on custody issues have to take account of changing roles. But they need to be aware as well of the pull of longer-standing gender role ascriptions and ideas about childhood. The dilemmas are multiple and complicated. Much of the research on custody and placement issues (including the fraught debates on cross-racial adoption)



The population of Khayelitsha is expanding rapidly due to the rapid rural-urban migration, there is also considerable movement within the area from unserviced to serviced areas and from violent to less violent areas.

comes from the USA and similar countries. South African cultural conditions, however, demand a slightly different emphasis at times. Consider, for example, the situation when a South African clinician is faced with a white Afrikaans-speaking father's plea that his son should stay in his care because he will assure his son's continued contact with the land and with the African bush. This plea, which in other contexts could be seen as of little psychological relevance, cannot be understood fully by reference to dominant western research. There is a long tradition within certain aspects of Afrikaans culture of an appeal to the land as signifying and indeed providing an emotional home. It is a challenge to clinicians to consider how best to take account of such a tradition in order to make the best recommendations for child care.

The ways in which culture enters the work of South African mental health practitioners are myriad and not entirely predictable. The task is not to have a recipe or formula for how to think about culture and mental health but rather to develop and to hold on to an intellectual and emotional flexibility about cultural issues. Nothing can be taken for granted; nothing can take privileged place as more 'truly cultural' than anything else. If this flexibility and fundamental scepticism (in its most positive sense) with respect to culture is necessary in South Africa, though, then how much more so is it relevant to the Australian situation. In Australia, contradictory processes of cultural assimilation, change, resistance and strife are common both amongst those who are new to the country and those who must adapt to the changing sociocultural environment. Perhaps a sense of how challenging these issues are in the South African context may help Australian mental health workers to maintain their flexibility without being overwhelmed by the undoubted challenges. □

Implications for clinical practice:

- * Do not assume that you 'know' a person's cultural background through external characteristics - always allow for discussion about this.
- * People may be ambivalent about their cultural identities - do not assume they value what you expect them to value.
- * 'Cultural brokers' and other informants are very useful but always remember that their agenda may be very different from those of clients.
- * Trauma and violence within and between communities can affect different community members differently - listen for the individual stories.

LATEST NEWS

Turn off the TV

Aggressive behaviour in children could be reduced by cutting their exposure to television, videos and electronic games, American researchers have found. Dr Tom Robinson of Stanford University said it was encouraging that some of the adverse effects of the electronic media - such as violence, teasing and bullying - could be reversed "solely by decreasing that exposure".

Dr Robinson and his team compared 105 children in one school who reduced their exposure to media violence for six months with 120 others in another school who did not. Both groups were from similar family backgrounds and aged around seven and eight years old.

The first group were asked to limit TV viewing to no more than seven hours a week and to be more selective with videos and games. At the end of six months, the children in that group had cut their TV viewing by a third and were less likely to see their peers as aggressive than at the start of the study.

And they were involved in about half as many incidents of aggressive behaviour as the second group.

Both boys and girls benefited from the intervention, he said, and the most aggressive students at the start of the study experienced the sharpest drop in combative behaviour at the end.

Sydney Morning Herald

National Register for counsellors and psychotherapists

Greater accountability for Australia's growing body of counsellors and psychotherapists has moved a step closer to reality with the establishment of a National Register of Psychotherapists and Counsellors by the Psychotherapy and Counselling Federation of Australia (PACFA).

The register will enable members of the community seeking the help of a counsellor or psychotherapist to be assured that the person they select has reached a recognised level of professional training, and that the person accepts and maintains the profession's standard for ethical conduct.

It is expected that the National Register of Psychotherapists and Counsellors will soon become the standard by which professional credibility is assessed, and also the primary reference for employers seeking to appoint a counsellor or psychotherapist to their organisation.

Forms for application for inclusion in the Register are now being distributed to the member professional associations of PACFA. It is expected the Register will be available online via PACFA's web site by June. The first print version will be available later this year. Eventually, some 3 000 counsellors and psychotherapists will be included in the Register. For further information please contact PACFA on tel: 03 9639 8330 or email: PACFA@bigpond.com.

RITALIN USE IN CHILDREN

One in every 36 boys in the latter years in primary school in NSW is taking stimulant medication for attention deficit hyperactivity disorder (ADHD), new NSW Health Department figures show. This represents a ninefold increase in their use between 1990 and 2000.

The prescription rate is four times higher for boys, but is growing for girls, and any NSW primary classroom has a one-in-two chance of including a child taking drugs for the condition.

Those aged seven to 11 are most likely to be prescribed the drugs and prescriptions continue strongly in the 12-15 age group, before falling away with those aged 16-17. The figures also reveal that an increasing proportion of children are taking drugs long-term, possibly into adulthood.

But the rising use of stimulants comes as overseas research questions their long term effectiveness in treating ADHD, compared with non-drug therapies.

Professor James Swanson, Professor of Pediatrics at the University of California, revealed results from a survey of 579 ADHD children in the US, which showed drugs were the most effective therapy in seven-to-nine year olds when their progress was checked a year later. But those who had undergone behaviour therapy, with or without drugs, fared better when they were followed up at age 15, he told a Sydney forum. In the US 'half of ADHD kids get arrested by age 18; that's six times the base rate of arrest.'

Sydney Morning Herald

Trung's Story

Prize winner in NSW Transcultural Mental Health Centre's Young Writer's Competition 2000

By Tin Ly

This story written by Tin Ly won Third Prize in the Young Writers' Competition 2000. The Young Writers Competition is an annual competition coordinated by the NSW Transcultural Mental Health Centre's NESB Youth Mental Health Network in conjunction with the TMHC School-Link Project.

The aim of the competition is to provide all young people with an opportunity to creatively express their concerns, thoughts, feelings and experiences about issues that directly impact on young people living in a multicultural society.

The competition is open to all young people, not only young people from culturally and linguistically diverse backgrounds. The competition in this way challenges all young people to think about the impact that immigration has on families and young people living in Australia.

Tonight sitting under the sad looking moon, I suddenly remember my best friend Trung, and I am hoping that wherever he is now, he has forgotten his pain.

I knew Trung from Liverpool Boy's High. I remember it was a Friday morning when I saw Trung walking out of the toilets looking very worried. I asked, and was told that he had just left home.

He had arrived in Australia in mid 1992, with his family, at the age of 10. His parents, being new to the country, spent a lot of time working to earn money. Because this was our first year in high school we stuck very close together. I got along very well with him because we liked to do the same things, and didn't attempt many sporting activities.

In the eyes of other friends Trung had a perfect family, nothing could stop him from getting what he wanted. But they didn't realise that Trung had one of the most unfortunate childhoods I had ever come across.

Trung's face was wet with tears. I knew that Trung had swallowed the pressure from his family for a very long time. That day we didn't attend class. I walked him to Westfield and sat beside him and listened very carefully to Trung's story which made me feel that I was much more lucky than a lot of people in this world.

Trung told me that when other people looked at him they wished that they could become him. "But did they ever realise that my life is not what it seems to be! Yes! Money overcomes many things, yes! I have money. But money is not important to me. What I really want is love! Everyday I feel very desolated. Since I knew how to walk and play... Tim! I can't take this any more". Trung continued with tears falling like rain. "Six! Since I was six years old I have had to cook my own food, all day walking around trying to find some fun. No one looked after me. Both of my parents were too busy at work. Sometimes I really wanted to run to mum and cry, so that I could get a close hug and kisses. But I can't! Because by the time they got home I would be fast asleep. Even if I was still awake, they would be too tired to do any of those things. I did not complain or get upset. I knew that they worked hard just for my future."

Continued Overleaf

Synergy Summer 2000

"Tim! I could forgive them four years ago, but not now. Now that I can look for love outside of the home, suddenly they object to every decision that I make! In their mind I am still just a child or a kid. Living in that house is like living in a gaol. No freedom or respect as a teenager! I thought I had freedom as a child, but it was really neglect! Tim, I don't know what to do!" I never saw Trung again.

Very soon after this day, both our families moved, and I did not know how to contact him. I often wondered how he was going and always planned to look him up. This was not to be.

On 18th September 1999 Mrs Nguyen, Trung's mother, called me to inform me of Trung's death. I shook in disbelief at the words of Mrs. Nguyen. I felt as if I was not myself and this was just a bad dream. I tried, without success, to find out the reason for my friend's death.

Two days after the funeral I received a box in the mail. It was from Trung. This meant that Trung already knew where I lived before he committed suicide. I felt as if I was the worst friend ever, because I was not there when I was really needed. The box inside was a diary of his death.

This is Trung's diary
(translated from Vietnamese)

Tim! You must be really angry and sad, but that's life Tim. Nothing is perfect. My life is nothing! I have nothing and I live for nothing. I worry a lot Tim, worry that no one will find out the reason for my death. Tim! Where did you go? Oh did you watch the movie 'The Mask'? I did! I really liked it, because.... I wear a mask Tim. I put it on every day, a happy mask! At school and at home, I

only take it off when I'm by myself. Tim! I really wanted to cry, but all of my tears were dried up. I'm tired Tim! Tired of my role, tired to live because there is nothing for me to live for. I hate pretending, I hate to put that mask on myself, to be happy to please people. Who'll please me!? My parents are still into work Tim, hey! I ask myself when I'm dead, where's all the money that my parent's make going to go? Anyway I'm in love Tim. She's nice and kind! By the way she likes me because she thinks I'm funny, so I decided to keep the mask on. She is the only hope for me now Tim.



Tin Ly (age 16) (formerly from Fairvale High School) with Mr Geoffrey Garland, Principal, Canley Vale High School

Tim! Like I said things never turn out to be the way you expect. I'm stupid, nothing but a cloud. She didn't love me! She never loved me anyway. She used me as if I'm a toy for her to play with. She used me to win money. She went out with me because of a \$10 bet. Tim! Life is unfair I cannot stand it, I don't want to see it happen. I want to be free where no one can hurt me again. The one right, decision that I've made and never regret, was to have you as a friend. Good luck to you, Tim.

I now have to face the fact that my friend is no longer alive. I spent a lot of time wondering back to the past, when I was still in Liverpool, and all the happy times of our friendship.

It's since occurred to me that many Vietnamese parents living in Australia are very confused about their values and don't know how to behave towards their children. They are still very strict and restrictive in what they allow their children to do socially, as they were in Vietnam. However, they are not available to their children to provide love and family support as they would in Vietnam. They are too busy making money, so the children are only getting all the negative things – no freedom, and no love or family support. This can cause a lot of stress in a young, sensitive person like Trung.

Stress can be a well-planned... murderer, which builds up and uses emotional pain as a weapon to kill people. From this tragic incident, we can understand how the feeling of being 'left out' or 'played with' can really create the type of stress that destroys a person's self-esteem, especially a young inexperienced and sensitive person. Trung was not tough, and because of his family problems, did not have the skills to solve his problems.

Trung because of my sudden departure from Liverpool, I didn't get to say goodbye. But all that is left, now, is just memories. Wishing you a thousand lucks wherever you are now. Your three weeks mate....

Tim

The Young Writers' Competition 2001 winners will be presented at Diversity in Health: Sharing Global Perspectives.

Evaluation of the Australian Transcultural Mental Health Network

Conrad Gershevitch
Commonwealth Department of Health and Aged Care



With completion of the second funding phase of the ATMHN in June 2001, the Commonwealth Department of Health and Aged Care is assessing the achievements, administration and general effectiveness of the ATMHN over the last couple of years and WestWood Spice Consulting and Professor Leslie Swartz (Child Guidance Clinic, University of Cape Town) have been contracted to conduct an evaluation from both local and international perspectives.

The evaluation will be conducted in parallel by both consultants. Westwood SPICE will collect information on how well ATMHN objectives have been achieved, the organisation's efficiency, client satisfaction and internal management. Professor Swartz will provide an international perspective, examining the work of the ATMHN in relation to contemporary theories and practices. The evaluation will also look at the relationship between the ATMHN and mainstream health and mental health services as well as specialised programs (such as trauma and disability services).

It is envisaged that a comprehensive analysis of the Network will be gained by evaluating both the workings of the ATMHN as well as comparing its model of operation with similar programs in other countries. This will assist the Department to assess the future directions for the program.

PROJECT TIMELINES

The local evaluation commenced in early 2001 and is due to report mid year. The WestWood Spice team will be seeking to consult with as many stakeholders in the ATMHN as possible. This will include visits to speak with the funding body, member organisations, local networks, staff in relevant services and consumers of ATMHN products and services. Professor Swartz will be in Australia from early May to June 2001. Both he and WestWood Spice will be participating at the Diversity in Health Conference in Sydney on 28-30 May 2001.

ABOUT THE CONSULTANTS

The WestWood Spice evaluation team consists of Deborah Fullwood (Project Manager) and Anne Gotsis based in NSW, Greg Turner in Queensland and Peter Gibbs in Victoria. The group has extensive experience working with government funded community organisations in the areas of mental health, aged care, disabilities, child care, juvenile justice and education and training. This has included program evaluations, policy development and financial viability studies.

Professor Leslie Swartz has a background in public health, clinical psychology and is an expert on the complex political and organisational issues that affect culture and health care. He has also been associated with the truth and reconciliation processes in South Africa. As the Associate Editor on the prestigious international journal *Transcultural Psychiatry*, Professor Swartz is in contact with people from many parts of the world working in this field.

WANT TO KNOW MORE?

If you would like to discuss the ATMHN evaluation or to offer comments on the services and the role of the ATMHN, please contact Peter Gibbs from WestWood Spice on
Tel: (03) 9548 1940 or
email pgibbs@bigpond.net.au

Handbook of multicultural mental health: assessment and treatment of diverse populations.

This handbook is divided into four parts. Part 1 provides a foundation of history, theory and concepts. Part 2 addresses methodological concerns vital to understanding and interpreting data obtained in cross-cultural clinical practice regardless of whether etic or emic measures were used in assessment processes. Part 3 provides essential content knowledge and research-based clinical knowledge. Part 4 addresses training concerns with respect to multiculturalism, undoubtedly a potent force in the behavioral sciences

Edited by Isael Cuellar

Freddy Paniagua

Academic Press ISBN 0121993701

Moderating effects of culture on suicide risk factors

A dissertation presented to the Faculty of Pacific Graduate School of Psychology Palo Alto, California.

Mondesir, Dr Darline

2000 ISBN 1587216876

Ethnicity and psychopharmacology Ruiz, Pedro (ed)

This book addresses the most theoretical and clinical aspects of ethnopsychopharmacology, with the aim of advancing this growing field well into the twenty-first century.

Review of Psychiatry, Volume 19; no. 4

American Psychiatric Press, Washington D.C.

ISBN 0880482745

Hidden messages in culture-centred counselling: a triad training model

Nowhere in the literature has the theory behind the Triad Training model been brought together and presented in a unified format. In this publication the author presents the theoretical underpinnings of the model, drawing not only from counselling but also from social psychology and other fields. Also shown are the major applications of the model in counselling training and education, some of the nontraditional applications, and the model's flexibility in a wide range of professional, practical/clinical, and academic contexts.

Pederson, Paul B.

Sage Publications, California 2000. ISBN 0761918078

Serbian Australians in the shadow of the Balkan War.

Using a mainly ethnographic approach this book explores how the Balkan wars have affected the everyday life and mental health in particular of Serbian immigrants and their families in Australia, and how they have responded to long distance grief, devastation and dislocation.

Procter, Nicholas G

Ashgate, England 2000. ISBN 0754612473

The psychiatric interview: a guide to history taking and the mental state examination.

This is a unique book. It deals with the basic issues in psychiatric assessment-which without guidance, may be distressingly difficult-and reduces them to easily digestible facts. This is a book for all those working in the field of psychiatric disorder. It is invaluable to medical students and doctors training in general practice, emergency medicine and psychiatry.

Pridmore, Saxby.

Harwood Academic Publishers. Singapore, 2000

Shifting the balance: services for people with mental illness in Central Australia: a framework for planning and resource allocation

This report explores two important issues for people who experience mental illness. The first issue is benchmarking the minimum level of funding required to provide basis specialist mental health programs. The second is; investigation the mix of services required by people experiencing mental illness. This project is one of the first attempts in Australia to grapple with these issues for people who live in remote areas.

O'Kane, Ann and Komia Tsey

Menzies School of Health Research, Casuarina, NT
1999

Macedonians in Victoria: Community Profile

This community profile is primarily written for human services decision-makers and providers to better understand Australians of Macedonian background, although it is intended to provide useful information to those who have an interest in the Macedonian culture. Macedonian Welfare Workers' Network of Victoria
Melbourne, 2000.

On "having a 'mental illness' in the family" – Care-giving in immigrant communities

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This brief article summarises the findings of a much larger report on "Care-giving and the social construction of 'mental illness' in immigrant communities." This report was launched on March 9th 2001, and provides a full account of our investigation into how carers' understandings and experiences of 'mental illness' and their utilisation of support services are influenced by factors such as culture, language, the experience of migration, and social relationships. Carers were drawn from the Bosnian, Chinese, Croatian and Polish communities of Perth, Western Australia.

Qualitative methods were employed in order to investigate the support services available to the carers of people who have been diagnosed with a 'mental illness'; and the informal support systems utilised by carers from immigrant communities. Focus group discussions with community members and in-depth semi-structured interviews with carers and health and mental health practitioners were conducted. In these, we explored carers' understanding of mental health and illness; their 'help-seeking behaviour'; the roles they played in the lives of their relatives; and their lived experience of the settlement process in Australia.

MAJOR FINDINGS

Care giving was described as an exhausting and ongoing duty. Most of the carers interviewed stated that there was simply no one else available to help. Many carers regarded caring as exclusively a family responsibility. In addition to financial burdens, social isolation and disruptions to daily life, considerable pressure is often placed on carers and their families. Some carers reported distress and frustration, and a number of carers described periods of verbal and physical violence. Many carers expressed a strong desire for 'time out', or for some relief from their roles. However, none of the carers interviewed were aware of any of the support services available to them, and indeed, many were more concerned with obtaining social support for their distressed relative. One carer suggested that there was a need for greater community acceptance of people diagnosed with 'mental illness', and that this kind of ongoing 'community support' would facilitate the 'resumption of a normal life', for both people with problems in living, and their carers. Carers also requested access to material forms of assistance. That is, help with mundane duties such as house and garden maintenance, and access to services such as 'Meals on Wheels', and childcare. However, it was also noted that a thorough assessment of the particular needs of individual carers should always precede any offer of service or support.

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

Continued Overleaf

Synergy Summer 2000

Many carers reported that they were 'coping in isolation.' A number of participants asserted that some families have isolated themselves out of fear of stigma and ostracism from their community, and out of the conviction that caring for 'the mentally ill' is exclusively a family responsibility. The social isolation of carers from immigrant communities may become more pronounced through difficulties in acculturation, broken social networks, discrimination and racism, socioeconomic restrictions, and due to the stigma often attached to 'mental illness'.

STRESS, MIGRATION AND MENTAL HEALTH

A strong theme that emerged from the interviews was that of the impact of migration on mental health. Many participants considered migration to have a significant impact on mental health, and were adamant that these issues needed to be taken into

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

Polish Carer

consideration in any discussion of mental health and illness in immigrant communities. It should be noted that these participants also stressed that many of the mental health issues faced by migrants are similar to those faced by the 'mainstream community'. With regard to the effects of migration on mental health, participants reported that the isolation and loneliness experienced by many recent migrants often leads to psychological distress, and that the absence of support in stressful situations may exacerbate this distress. Further, people may grieve for the loss of their family, friends, and familiar way of life. Others may experience a 'postponed reaction' to the migration experience. A number of

participants reported that 'cultural clashes' between generations may be a further source of psychological distress, and that young migrants may experience 'peer pressure' and discrimination.

Some participants argued that migration itself is not the major precursor to the development of mental health problems, but may be a risk factor for mental health, and that this is particularly the case for refugees. A number of participants asserted that the manifestation of mental health problems related to traumatic experiences is dependent upon the circumstances that exist after settlement. The stress of resettlement may compound 'traumatic dislocation', which can result in mental health problems. The loss of status due to unemployment, or downward mobility, may render people from immigrant communities particularly prone to psychological distress.

A number of participants reported that people are often more tolerant and supportive of the 'mentally ill' and their carers within smaller, close-knit communities. Some participants noted that people diagnosed with a 'mental illness' are less likely to be stigmatised if there is seen to be a precipitating 'cause' (for Bosnian and Croatian groups, recent war experiences were frequently cited as a cause of 'mental illness'). It was also reported that people from cultures more proximal to the 'Anglo-Australian' culture may be more likely to benefit from existing support services, and that religious groups may provide a vital support mechanism for some groups.

Speaking openly about 'mental illness' was described as 'interfering

in other people's problems', and as being culturally inappropriate. Participants from all four cultural groups reported that 'mental illness' was heavily stigmatised in their communities. A number of participants suggested that mental illness' may be 'destigmatised' via more information about forms of psychological and psychiatric treatment, and through professional explanations that emphasise 'normal responses to life's problems', and 'stress management', rather than 'madness', and 'illness'.

From the carers' accounts, it is evident that health and mental health systems are often not sensitive to differences of culture and language. The service providers interviewed also drew attention to the need for 'mainstream' services to become more culturally competent. Carers also reported difficulties in communicating with service providers, and that they found it hard to gain access to clear explanations about the 'condition' of their relative. These difficulties are compounded by the fact that mental health information is often only available in English.

COMMUNICATION DIFFICULTIES

Communication issues emerged as a major barrier to culturally and linguistically diverse clients' utilisation of services, understanding of information, and interactions with health professionals. Further, language barriers can reinforce the reliance of people experiencing problems in living on their immediate family. These 'communication difficulties' are not merely the result of the inability of many service providers to communicate in a language other than English. Carers, community members and mental health practitioners all characterised medical consultation times as being

too short to conduct a 'meaningful conversation'. This may be particularly pronounced when an interpreter is present.

Some general practitioners reported difficulties working with interpreters, and expressed reservations about their financial cost to their practice. According to community members and carers, whilst interpreters are usually welcome and often necessary, in particularly sensitive situations, such as in the discussion of psychological problems, care must be taken to employ an appropriate interpreter. Trust and confidentiality were raised as issues that may concern people when faced with an interpreter from the same community. Ethno-specific, and bilingual, professionals were described as a vital resource for culturally diverse clients.

PRACTITIONERS' CONTACT WITH CARERS

General practitioners are often the first, and sometimes the only, health professionals approached by carers. Many carers regarded general practitioners as especially trusted figures, as they have ongoing contact with families. However, general practitioners were not necessarily aware of the support services available to carers. Of those who were aware, none had followed up as to whether their clients had accessed these services. It was also reported that the short consultation times available with general practitioners operate as a barrier to discussing mental health concerns.

It was noted that people from immigrant communities who are experiencing problems with living tend to seek professional help only after other avenues have been exhausted, or once their problems have become unmanageable. Several mental health practitioners asserted

that the stigma associated with 'mental illness' contributes to the late presentation or referral of many clients from immigrant communities. The 'pathways' people took, before reaching a mental

support services being perceived as culturally inappropriate or as unable to meet their needs. It was noted that the regionalisation of available services may prevent people from accessing the assistance they might

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

Bosnian Carer

health practitioner were many and varied. Participants reported receiving referrals from other health care providers, and other mainstream service providers (e.g. Centrelink); religious institutions or spiritual centres; indirect, and less formal routes (e.g. adult education classes); and that some clients 'self referred'.

The practitioners interviewed reported that different practice situations provide different opportunities for contact with carers. Practitioners also differed in their views about the need to see carers. Some practitioners asserted that carers may usefully assist practitioners by describing the client's 'problems with living'. Torture and trauma counsellors reported their preference for working with clients and their carers. The participants also agreed that reaching a common understanding of concepts relating to mental health and illness was essential to the development of trust in therapeutic relationships.

ACCESS TO SUPPORT SERVICES

The carers interviewed described a number of difficulties in accessing support services. These include the lack of knowledge held by carers about the existence of support services; the belief that caring is exclusively a family responsibility; previous negative experiences in trying to access support; or to

prefer if given the choice. Further, a number of carers reported having to be pro-active in order to receive information about the mental health of their relative. These barriers are perhaps compounded by the fact that many carers reported significant difficulties with the English language.

The participants reported that language barriers and social isolation make it especially difficult for carers from immigrant communities to access support services. It was also noted that the stigma attached to 'mental illness' may prevent carers from seeking support, and that, in any case, many services do not have the resources to adequately meet the needs of people with mental health problems and their carers. Further, support services are seldom adequately publicised. However, a number of participants did note that some carers manage to obtain support through migrant resource centres and religious institutions.

STRATEGIES FOR SUPPORTING CARERS

It was suggested that carers' utilisation of support services could be improved by increasing the cultural sensitivity and cultural competence of these services, and through the development of partnerships with carers and ethnic communities. Community education was also suggested as a useful strategy, as were various

Continued overleaf

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concrete improvements in support services for the 'mentally ill'.

The participants in the study offered a comprehensive series of suggestions as to the means by which the support available to carers from immigrant communities might be improved:

- Carers need access to education, information and support. It was noted that informed and well-supported carers are vital partners in the process of the early identification of mental health related problems.
- Migrants should be familiarised with the Australian health system.
- Ethnic media, and in particular, ethnic radio, could be used to provide information about mental illness and to reduce stigma through community education.
- The mainstream media need to take on a more significant role in providing culturally accessible information about mental health issues.
- Migrant resource centres, religious institutions and other spiritual centres need to be supported in their provision of support and information about mental health.
- Ethnic clubs and other ethnic organisations need to be provided with the resources to play a more pronounced role in addressing the needs of specific communities.
- Culturally and linguistically appropriate information should be made available from general practices.
- More information should be provided in languages other than English and both government and non-government sectors should become involved in the provision of information about mental health, and mental health promotion.
- Language-specific support groups should be formed within existing

support organisations.

- There is a need for more bilingual practitioners and culturally competent workers within the mental health system, as it is the language skills of practitioners, and their cultural competency, rather than their status as a member of their client's ethnic community, that enable 'culturally appropriate' support.
- Training in cultural competency could serve to reduce the incidence of cultural stereotyping and racism that may occur when practitioners are faced with clients from an unfamiliar culture.
- Clients from immigrant communities should be encouraged to provide input for the planning and evaluation of mental health and support services.

CONCLUSION

These results clearly demonstrate that carers from culturally and linguistically diverse communities face a particular series of challenges. They are subject to the barriers typically encountered by the unpaid full-time carers of people diagnosed with a 'mental illness' (e.g., Morse & Messimeri-Kianidis, 1997). That is, the carers interviewed experience social isolation, financial burdens, and describe themselves as being stressed and tired. However, for carers from immigrant communities, these barriers are compounded by a number of factors. 'Mental illness' is, particularly stigmatised across culturally diverse communities. As the carers themselves attest, this makes it especially difficult to seek external help, for fear of a negative reaction from the community. Caring is also often regarded as exclusively a family responsibility, thus discouraging access to external agencies. Communication difficulties and short consultation times make it difficult for carers to

have their support needs heard, and cultural insensitivity on the part of health and mental health professionals can make negotiations with an unfamiliar health system particularly trying. In practice, the support and information needs of carers from immigrant communities are not being effectively addressed.

The recommendations contained in the full report of this investigation are based on the issues most frequently identified by the carers, community members, and health and mental health practitioners who participated in this study. Many of these are designed to enhance carers' awareness and utilisation of support services. A number of general recommendations are also presented. These general recommendations provide for the beginnings of a broad, policy-based, support structure for sustainable programs for carers. As many participants pointed out, structural changes are necessary in order to address the complex needs of carers from immigrant communities. □

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A full account of this study is available online, at www.rph.wa.gov.au/hpnetwork

For further information, please contact Renata Kokanovic Renata.Kokanovic@health.wa.gov.au

Book Review:

The Spirit Catches You and You Fall Down

Anne Fadiman

Review: Sandee Baldwin, Australian Transcultural Mental Health Network

The Spirit Catches You and You Fall Down explores with extraordinary skill the clash between the Merced Community Medical Centre in California and a Hmong refugee family from Laos over the care of Lia Lee, a child diagnosed with severe epilepsy. The Spirit Catches You, winner of the National Book Critics Circle Award for Nonfiction, USA is an excellent study in cross-cultural medicine

In 1981 Lia Lee was born to a family of recent Hmong immigrants and soon developed symptoms of epilepsy. By 1988 when Ms Fadiman met the Lees, Lia was living at home but was brain dead after a tragic cycle of misunderstanding, overmedication, and cultural clash.

Lia's treatment was complex, her anticonvulsant prescriptions changed 23 times in four years. The Lees were sure the medicine was bad for Lia, and their lack of administering the medication correctly led to regrettable claims of negligence of the parent's care for Lia.

In the Lees' view, Lia's soul had fled her body and become lost, her epilepsy a sign that the spirit had caught Lia causing her to fall down. American doctors, in turn often considered the Hmong to be ignorant and too reliant on animal sacrifices. Unfortunately during Lia's treatment, the assumptions and beliefs that both parties brought to the patient-doctor interaction were never adequately explored.

Ms Fadiman weaves the story of the Lees, their doctors and the social and political history of the Hmong people and their unwilling immigration to the United States into an informal cultural anthropology.

We learn for example that long before the Lees even considered going to the United States they had heard rumours about American doctors: doctors casually take blood from people, including children (the Hmong believe the body contains a finite amount of blood that is not replaceable); doctors anaesthetise patients and in so doing put their patients soul at large, leading to illness or death.

A wonderful aspect of Ms Fadiman's book is her evenhanded, detailed presentation of two disparate cultures and divergent views. "Ms Fadiman tells her story with a novelists grace, playing the role of cultural broker, comprehending those who do not comprehend each other....her story is a gripping one." The New York Times Book Review, Richard Bernstein

The Spirit Catches You illustrates how much time, energy and commitment are necessary to understand another culture's perspective on health and wellness and to translate that understanding into the day-to-day practice of good health care.

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CALD Consumer Participation in ATMHN

The ATMHN has joined forces with the National Ethnic Disability Alliance (NEDA) to undertake an exciting new Project that will focus specifically on the mental health needs of people from culturally and linguistically diverse (CALD) backgrounds.

People from CALD backgrounds continue to be under-represented in service usage across the areas of health and disability. Some factors that contribute to the under-utilisation of mental health services include:

- a reluctance to use services due to language and cultural differences
- experience of pre and post migration trauma
- lack of information in community languages
- lack of culturally appropriate services.

A consultation will be conducted very soon in every State and Territory across Australia to obtain information about the needs and concerns of CALD mental health consumers.

Keep a look out for the date and times of these consultations and spread the word to any mental consumers you have contact with.

Some of the outcomes from the consultations will be discussed at the upcoming Diversity in Health Conference. Mental consumers from CALD have been encouraged attend this conference where an additional consultation will be held. Check the Conference program for details.

The information obtained from the consultations will be used to develop local and national strategies, including a five year Consumer Action Plan, that will encourage greater consumer participation in all areas of the mental health sector.

It is also hoped that a network of CALD consumers will emerge from this Project that ATMHN and other groups could utilise in the future.

Finally, the outcomes from the Project will assist with ATMHN strategic planning and other operational and policy purposes.

To find out more about this initiative contact NEDA's Executive Director, Lou-Anne Lind:

Tel: (02) 9687 8933

E-mail: neda@ozemail.com.au

Transcultural Mental Health Project, Tasmania

The Tasmanian project involves reinvigorating the Tasmanian transcultural mental health network, attempting to build a sustainable base for the network, and improving access to information about mental health services for people from culturally and linguistically diverse backgrounds, in particular, for those living in the north and north west of Tasmania.

The Tasmanian project has commenced, and the project officer, Gloria Lee, spent the first few months compiling an analysis of mental health needs within migrant communities in the North and North West of the State. This qualitative study provides a useful overview of the current situation, and identifies barriers between clients from CALD backgrounds and mainstream service providers. The report recommends several key areas for future work.

Gloria has now left the project, and the position has just been refilled. Zhen Xiao has now been appointed, and is in her second week. Zhen has a background in

health promotion and general practice, and it is anticipated that she will bring this valuable experience to the next stage of the project, which will be more focussed on implementation.

The project is supported by a Steering Committee comprised of mental health service providers from the North/North West, the mental health policy adviser, and a representative of the Good Neighbour Council.

Mental Health Services (DHHS) has recently created a new position, of policy officer (Promotion/Prevention). Sarah Dac commenced within the past three weeks. It is planned that this additional policy resource at State Office level will provide more assistance to the project than has been possible until now.

Victoria Rigney
Senior Consultant Policy
DHHS, Tasmania

Reciprocity in Education, South Australia

Reciprocity in Education is a community based model for cultural awareness in mental health. This initiative has developed and trialed a model of educational interaction between members of strategically selected culturally and linguistically diverse communities and health care providers. It has focused on cultural awareness in mental health at a community level, concentrating on depression.

CONFERENCE PRESENTATIONS

Members of the project team are busy preparing three paper presentations for the conference Diversity in Health. These papers will focus on:

- Developing trust with Middle Eastern new arrivals;
- The model of interactive learning, and,
- From policy rhetoric to action (with Conrad Gershevich and Meg Griffiths from the ATMHN)

MIGRATION MUSEUM EXHIBITION AND CELEBRATION

At the same time preparations are well under way for a three-month exhibition about the project which will be launched at the South Australian Migration Museum, Kintore Avenue, Adelaide on Friday June 15 at 10.30 am. Based upon year 2000 visits to the Migration Museum it is estimated that exhibition entitled, The Heart of Acceptance: Cultural Healing Uncovered, will attract a viewing public of approximately 40,000 people. Community participants are working closely with project team in the collection of appropriate artefacts and stories. At

the time of the project launch all the community participants will be awarded certificates of appreciation as a thank-you for the time and effort they gave to the project.

PROJECT EVALUATION

The South Australian Community Health Research Unit has begun evaluating the project. Several interviews have been completed with each of the three community groups. Interviews with key stakeholders, local and international advisory groups, and mental health services will follow shortly. Project evaluation should be completed by mid-late May.

SUBMISSIONS FOR FURTHER FUNDING

The project has inspired a number of new program initiatives in the area of transcultural mental health. Two of these projects will be briefly summarised here:

- Eastern Community Mental Health and Forensic Services are currently consulting with key-stakeholders to use the model with Indigenous clients.
- Migrant Health Service has put forward a proposal for using the model of interactive with Middle Eastern New Arrivals (Iranian, Iraqi, Kurdish, Afghani and others). Funding has been sought from the Department of Human Services Innovative Grants Scheme.

Please contact Dr Nicholas Procter for more information about the Reciprocity in Education Project on 08 8200 3900.

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Promoting Cultural Awareness in the Management of Mental Illness, WA

This project is developing and evaluating an information kit to be used by mental health practitioners to promote culture specific awareness in the management of mental illness in culturally and linguistically diverse communities.

Due to unforeseen personal circumstances, the project officer initially recruited for this project had to withdraw in December last year. This has delayed the project by three months. However, two new part-time project officers have since come aboard and the project has quickly resumed momentum and is meeting its scheduled deadlines within the newly revised and approved timeframe. A comprehensive literature review has since been submitted, as per the scheduled agreement.

A prototype of the tool has been developed and is being pilot-tested by practising mental health professionals from a range of disciplines. This followed a wide consultation phase with practitioners,

which proved valuable in informing the development of the prototype. A further consultation phase will occur at the post-pilot phase. This will be to feedback opinions on the tool's effectiveness. Further modification to the tool is therefore anticipated.

The Project Team has met on a regular basis to keep the project on track and the next phase of the project will be to trial the tool among 200 practitioners. Assistance has been offered by a range of stakeholders to disseminate information about this tool and to promote the trialing of the tool among members of various professional bodies. There has been widespread interest expressed surrounding this project including from a particular pharmaceutical company whose representative has maintained regular contact with the Project Team on the tool's development and has offered valuable assistance where required.

For further information please contact Bernadette Wright on tel: 08 9224 1761

Carer Profile - NESB Carers of People with a Mental Illness

The Carer Profile project is a 9-month project aiming at adapting the generic Carer Profile: The Value of Carer Assessment in Supporting Carer/Family Relationship (Carers NSW, Inc., September 1999). The Carer Profile is an assessment tool, which assist service providers to understand needs and issues around each carer in their caring situation so that better support is provided to the family.

This project looks at carers from two selected communities, Chinese and Greek, who care for a person with a mental illness.

A Carer Survey Questionnaire has been developed and translated into the each languages. Carers will be surveyed via telephone or face-to-face whichever is more appropriate. Currently we are targeting 50 completed questionnaires from each of the communities.

Carers of people with all types of mental health problems, including people with dementia are our target group. Carers of all age groups and country of birth (as long as they identify themselves as Chinese or

Greek carers) are welcome to participate in the Survey. Carers who participate in the Survey may also attend to one of the focus groups happening in May.

There is also a Service Provider Survey Questionnaire which will be sent to health/mental health services, bilingual health/mental health workers, ethno specific and multicultural organisations. A number of focus groups for service providers and workers will also be run in May. Service providers who have an interest in providing a service to carers of people with mental illness from the two communities may also choose to participate in a training session and the trial of the Carer Profile following completion of the survey and focus groups. The trial will be evaluated by consulting both service providers and carers for its appropriateness and usefulness. (Electronic versions of questionnaires are also available.)

A presentation of the project will be given at 1:30pm, 29 May 2001 at the Diversity in Health Conference in Darling Harbour. For more information please contact Grace Chan on 02 9280 4744.

The project continues with its objectives of mental health promotion in selected culturally diverse communities and identification of needs in relation to mental health for these communities. In seeking to meet a further objective, the project has maintained the momentum in relation to development of ACT Mental Health Services as a more responsive organisation to communities from culturally and linguistically diverse backgrounds. In addition, the project has progressed its objectives relating to the establishment of links in both the government and non government sector, acting in a liaison and advisory capacity and strengthening the newly reconvened ACT Transcultural Mental Health Network.

CURRENT WORK

Targeting selected ethnic communities

The Steering Committee for the Transcultural Mental Health Project has continued to meet on a regular basis and, at this time, has representatives from three selected communities: Italian, Croatian and Spanish speaking.

The Italian community: in the ACT it is the largest overseas-born from a non-English speaking country. This community does not have any paid workers and relies on voluntary workers most of whom have no formal training in health/welfare. The previous work undertaken in promoting mental health appeared to have little impact on utilisation of mental health services. Stigma remains a huge issue in this long-term established community. A meeting was organised for all involved in health/welfare in order to resolve lack of communication, coordination and cooperation within the community which have contributed to resistance to using mental health/other health services. Outcomes which can be attributed to this unique occurrence are the following: formation of a Working Group which has continued to meet, purchase of an information stand which is housed at the Italo-Australian Club, a greater awareness of mental health issues amongst key members of the Working Group, and a request to the Project Officer for assistance in submitting to the National Suicide Prevention Strategy in order to obtain a worker in the mental health area.

The Project Officer has been on the Italian radio program to promote mental health which has coincided with several referrals being made via the ACT MHS Triage/Crisis Team. The Project Officer has encouraged a member of this community to become a consumer consultant in mental health.

The Croatian community is one of the larger non-English speaking communities in the ACT and along with other members of The Former Yugoslavia is seen frequently by ACT MHS at the crisis end of the service. This is the only community in the ACT with its own welfare centre albeit a small under-funded one, with no mental health trained staff (or any professional/health related qualifications). Mental health promotion couched in broader health terms (via lunchtime talks 'as with the Italian community) had a very poor response from the community and consequently has had little impact on usage of services. Future action is the placement of an ACT MHS clinician at the Centre to act as consultant to the workers. The Croatian Community Welfare Centre is likely to request assistance from Project Officer in obtaining funding through the National Suicide Prevention Strategy in order to employ a mental health worker.

The Spanish-speaking community is a considerably large one in the ACT when all the population from Spanish speaking countries is taken into account. This community too, is seen frequently at the crisis end of ACT MHS and a Spanish speaking worker is employed at one of the largest non-government mental health organisations (Mental Health Foundation). In addition, there are two Spanish-speaking psychologists to whom referrals can be made. Similar to the Italian community this community relies heavily on voluntary workers but unlike the Italian community is much better organised and united. Work has recently commenced in providing education on mental health issues to a large well-established Carers' Group.

For more information please contact Salva Crusca, Transcultural Mental Health Project Officer
Tel: 02 6205 1887

Bringing the Focus on Transcultural Mental Health to the South West Region of Western Australia

For further information please contact;
Peter Taplin
Staff Development Unit
Graylands Hospital
Tel: 08 9347 6600 or
Dr Bernadette Wright
Transcultural Psychiatry Unit,
Tel: 08 9224 1760

news & views

The Transcultural Psychiatry Unit is predominantly staffed by clinicians – all with wide expertise in clinical service delivery to people from different cultures for whom our cumulative experience and understanding of culture-bound beliefs about mental illness and its management, can facilitate treatment efficacy.

Consistent with its statewide function, the Transcultural Psychiatry Unit is in the process of establishing a clinical outreach in the rural south west region of Western Australia. Preliminary discussions have been conducted between the Transcultural Psychiatry Unit and the South West Mental Health Service based in Bunbury.

In partnership with South West Mental Health Service, the Transcultural Psychiatry Unit will be locating an 'on-site' clinical consultation service for patients residing in the south west catchment area. Clinicians from the Transcultural Psychiatry Unit will receive direct referrals of CALD background patients from the South West Mental Health Service, and patients will be seen by Unit clinicians, with an accredited interpreter at the South West Mental Health Service campus or, if necessary, at the patient's residence. However, it is anticipated that, with support from Transcultural Psychiatry Unit staff, ongoing care of the patient will remain with the South West Mental Health Service or with the referring general practitioner. This will, subsequently, involve significant skills transfer to other health providers in the areas of transcultural mental health.

Arising from these discussions, the following objectives have been set and will be met in collaboration with South West Mental Health Service Multicultural Program:

- To increase the level of awareness, knowledge and skills of general

practitioners, police and accident emergency departments in assessing and managing mental health patients from CALD backgrounds;

- To develop and deliver education/training programs to mental health service providers in the region on transcultural mental health care provision;

- To identify gaps in service knowledge concerning extent of unmet mental health 'needs' of the CALD background population residing in the service catchment area.

A MENTAL HEALTH PROMOTION AND ILLNESS PREVENTION COMPONENT

Mental health promotion and illness prevention initiatives have, and continue, to be a significant component of the work conducted by the Transcultural Psychiatry Unit. We consider it to be an essential adjunct to the clinical work we provide. In collaboration with the South West Mental Health Service Multicultural Program, the staff of the Unit will utilize their clinical training and expertise in transcultural mental health to develop and deliver mental health promotion and illness prevention initiatives. This will be conducted with a view to establishing an infrastructure that would facilitate and support community development initiatives for rural-based ethnic communities in relation to mental health promotion and illness prevention. Our role in this area will be an extension of the mental health promotion program which the Unit has effectively implemented amongst the CALD background population in the Perth metropolitan area.

All parties who have been involved in the development of this outreach program consider this to be an exciting initiative. It is timely that a concentrated effort now be made to understand and service the needs of our CALD background population in the rural and remote regions of our state.

With a number of new staffing appointments in early 2001 in the positions of manager (Rita Prasad-Ildes), Mental Health Promotion Coordinator (Elvia Ramirez) and project officer for phase 2 of the NESB Youth Mental Health Needs Assessment (Sumathy Selvamanickam) the Centre has been busy developing a three year operational plan as well as continuing to provide clinical consultation, education and training and mental health promotion services and programs.

To maximise the impact of our work, as we are essentially a small centre covering a large and decentralised state, our approach will be "whole of centre" where a number of program areas will be addressing the same issue from a different perspective and our partnerships will be strategically focused.

The following highlights a number of our current activities:

Referrals continue to increase for clinical consultation services with a steady increase of referrals for Arabic and Farsi speaking clients. Quarterly information and resource meetings with the bilingual mental health professionals who provide services through the clinical consultation service have commenced.

The development of a postgraduate subject in Transcultural Mental Health in partnership with the Department of Psychiatry, University of Qld, is progressing and on track to be piloted 2nd semester this year.

The "Managing Cultural Diversity in Mental Health" Train the Trainer Program modules 1-4 are currently being rewritten based on a revision conducted by external referees and participant feedback and will be completed by July this year.

The NESB Youth Mental Health Needs Assessment has commenced phase 2 and is focusing on completing the in-depth analysis of interviews conducted with young people, carers and service providers. A final report and community information sheets will be completed by November this year.

The newly funded Multicultural Older People's Information Project has commenced and is a project managed by a coalition of ethnic older people's services and will be focusing on bilingual GPs and the ethnic media.

The centre continues to take a lead role in the Multicultural Disability Network which has now received funding for a statewide consultation process to establish an ethnic disability agency and has received 3 yrs recurrent funding from Qld Disability Services.

The NESB Mental Health GP Shared Care project has commenced the production of a handbook, which will contain the lessons learned from the project as well as information on how to establish mental health shared care programs for ethnic communities. This resource will be available in June this year.

The FRIENDS Anxiety Prevention Program has completed the adaptation of the program for children of NESB and a draft group leader's manual is now available.

For further information on these projects, please contact the QTMHC
Tel: 07 3240 2833 or the manager
rita_prasad-ildes@health.qld.gov.au

news & views

For further information please
contact the NSW TMHC
Tel: 02 9840 3800

news & views

MULTICULTURAL PROBLEM GAMBLING PROGRAM

The Program, funded by the Casino Community Benefit Fund, was launched by Mr Richard Face, MP, NSW Minister for Gaming and Racing on Thursday 26 April in Parramatta. The Launch was held in conjunction with a Planning Day for the project to which all key stakeholders were invited, including representatives from mainstream and ethno-specific problem gambling services, as well as ethnic community organizations and welfare services. The counseling service will be based on the NSW TMHC Clinical Brokerage Program model in order to provide access to individuals and their families from as diverse a range of language and cultural groups as possible. The Program will also involve community education initiatives and cross-cultural consultancy and training.

LIGHTNING RIDGE REPORT

This report entitled The Health Needs of the Lightning Ridge Community has been completed and is now available. It documents the findings of TMHC's health needs assessment of both physical and mental health at Lightning Ridge, a remote mining community in far north west NSW.

NSW TMHC SCHOOL LINK PROJECT

The School Link Project offers an innovative opportunity to work collaboratively with Area School-Link Coordinators in liaising with schools and child and adolescent mental health services to promote mental health, prevent mental health problems and facilitate evidence based identification, management and support for students from culturally and linguistically diverse backgrounds with mental health problems. The work of the Project to date has included:

1. Active consultation in the development of a comprehensive training program for school counsellors across the state on depression and related disorders in young people.

2. Raising the awareness of School counsellors, youth and mental health workers on the mental health issues impacting on young people of NESB.

The NSW TMHC monograph Deeper Dimensions, Culture, Youth and Mental Health (2000) was distributed to all School-Link Training Participants (over 2000 copies) as background reading on mental health issues pertaining to young people from culturally and linguistically diverse backgrounds.

The development of a factsheet that outlines the major mental health issues impacting young people of NESB in school. The Factsheet will be distributed to every school in NSW.

3. Coordinating the third state-wide youth writing competition on mental health issues in a multicultural society.

Events Calendar

2001

May

21-24

Causes

The Royal Australian and New Zealand
College of Psychiatrists 36th Congress
National Convention Centre, Canberra
Tel: 02 6257 3299
Fax: 02 6257 3256
Email:
ranzcp2001@ausconvservices.com.au

28-30

Diversity in Health: Sharing Global Perspectives:

2nd ATMHN Conference
3rd Australian Mental Health Conference
6th NSW TMHC Conference

Sydney Convention and Exhibition Centre,
Darling Harbour, Sydney
Conference Secretariat
Tel: 02 9518 9580
Email: diversity@pharmaevents.com.au

June

27-28

Health Outcomes 2001: The Odyssey Advances

7th Annual International Health Outcomes
Conference, Canberra

Tel: 02 6205 0869
Fax: 02 6205 2037
Email: jan.sansoni@act.gov.au

August

27-30

No One is An Island

11th Annual TheMHS Conference
Wellington, New Zealand

Tel: 02 9926 6057
Fax: 02 9926 7078
Email: enquiries@themhs.org

Sept

23-26

A Public Health Odyssey Popular Culture, Science & Politics

33rd Public Health Association of Australia
Annual Conference
Hilton Hotel, Sydney

Tel: 02 6285 2373
Fax: 02 6282 5438
Email: conference@phaa.net.au

Visit the ATMHN Website
www.atmhn.unimelb.edu.au

Contacts

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 Australia

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For information on transcultural mental health issues contact the ATMHN or your local transcultural mental health service. For those living in the Northern Territory or Tasmania contact your local Dept. of Health.

Australian Transcultural Mental Health Network

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02 9840 3333
 Fax: 02 9840 3388

Transcultural Mental Health Services

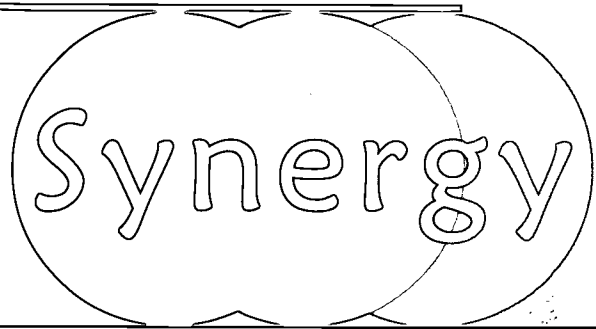
ACT Transcultural Mental Health Network	02 6207 1066
NSW Transcultural Mental Health Centre	02 9840 3800
QLD Transcultural Mental Health Centre	07 3240 2833
SA Transcultural Mental Health Network	08 8243 5613
Victorian Transcultural Psychiatry Unit	03 9411 0308
WA Transcultural Psychiatry Unit	08 9224 1760

Other Contacts

Aust. Mental Health Consumers Network	07 3394 4852
Carers Association of Australia	02 6282 7886
Federation of Ethnic Communities	
Councils of Australia	02 6282 5755
Mental Health Council of Australia	02 6285 3100
National Ethnic Disability Alliance	02 9891 6400
National Forum for STARTTS	02 9794 1900

Government Mental Health Services

Commonwealth Dept. of Health and Aged Care	1800 020 103
ACT Dept. of Health and Community Care	02 6205 5111
NSW Health	02 9391 9000
Territory Health Services, NT	08 8999 2400
QLD Health	07 3234 0111
Dept. of Human Services, SA	08 8226 8800
Dept. of Health & Human Services, TAS	03 6233 3185
Dept. of Human Services, VIC	03 9616 7777
Health Department of WA	08 9222 4222



Winter 2001

YOUNG PEOPLE

Inside This Issue:

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The Heart of Acceptance: Cultural Healing Uncovered
Exhibition Launch in Adelaide

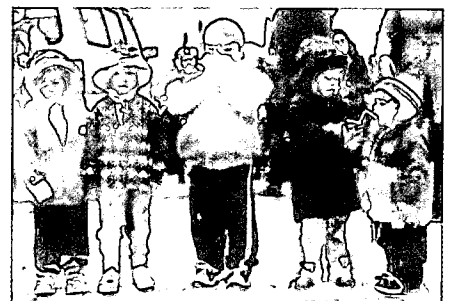


From left to right; Nicholas Procter, Mafalda Di Maria receiving her certificate of appreciation, Angela Eaton and Arthur Moutakis. Many thanks to Sam Noonan for his photography.

In June “The Heart of Acceptance: Cultural Healing Uncovered” an exhibition about the Reciprocity in Education Project was launched by the South Australian Department of Human Services Director of Mental Health, Dr Margaret Tobin. More than 250 people attended the launch and community participants each received a Certificate of Appreciation for their time and effort in making the project a success.

The three-month exhibition at the South Australian Migration Museum is the culmination of work undertaken by people from Adelaide’s Cambodian, Persian, Afghan and Italian communities, mainstream mental health services and the project team. For a year participants worked together on cultural perspectives of sadness and depression. An interactive two-way learning process between the communities and mainstream workers achieved collaboratively developed composite stories and staff development programs.

The educational interaction between community people and mental health workers has been built around each group being seen as “grass-roots” experts on the topic of their experience. The community participants have been teachers to both the project team and mainstream mental health workers. They have taught us about the way that culture and tradition are a central part of the inner life of people.

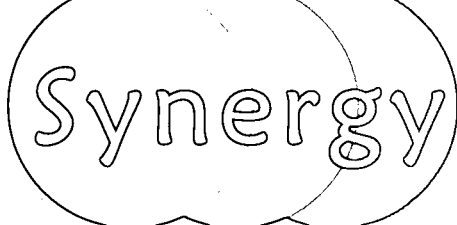


The exhibition reflects the community people involved in the project, with participants placing their personal items and artefacts on display. Items include family photographs, items of jewellery, baby and adult clothing, food utensils, blankets, quilts, carpet, sculpture and personal items made when participants were in prison. All these items and accompanying stories say something about the inner life of people who participated in the project.

The display is presented in the four languages of the project: Cambodian, English, Farsi and Italian. The exhibition will run until the end of August and is expected to attract a viewing public of approximately 40, 000 people. Plans are being made for the exhibition to tour rural and regional South Australia. For further information please contact:

A/Prof. Nicholas Procter telephone 08 8302 2148 or E-mail nicholas.procter@unisa.edu.au





SYNERGY is the quarterly newsletter of the Australian Transcultural Mental Health Network (ATMHN).

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Contributions to this newsletter do not necessarily reflect the views of the ATMHN.

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Anyone interested in contributing to future issues of Synergy please contact the editor at: sandee_baldwin@wsahs.nsw.gov.au
Or 02 9840 3381

A Critical Look at Cultural Diversity and Infant Care Studies

Mark Tomlinson
Director, Thula Sana Mother-Infant Project
Cape Town, South Africa

Let us for a moment think of a hypothetical research project. Suppose I were to spend a short period of time in Sydney studying the child care practices of a number of families. Or perhaps I simply remained at my university desk in Cape Town and consulted a variety of secondary sources about these practices of Australian mothers. Imagine were I then to attempt to have a descriptive work on the child care practices of white, middle class Australian mothers published in an academic journal. A working title might be "Work, gym, television and the Australian mother".



Mark Tomlinson

This paper was presented at the 'Diversity in Health: Sharing Global Perspectives' conference in Sydney, May 2001. An enlarged version is presently being prepared for journal publication

At best I would receive a polite, if not slightly patronizing refusal. At worst I would be crucified for my arrogance, for my neglect of political and social forces that explain the current context, taken to task for my many generalizations given the reality of individual variation, and certainly be castigated for the patriarchal stance of the paper. While I have deliberately exaggerated this example for effect, it is not far from the truth with respect to many studies that have been published about the infant care practices of mothers and communities in the developing world.

A case in point is a recent book (A world of babies: Imagined childcare guides for seven societies. DeLoach & Gottlieb, 2000), where the six contemporary cultures that are described are contrasted with the Puritans of the USA (dated around 1630!). I can see no illustrative advantage of such a collection (regardless of how valid or seemingly well argued), that can outweigh the ideologically patronizing implication of juxtaposing contemporary cultures with a society that existed four hundred years ago (no matter how many puritanical elements contemporary America might possess). Furthermore, chapters on the Warlpiri of Australia and Balinese child-care were written by people who had not conducted their research in these countries, but had rather consulted secondary sources. Finally, one caption in the book is as follows "although there is great diversity in infant care practices in the seven societies discussed in this book, babies are considered precious in every one" (p4), a statement so devoid of any real analysis as to render it meaningless.

THE THULA SANA PROJECT

I am the director of the Thula Sana Mother-infant project. (Thula Sana means 'hush baby' in Xhosa, the language spoken by the mothers in our study). It is a four year controlled trial, looking at the efficacy of a community based mother infant intervention. The aim of the study is to determine whether the adverse impact of postnatal depression and social adversity on child outcome can be mitigated by an intervention designed to improve maternal mood and enhance the development of the early mother-infant relationship. The treatment trial follows an epidemiological study we completed in 1999 looking at postpartum depression and the mother-infant relationship. Time constraints preclude me from fully discussing this study save to say that the point prevalence of postpartum depression was found to be 34.7%, and that this was associated with insensitive engagement with infants. The study is being carried out in Khayelitsha, a peri-urban settlement of around 500 000 people on the outskirts of Cape Town. It is predominantly an informally organized area, and is made up of serviced and unserviced shacks. The population is highly unstable, with steady levels of migration

Continued Overleaf

Synergy Winter 2001

both within Khayelitsha (movement to improved living situations or because of violence), and between Khayelitsha and the rural areas.

An important element of the work that we are doing is the assessment of conceptualizations of infancy and childhood. With this in mind, I conducted a number of interviews. Prior to conducting the interviews and having read aspects of the literature my intention was to produce a paper, a chapter or perhaps even a book entitled for example 'The Xhosa infant' or 'Xhosa conceptualizations of infancy'. However, as I hope to show by way of these interviews, the notion of 'A Xhosa infant' or 'A Xhosa mother' is simply not a tenable concept, regardless of the fact that the literature is full of similarly titled works (see for example Alessi, 1997).

CHILD CARE PRACTICE AS A FIELD OF STUDY

The practice of studying the child care beliefs of other cultures is not a new one and dates back to the 4th century with the fascination of the Athenians for the child care practices of the Spartans (Bornstein, 1991). The burgeoning of infant research during the 1960' and 1970's brought with it an increase in the number of texts looking at (predominantly) maternal conceptualizations of infancy and childhood. While much of the descriptive focus was essential initially, I believe that more recent works purporting to deal with conceptualizations of infancy and the link with actual child care practice, often fail to locate their descriptions politically, economically and socially. The result is that many paint a rather quaint picture of mothers and families in the developing world, and as Lewis (1999, p123) has so aptly put it "teeter on the brink of becoming a fashionable literary pursuit, a dilettante traveler's belles lettres". This stance is, I believe, one which ultimately falls prey to an attitude which could be termed colonial, and one which I believe does significant harm both in terms of the stereotypes it confirms, and others it creates.

THE INTERFACE BETWEEN CULTURE AND THE INDIVIDUAL

A commonly stated belief amongst many Xhosa people has to do with how parents are to understand the crying of their infant. Providing that the infant has been fed and does not need to be changed, then the crying is understood as a signal reassuring the parents that the infant is still alive. Furthermore, it is seen as a device to ward off evil spirits.

In one of my interviews I asked an older mother (both her children were now adults) about whether the belief about why infants cried was in fact something that she subscribed to and had followed. She said yes and that in the case of both her children this was in fact the way that she had dealt with their crying. I asked her whether her children believed the same thing. She said no. She stated that she had informed them of these beliefs but had also told them

that infants might cry for a number of other reasons – illness, or the need for contact and comfort being just two of these alternative reasons. I then asked her how she had come to these alternative beliefs. She said that she had always believed that infants cry for various reasons. Why she had left her infant to cry was that she was living in the house of her mother-in-law. Her status within the house required her to respect the child care views of her mother-in-law – even if they contradicted her own.

In this brief sketch there are two crucial issues that could be seen as illustrative of the care that needs to be taken when reporting on an expressed belief system. The first could be seen as generational and one of respect - her status compelled her to put her own beliefs on hold in deference to her mother-in-law. The second involves temporality and how belief systems change over time. The simple presentation of an oft-repeated belief system (as might happen in an ahistorical ethnographic description) omits the crucial element of individual difference, and how this might vary (even within one individual over a period of time) but certainly between generations. It is not sufficient to merely focus on the social and aggregate phenomena – individual choice and difference in a fundamentally shifting and changing world must be factored in.

THE INTERFACE BETWEEN POLITICS AND THE PERSONAL

A commonly reported belief by Xhosa mothers is that little boys must grow up strong and must learn, very early on, that boys do not cry. A belief system such as this is by no means unique to Xhosa culture or even the developing world. An interesting facet of this however occurred in an interview with another mother (whose child was also now an adult). I asked her about this belief and she laughed saying "why should little boys not cry, maybe men should not cry, but little boys should be allowed to". She confirmed however that when her son had, as an infant and young child cried she did not in any way comfort him or in any other way affirm his crying but rather allowed him to continue crying. Her reasoning she explained had nothing to do with a cultural belief system but was rather practical and political. When her son was growing up it was in the midst of some of the worst excesses of the apartheid regime. This was a time when she fully believed that only one path was possible for her son - his eventual leaving of the country in order to join the armed struggle, Umkhonto we Sizwe. She felt it to be her duty as a mother to ensure that he 'grew up to be tough ... to be able to look after himself ... from as early on as possible. It was for this reason that when he cried as a child she did not seek to comfort him but rather strived to ensure that he learnt that little boys do not cry.

This example serves to illustrate what Azuma (2000) refers to as the fluidity of culture and the idea of a 'personal

culture'. Using Cole's (1996) notion of artifacts, Azuma argues that people are active agents in collecting artifacts around them. Azuma states that people are not solely shaped by the broader cultural artifacts around them, but are instrumental in creating this unique system.

CARE AS FUNCTIONAL ADAPTATION

Differences in practice only have meaning in context and when they are approached and seen in a functional and adaptive way. Unless the actual care practice (be it widely or locally held) is analyzed in terms of its functional meaning at a particular historical moment, it becomes little more than an interesting tale, signifying little. The swaddling of infants and keeping them for long periods of the day alone in a hut, is adaptive and makes sense in rural Guatemala given the myriad dangers which the infant faces (Kagan et al, 1979). Hypothetically, in a more urbanized community without the same dangers, the same may not be true, and the practice may not exist. And even if it did, the important element is that it would, in all likelihood, have to be understood differently.

Chalmers (1990) makes the point that it is very easy to romanticize 'traditional cultures' and to "glorify characteristics which are, in reality, necessities for survival" (p 84). The example that Chalmers uses is to do with communal care. Viewed from the West this may be perceived as a superior quality of human nature stemming from an altruistic need to help others, when in fact, survival without the help from friends and neighbors might well be impossible. This is borne out in the findings from our epidemiological study in Khayelitsha where almost 50% of the women reported having no income at all and that it was only through the assistance of family, friends and neighbors that they were able to survive. The frequently 'asocial' and 'apolitical' stance (however unintended) of many cultural studies of infant care, ignores the crucial interplay/relationship between culture and society which has very "unfortunate implications for reification" (Lewis, 1999, p21). Intracultural variations between urban and rural, and between young and old (for example) may, in many instances, be greater than intercultural variation, and unless this is factored in and acknowledged then the description of the care practice has no validity in the lived world.

CONCLUSIONS

The aim of this paper has not been to simply point out a few observational lapses or methodological shortcomings of some of the work in the field of cultural conceptualizations of care, but rather to show that these seemingly innocuous shortcomings do, in fact, have serious consequences. My opposition to this kind of research is not simply intellectual or academic, or a polemic against the telling of a story that I believe to be often somewhat

banal and devoid of any real meaning. Rather it is dangerous in that it permits the drawing of false dichotomies between methods of childcare in the developed world and the rest. It sets the scene for a paternalistic attitude of "look how quaint the natives are – they believe that infants come from the sky'. If you as a mother have been cast as 'the natural African earth mother' to whom do you go when you are in distress. For a depressed unemployed mother in Khayelitsha, whose husband has deserted her, and who has to feed a number of children, to then have to labor under this stereotype is not simply unfortunate but critical for the health of both her and her infant. It results in her silence, and often a distancing of herself from her infant (for her very survival). Equally important, and often not acknowledged is that if the health system also subscribes, (however unconsciously) to the stereotype, then problems or difficulties are simply not seen. And I mean this both at a metaphoric level (problems become invisible) as well as at a practical level (services simply not created to serve the needs of depressed mothers).

Descriptive accounts of childcare practices must, intrinsically contain a critical analysis and pay more than lip service to context and socio-economic determinants. If they do not then they are liable to fall prey to the worst kind of ethnocentrism – no matter how unintentional this might be. □

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Sixty per cent of people who visit general practitioners have a mental disorder, according to a groundbreaking study of 46 000 patients. The findings, by Professor Hickie and a team of scientists at the University of NSW's School of Psychiatry, point to higher rates of mental illness than have been acknowledged to date.

The research showed GPs consistently underestimated their patients' mental disorders. In those with severe symptoms, doctors failed to recognise a problem in just under half of cases. Where the symptoms were less severe, GPs recognised even fewer cases. They were least likely to do so if the patient reported somatic symptoms rather than psychological distress.

While more than half the patients were suffering some mental disorder, only half of these would need immediate medication or psychological therapy. The rest would require close monitoring. The research showed that screening - using a questionnaire filled out in the doctor's waiting room - could reveal psychological conditions that would otherwise go unnoticed. Professor Hickie said a screening program should be rolled out next year, after Medicare is changed to allow doctors to spend longer with depressed patients.

Sydney Morning Herald

Results of Studies on Antisocial Children

Children who display antisocial behaviour cost society 10 times more than those with no problems and are at high risk of lifelong social exclusion, concludes a study in a recent British Medical Journal. However, a second study reports that parental training programmes can be a cost effective way to nip serious antisocial behaviour in children in the bud.

In the first study Stephen Scott, Senoir Lecturer in Child & Adolescent Psychiatry, Kings College London, tracked the costs to the public sector of 142 children with different levels of antisocial behaviour, from age 10 to their late 20s. By age 28, costs for individuals with serious antisocial behaviour were 10 times higher than for those with no problems. Crime incurred the greatest cost, followed by special educational provision, foster and residential care, and state benefits. Early interventions to reduce antisocial behaviour in childhood could result in large cost savings, they conclude.

In the second study, also led by Stephen Scott 141 highly antisocial children aged 3-8 years were identified. The parents of 90 children completed a training programme; the remaining 51 parents received no such training. Children in the training group showed a large reduction in antisocial behaviour, while those in the control group did not change.

Although such parenting programmes are only just beginning to become available in the United Kingdom, they show promise as a cost effective way to reduce the personal and economic burden of antisocial behaviour in children and to prevent criminality and social exclusion, conclude the authors.

Financial Cost of Social Exclusion:
<http://bmj.com/cgi/content/full/323/7306/191>

Controlled Trial of Parenting Groups:
<http://bmj.com/cgi/content/full/323/7306/194>

AICAFMHA News

Life Tough on Young Men

Life is not easy for young Australian men. A national survey has found nearly all young men who don't have a girlfriend are dissatisfied with life.

And their family's adoring relationship with them drops away sharply from the age of five, to such an extent that only 18 per cent of fathers feel they have an extremely satisfying relationship with their teenage sons.

Dianne Gibson, the national director of Relationships Australia, which commissioned the survey, said the slide in father-son relations were alarming.

"It is interesting in how this sets boys up, if they are not having good relationships with their families, to go on in their 20s and form strong loving relationships with women," she said.

While nearly 80% of those surveyed who were in a relationship said they were satisfied with life, nearly all men without a partner said they were dissatisfied. In this group, unemployment, lack of direction or stressful work - which all affected their ability to form and sustain relationships - were mentioned.

Sydney Morning Herald

Beyond Depression

Excellent 4 part series, Beyond Depression by The Age newspaper is now online at:
www.theage.com.au/issues/index.html

Kids Help Line Survey on Callers of Non-English Speaking Backgrounds

The information presented in this report is based on data collected between 1995 and 1999. Across this five year period, 6,614 calls were recorded from NESB children and young people. Given that only 27% of callers choose to reveal their ethnic background, this figure is a significant under-representation of actual calls from children and young people of non-English speaking backgrounds.

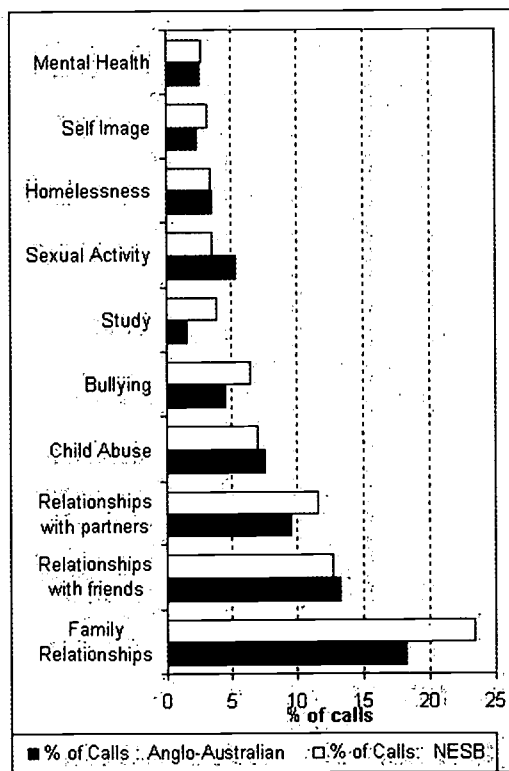
The proportion of calls Kids Help Line receives each year from children and young people of non-English speaking backgrounds has steadily increased from 4.1% in 1995 to 9.4% of all counselling calls made in 2000.

Kids Help Line defines NESB callers as any caller whose first language is not English or whose cultural background, of immediate family, is derived from a non-English-speaking tradition. This does not include callers from English speaking nations such as England, USA or Canada.

MAIN PROBLEMS

Ten issues stand out as the major concerns for NESB callers. Together these ten problems (of a possible 35) account for over 75% of calls from young Australians of non-English speaking backgrounds.

The graph below compares the percentage of calls from NESB and Anglo-Australian groups for these ten problems (as represented by proportion of calls from each group).



As is the case for all callers, regardless of background, callers of non-English-speaking backgrounds most often contact the service to talk about problems related to their family and family relationships.

For issues such as bullying, study, self image and relationships with partners, callers of NESB backgrounds make higher proportions of calls than their Anglo counterparts. Problems concerning pregnancy, sexual-activity, drug use and developmental issues attract a significantly lower proportion of calls from this group.

AGE & GENDER DIFFERENCES

Of the NESB young people, females make the majority (73%) of calls with males making 27%. While family relationships represent the main concern for both genders, differences are apparent in the problems which concern males and females of non-English speaking backgrounds. The table below shows the top 7 problems, in rank order, for each gender.

Females	Males
Family Relationships	Family Relationships
Relationships with Friends	Bullying
Partner Relationships	Sexual Activity
Bullying	Relationships with Friends
Study	Partner Relationships
Self Image	Study
Physical Abuse	Loneliness

Family relationships and child abuse emerge as concerns for NESB children across all ages while bullying is more of an issue for callers younger than 15. As children grow older, problems involving relationships with partners, homelessness, self image, sexual activity and study become more of an issue.

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The majority of callers of non-English speaking backgrounds are aged between 15 and 18. This is a different pattern of service usage than is the case with callers from an Anglo background (see table below).

	NESB	Anglo
5-9 years	3.0%	3.7%
10 - 14 Years	39.7%	53.5%
15-18 years	57.4%	43.1%

FAMILY RELATIONSHIPS

Relationships with parents and family is the biggest concern, accounting for 1 in 4 calls from NESB young people. Almost 60% of these children and young people report experiencing frequent or major family conflict or disruption.

Compared with their Anglo-Australian peers, NESB callers are more likely to seek help about frequent or major family conflict and disruption and less likely to be phoning about family breakdown, separation or divorce.

In addition, qualitative analysis reveals conflict in NESB families is more likely to be intergenerational conflict as opposed to marital conflict/disruption caused by separation or divorce. The sources of intergenerational conflict include:

- The struggle for independence, with young people feeling their parents are overprotective and overly strict;
- Living between two cultures – parents of non-English speaking background and children growing up in “Australian” culture;
- Young people feeling restricted in their choice of and time with friends;
- Parental restrictions on dating and socializing; and
- Academic expectations and pressure from parents.

PEER RELATIONSHIPS

Friendship and peer relationship concerns are the second most common reason NESB young people seek help. When compared to their Anglo-Australian counterparts, NESB callers are less likely to phone about occasional or one-off problems but more likely to phone about significant or ongoing problems with friends and peers. These young people are also more likely to report difficulties making or

maintaining friendships.

The 30% of NESB callers who report significant or ongoing friendship problems reveal that these problems are often related to teasing and bullying or cultural and language differences. Similarly, language and cultural differences are the major themes in calls related to making and maintaining friendships for NESB children. Significant peer relationship issues may also be linked to parental restrictions on friendships, study commitments and being different in a new school.

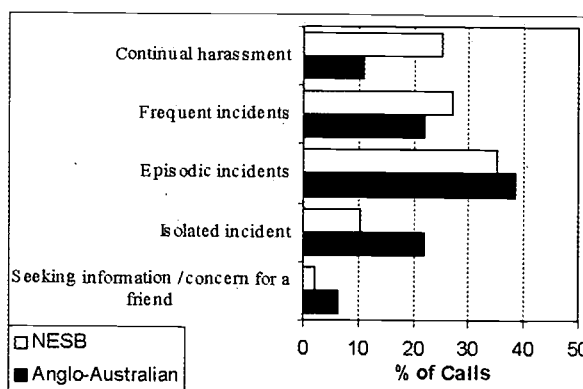
INTIMATE RELATIONSHIPS

Relationships with partners is the third most common concern for young people of non-English speaking backgrounds, accounting for almost 12% of their calls.

When examining the nature of these calls, young people of non-English speaking backgrounds call less often about pressure to have sex or uncertainty about sex in their intimate relationships than their Anglo counterparts. The majority (57%) of their concerns relate to establishing or negotiating new relationships. A further 40% of calls relate to significant relationship difficulties or relationship breakdown.

BULLYING

Children and young people of non-English speaking backgrounds make 40% more calls concerning bullying than their Anglo-Australian counterparts. Furthermore, the bullying NESB callers report is more severe and often based on racial or cultural differences. The graph below compares the severity of bullying calls.



Children and young people of non-English speaking backgrounds are more likely to be experiencing frequent bullying or continual harassment (52%) than their Anglo-Australian counterparts (33%). Qualitative data suggests much of the episodic, frequent and continual bullying is related to racial differences.

STUDY ISSUES

Young people of non-English speaking backgrounds are more than twice as likely to be concerned about study issues, accounting for 3.9% of NESB calls as compared to 1.5% of Anglo-Australian calls.

In addition, NESB young people are more likely to be calling about study-related stress than Anglo callers. Almost half (43%) of these calls relate to workload, study pressure or exams, compared to 24% of Anglo callers. Other common issues (35%) include difficulties with study or need for assistance in managing schoolwork. Qualitative evidence of NESB calls shows that study stress is often related to parental expectations while difficulties with study often centre on difficulties coping with English as a second language.

SELF IMAGE

Self-image issues are the ninth most frequent reason that children and young people of non-English speaking

backgrounds contact the service, accounting for 3% of all counselling calls. This proportion is 30% higher than for Anglo-Australian callers.

The majority (59%) of NESB self-image concerns relate to persistent low self-value or severe feelings of worthlessness. A further 27% of callers report occasional dissatisfaction with self. The remaining self-image calls are from children and young people seeking information or concerned about a minor or transient issue. □

A comprehensive report is available for purchase, "Issues and Concerns Facing Young People from Non-English Speaking Backgrounds" can be ordered from Kids Help Line by phone or email.
Ph (07) 3369 1588 Fax (07) 3367 1266
Email admin@kidshelp.com.au
24 hour telephone counselling line: 1800 55 1800
www.kidshelp.com.au

Youth Websites

AUSTRALIAN INFANT, CHILD, ADOLESCENT AND FAMILY MENTAL HEALTH ASSOCIATION

www.aicafmha.net.au

The overall aim of the association is to actively promote the mental health and well being of infants, children, adolescents and their families and carers.

FOCUS: PROMOTING EFFECTIVE PRACTICE IN CHILD AND ADOLESCENT MENTAL HEALTH

www.rcpsych.ac.uk/cru/focus

FOCUS was launched in 1997 to promote clinical and organisational effectiveness in child and adolescent mental health services, with an emphasis on incorporating research into everyday practice.

REACH OUT!

www.reachout.com.au

ReachOut! is a service that uses the Internet to help young people get through tough times. ReachOut! provides information, assistance and referrals in a format that appeals to young people.

CHILD & YOUTH HEALTH

www.cyh.com.au

A web-site full of information for 12 -25 year olds. The website addresses issues such as mental health, relationships, families, general health and sexual health.

HEADROOM

www.headroom.net.au

An innovative Australian website designed by young people promoting positive mental health. The interactive website caters for adolescents, children, families and friends, and professionals and service providers.

HERE FOR LIFE

www.hereforlife.org.au

Here for Life is a not-for-profit public benevolent institution focusing on education, awareness and research aimed at the prevention of youth suicide.

THE CHILD & ADOLESCENT BIPOLAR FOUNDATION

www.bpkids.org

The Child & Adolescent Bipolar Foundation (CABF) is a newly-founded, not-for-profit organisation of families raising children diagnosed with bipolar disorder.

MENTAL HEALTH RISK FACTORS FOR ADOLESCENTS

www.education.indiana.edu/cas/adol/mental.html

This site contains lots of mental health information for adolescents; eating disorders, depression, suicide and bipolar.

SNAPSHOTS Diversity in Health



Uncle Max (pictured above) an aboriginal elder performed the traditional welcoming on the opening morning of Diversity in Health.



Diversity in Health, which incorporated the 2nd ATMHN National Conference, was officially opened by Her Excellency, Marie Bashir AD, Governor of New South Wales (pictured right). The Hon Craig Knowles, NSW Minister for Health (pictured below right) presented the Opening Address and Emeritus Professor Beverley Raphael as Chair of the National Conference Steering Committee (pictured below) welcomed the delegates to the Conference.

National and international speakers and close to 1000 people attended Diversity in Health. We were pleased that many consumers, carers and community representatives from around Australia attended the conference.



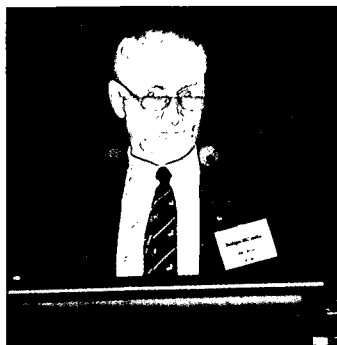
THANK YOU Ruth Lilian (pictured right) and all the staff at Pharma Events for their hard work and professionalism in organising Diversity. The ATMHN would like to thank all those who contributed to making Diversity such a success.



Many of the international speakers, organising committee and supporters are pictured, from left to right; Kgamadi Kometsi, Cecil Helman, Parameshvara Deva, Abd Malak, Sam Choucair, Alan McCarroll, Stepan Kerkyasharian, Esther Price, Anthony Marsella, Ruth Lilian, David Bennett, Harry Minas, Chiwoza Bandawe, Mark Tomlinson, Sandee Baldwin, Leslie Swartz and Vikram Patel.

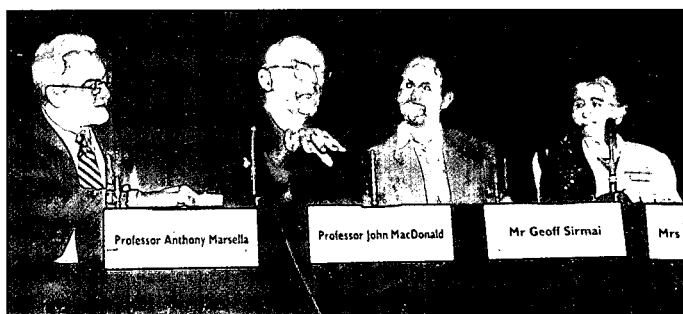
Sharing Global Perspectives

Mens Hypothetical



The Mens Hypothetical was a great way to end Day 1 of Diversity in Health. Robin Williams excelled as the moderator while the panel presented many insights and lots of humour. Many thanks to Carmine Di Campli for all his hard work in coordinating a wonderful session.

Fiesta Time



Diversity in Health was the first national conference of its kind; health and mental health issues for people from culturally and linguistically diverse background were brought together in a single forum. A wide range of themes were presented, discussed and debated usually seriously, occasionally with much laughter.

Fiesta Time on Monday evening provided an opportunity for delegates to let their hair down, renew old friendships and meet new colleagues. Delegates were entertained by many talented performers representing Sydney's diverse communities.



ATMHN Evaluation

The ATMHN evaluation is now nearing completion with WestWood Spice finishing the first interim report of their evaluation in June 2001. This report acknowledges the many positive outcomes and achievements of the ATMHN during its second phase and also makes a number of recommendations regarding the future direction of the organisation. One of the key recommendations proposed in the interim report is to hold a workshop to discuss the future directions and administrative models for a possible third funding period. This workshop will be conducted in August 2001.

The final evaluation will incorporate both the international and national report and will be completed toward the end of September. During the later part of this year decisions will be made on the ATMHN's future structure and priorities based on the evaluation findings, a national agenda document on transcultural mental health, and consistent with the goal of the Network forming partnerships with broader communities of interest.

**For further information please contact: Conrad Gershevitch
Tel: 02 6289 7722**

New Postgraduate Course at Qld University

Queensland Transcultural Mental Health Centre's revised "Managing Cultural Diversity in Mental Health" training program, comprising of four training modules (Introduction to cross cultural issues in mental health, language matters, assessment and diagnosis and treatment) will form the basis of a new postgraduate subject to be offered by the Department of Psychiatry, University of Qld in 2002. In addition four new modules are currently being developed focusing on "migration and settlement issues in mental health", "trauma", "practice issues in transcultural mental health" and "transcultural child and youth mental health issues". These will complement the existing training modules to form a comprehensive eight module post graduate subject. It is planned that the subject can be undertaken as part of a post graduate study course or individuals may attend single modules as part of their professional development.

For further information please contact the Qld Transcultural Mental Health Centre on 07 3240 2833

Attention All Carers

The Carer Profile Project is aiming to adapt the generic Carer Profile (Carers NSW) to assist service providers in assessing CALD carers of people with a mental illness or dementia. The Carer Profile is an assessment tool that allows service providers to gather information from carers to create a better picture of the "situation at home", and is used to identify current service usage, where the needs or gaps are and how best to cater for these needs.

The Carer Profile Project is focusing on two community groups, Chinese and Greek. A carer survey questionnaire has been developed and the project is targeting 50 completed questionnaires from each community. The information gathered from the project will enable service providers to gain knowledge about carers from the two cultures and develop better strategies for service provision.

There is also a service provider questionnaire to identify the services and their experiences in supporting Chinese and Greek carers with a mental illness.

If you would like to participate, the questionnaires can be download from the Carers NSW website at www.carernsw.asn.au. or contact Grace Chan 02 9280 4744 or 1800 242 636 (NSW)

Training Initiative On Depression In Young People

The NSW Transcultural Mental Health Centre's School-Link Project is currently working in partnership with School-Link Coordinators across NSW to assist in the integration of transcultural mental issues in the work that is being coordinated between adolescent mental health services and schools. The NSW TMHC initiative aims to promote the health and well being, and prevent mental health problems, in young people of culturally diverse backgrounds. One of the key objectives of the project is to develop a half-day training module on young people, culture, migration, depression and related disorders, which will accompany the School-Link Training Program.

The training module will hopefully be delivered to every High School counsellor in NSW and selected child, adolescent and adult mental health workers. We are interested in identifying any training manuals that have been developed that focus on young people of culturally diverse backgrounds who are experiencing depression. If you are aware of any training manuals or packages or work being conducted in this area, **please contact Andrew Sozomenou: email: Andrew_Sozomenou@wsahs.nsw.gov.au; Ph (02) 9840 3800; Fax (02) 9840 3755.**

Protective factors in young people

The NESB youth mental health needs assessment project (conducted by Qld TMHC) is continuing to analyse the wealth of information gathered from in-depth interviews conducted with NESB young people aged between 16 and 24, carers, mental health service providers and other service providers. The purpose of the interviews was to collect comprehensive information about direct personal experience of some form of stress and pressure, depression or anxiety by young NESB people themselves, their carers and service providers.

Interviews with young people focused on the coping strategies and resources used by the young person to deal with the mental health issue. Preliminary findings indicate a range of strategies used by the young people interviewed including entertainment and socialising, physical activities, internal resources, spirituality, avoidance, connecting to original culture, substance use, and talking about it.

Carers interviewed included parents, siblings and friends and they identified a range of issues that they felt had contributed to the mental health issue for the young person in their care, including peer pressure, bullying at school, abuse, language barriers, adjustment difficulties and displacement.

The information is currently being documented in a detailed report. In addition, the project is producing Information Sheets on each community. The report and information sheets will be available by November 2001.

For further information please contact Qld TMHC on 07 3240 2833

Cultural Awareness Tool

The prototype of the Cultural Awareness Tool (CAT) has been produced and is currently undergoing a pilot phase involving approximately 100 mental health practitioners in Western Australia. An evaluation component has been incorporated to allow the opportunity for both practitioner and client to assess the effectiveness of the tool on the practitioner's clinical practice and how the practitioner's use of the tool may have impacted on the client. The data generated from this evaluation procedure will inform further refinement of the CAT to ensure that the final version to be subsequently released for wide distribution is user friendly; and, irrespective of the cultural background of the client, it is envisaged that the CAT will elicit a comprehensive understanding of the client's explanatory model of their presenting problem. Completion of the project is now scheduled for August 2001.

For further information please contact Project Managers, Dr Rosie Rooney (08) 9266 3050 or email: r.rooney@psychology.curtin.edu.au, or Dr Bernadette Wright (08) 9224 1760 or email: bernadette.wright@health.wa.gov.au.

Hot on the Printers Press!!

Going to print shortly will be *Mental Health Shared Care for Ethnic Communities project- a handbook*. This handbook has been produced by the Mental Health Shared Care for Ethnic Communities Project, a partnership project between the Brisbane Inner South Division of General Practice and the Queensland Transcultural Mental Health Centre. The handbook has been developed offering practical strategies for the establishment of mental health shared care arrangements focusing on consumers of non English speaking background. The purpose of the handbook is to assist divisions of general practice, multicultural health organisations and mental health services to plan and implement programs in shared care that meet the specific needs of consumers of NESB.

For further information please contact the Qld Transcultural Mental Health Centre on 07 3240 2833

South Australian Review

The Multicultural Mental Health Access Program Inc. (McMHAP) in South Australia has recently completed a independent review process undertaken by the South Australian Community Health Research Unit.

The recommendations of the report list that McMHPs roles should:

- ♦ be aimed at building the transcultural capacity of the mental health services sector
- ♦ promote and reflect the voices of the NESB community members in their views and experiences in mental health care
- ♦ not take on service delivery roles of mental health, community health and other specialised multicultural programs

The remaining recommendations suggest that worker training and community education and information are priority areas of planning for McMHP.

Interested readers can contact Debbie Martin or Mark Loughhead on 08 8243 5611 or email mcmhap@arcom.com.au



The Heart of Acceptance: Cultural Healing Uncovered Exhibition Launch

Dr Margaret Tobin

Director of Mental Health, South Australian Department of Human Services

Welcome and thank you for inviting me to open this exhibition, "The Heart of Acceptance: Cultural Healing Uncovered" and to launch the brochure describing the background to this exhibit. Thank you to Professor Rob Barrett for his introduction and kind words. I am very happy to be here in SA and to be chosen to facilitate the reform of mental health services that will contribute to placing mental health issues firmly in broad community awareness.

It is vital that mental illness and mental health issues do not continue to be seen as something to be hidden or seen separately from a person's or communities overall health and wellbeing. It is very much about how we approach citizenship and connectedness and how we support each other. It is the process of saying to someone who is having a difficult time "Can I help, do you need to talk about it?" rather than see their distress as something to be avoided or ignored.

The mental health reforms that we are currently undertaking in SA are informed by past experiences and hence by the understandings generated from projects such as this one, as well as by the views of the consumers of services and the community where these services are located. Hence it is important that we understand and acknowledge that we are all responsible for the health and therefore the mental health of the community.

This three-month exhibition reflects the visible presence of the people who were involved in and

contributed to the "Reciprocity in Education" project.

It is important that we recognise and respectfully acknowledge the cultural context, views and experiences of the people who contributed to this project and the strengths this example of cultural diversity brings to South Australia.

This exhibition, held in the South Australian Migration Museum under the auspices of the History Trust of South Australia, is expected to attract a viewing public of approximately 40,000 people.

The Reciprocity in Education Project, funded by the Australian Transcultural Mental Health Network and the DHS has used peoples real experiences and stories to move us ever closer to understanding cultural contexts with the achievements being:

- ◆ Information exchange and capacity building between migrant communities and mental health service providers;
- ◆ A strengthening of existing community and mental health networks; and
- ◆ Providing an example for the future development of partnerships and alliances within other health and community services.

Reciprocity is the process of "giving in return" a striving for mutual understanding by shared experience, knowledge and seeking common understanding of meanings. In the context of the Reciprocity in Education Project it is the process of

shared understandings and learning that leads us to a valuing of diversity and to recognising common understandings of what is meant by "sadness, loss or unhappiness" as opposed to "mental health or illness".

Mental health reform in South Australia is leading to a change in the way people with mental health issues are treated. There has been a move away from segregated and custodial institutional care to a community model that integrates hospital services with community health and promotes partnerships in providing services. It is against this background that The Reciprocity in Education Project has been set.



Most recently the Mental Health Unit (DHS) has engaged in further activity with a key priority of improving community feeling and awareness of mental health and consequently improving the mental health of all South Australians.

This will create a greater focus on the issues of recovery, early intervention and the need for public mental health services to be provided in culturally appropriate and sensitive fashion.

I congratulate Professor Procter, his team and most importantly the community participants in this project and declare the exhibition open.

A Model for the Access and Engagement of Young People from Culturally and Linguistically Diverse Backgrounds

Lisa Beasley
Vanessa D'Souza
High Street Youth Health Service

This paper will outline a project undertaken by High Street Youth Health Service (HSYHS) with the aim of defining the cultural and linguistic diversity of its population over a defined period of time. It will also describe the basic needs of young people from culturally and linguistically diverse (CALD) backgrounds and service development principles as a way of promoting youth health service delivery to young people from CALD backgrounds.

High Street Youth Health Service is a community based health service for young people aged twelve to twenty-five years. The service is a unit of the Western Sydney Area Health Service and is located in Harris Park, an outer western suburb of Sydney, New South Wales. The service has a brief to work with young people who are at risk and those experiencing homelessness.

Young people experiencing homelessness are not a homogenous group. The Council for Homeless Persons Victoria (cited in Wesley Mission 2001:3) defines homelessness as:

Someone without a conventional home, lacking the economic and social supports that a home normally affords. Often cut off from the support and relatives and friends, few independent resources ...no immediate means and, little prospect of self-support.

There are varying degrees of homelessness experienced by young people, ranging from living in insecure or unaffordable housing and being at risk of homelessness, to young people living on the street, in parks, or squats. 'Homelessness may represent a single episode in a person's life, or a condition into which individuals enter and exit repeatedly over a period of time' (Council for Homeless Persons Australia, cited in Wesley Mission 2001:4).

The Human Rights and Equal Opportunity Commission (1989, cited in Wesley Mission 2001:6) found that there were a total of 70,000 young people who were homeless throughout Australia in 1989. In recent years this figure has risen to over 100,000 young people (Wesley Mission 2001:6).

YOUNG PEOPLE FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

It is widely accepted that young people from minority groups, such as culturally and linguistically diverse backgrounds, may experience various social barriers such as poverty, limited education experience and unemployment (Blackwell and Hart (1982); Gibbs (1988) cited in Phinney, Lochner and Murphy 1990:54). These barriers, in addition to length of residency in a new country, influence the process of acculturation or an individual's ability to adapt to a new culture and environment (Gopaul-McNicol and Thomas-Presswood 1998:9).

Phinney et al (1990:54) argue that young people from culturally and linguistically diverse backgrounds must resolve two conflicts, which originate from their status as minority group members, in order to successfully adjust to a new culture – stereotypes and prejudice; and dealing with conflicting norms and expectations from their own culture and that of the dominating culture. Guera and White (1995:2) affirm that this phenomenon is common for young people and that, coupled with normal adolescence being a time of exploration and identity-formation, children of migrants face added complications, needing to balance parental expectations and deal with familial conflict as they search for their cultural identity.

Continued Overleaf

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As young people adjust to their new situations and cultures, they are likely to experience feelings of “anxiety, depression, guilt, anger, and other psychological disturbances suggestive to adjustment problems” (Gopaul-McNicol and Thomas-Presswood 1998:8). Other concerns include behavioural problems, substance use, social withdrawal and difficulties in socialising and achieving.



HSYHS has developed processes that enable access, respect, sensitivity, social connectedness and participation to young people who are marginalised.

Newly arrived and refugee young people require special consideration for they must cope with additional barriers of language, trauma, possibly disrupted education, family separation and adjusting to different welfare, education and health systems and service delivery. In addition, according to Cahill and Ewen (1987; cited in Guera and White (1995:5)) young people of culturally and linguistically diverse backgrounds are at further risk if their ethnic minority group is small, publicly visible or limited in terms of institutional support.

A PROJECT TO IDENTIFY THE CULTURAL AND LINGUISTIC BACKGROUNDS OF CLIENTS OF HSYHS

A strategic priority for HSYHS in 1999-2000 was to define the cultural and linguistic diversity of HSYHS's clientele. The service decided that the initial stages of the project would need to measure the number of young people from culturally and linguistically diverse backgrounds that HSYHS was currently accessing. A survey was developed and administered across all programme strands and that provided staff with information as to the young people's ethnic background and cultural identity.

SURVEY DESCRIPTION

In designing a survey that would provide the service with a meaningful analysis of the clients' ethnic and cultural backgrounds, staff felt it essential that the service should inquire as to the young person's familial ethnic background, the ethnic background that the young person identified with, in addition to what languages were spoken at home.

The survey was completed over a three-month period (April, May and June 2000) and a total of 406 young people completed the survey. Of the 406 respondents 46% were young women and 54% were young men.

In analysing the cultural and language backgrounds of the young people accessing HSYHS during the survey period, two notable points should be highlighted. Firstly, the wide range of cultural backgrounds listed and secondly, the diversity of combinations of familial cultural and language backgrounds of the participants.

255 respondents (64%) identified their own ethnic background as being Australian. Despite this fact, the statistics also indicate a large proportion of young people reported having at least one parent whose ethnic background is not 'Australian'. 131 respondents (32%) identified both their parents as being from two different ethnic backgrounds. This possibly indicates that young people may choose to identify as 'Australian', dismissing society's conventional labelling according to dress, name, and language. It also indicates the need to recognise the growing diversity of Australia's community, due to an inter-cultural relationships.

58 respondents (14%) described themselves as speaking English and another language at home. 26 respondents (6%) reported that they only spoke a language other than English at home. Respondents cited a diverse range of languages other than English being spoken at home. A total of 39 different languages were cited. Lebanese, Spanish and Mandarin were the highest scoring languages other than English spoken at home.

The report marks the preliminary stages of HSYHS's attempt to report on cultural and linguistic diversity of the service's clientele and to seek methods for improving its service delivery to young people of culturally and linguistically diverse backgrounds.

SERVICE DELIVERY PRINCIPLES

On reflection of the above documentation, research outcomes and the working philosophy of the service, HSYHS promotes the following service delivery principles as a means of accessing and engaging young people from

culturally and linguistically diverse backgrounds.

Cultural identity formation should be viewed in the context of generic adolescent development

According to Geura and White (1995:2) many young people dislike society's labelling of their identity according to their ethnicity. In fact, the authors believe that many young people prefer to identify themselves as 'Australian', despite the community's perception that they are from a culturally and linguistically diverse background due to their physical appearance, dress and name.

The results from HSYHS's survey regarding the identification of cultural and linguistic backgrounds of clients, in addition to an analysis of HSYHS client records, further support the findings of Geura and White (1995:2). A large proportion of the respondents self-identified as 'Australian', despite their parent's cultural background being culturally and linguistically diverse; the non-Anglo nature of their Christian and/or surname; and their appearance and cultural beliefs which stereotypically places them under label of non-English speaking background.

HSYHS recognises that in describing its client-base, the service must not define a young person according to cultural stereotypes but according to each young person's own cultural view.

Services targeting access of young people from culturally and linguistically diverse backgrounds should view young people in a holistic and integrated framework and offer a range of service options

Young people from culturally and linguistically diverse backgrounds are not a homogenous group. The labels of cultural and ethnic backgrounds succeed in disguising the great diversity within various cultures. Individual experiences, beliefs, familial structures, length of stay in Australia, socio-economic status and so forth, mean that young people from culturally and linguistically diverse backgrounds often share very little in common, besides the stereotypical cultural identity that the community places on them.

Young people from cultural and linguistically diverse backgrounds share many disadvantages with other young people, such as access to education and employment, limited means of self-expression, limited social and political rights and limited access to health care and other services.

HSYHS supports Cahill and Ewen's (1988:39) advocacy for separate service provision for young people who are recently arrived migrants, especially those from ethnically diverse backgrounds. The service acknowledges that ethno-specific services will provide these young people with

opportunities to build their confidence and develop skills to effectively deal with their new life in Australia. In time, interactive activities between young people of culturally and linguistically diverse backgrounds and mainstream society may then take place. The important role of social supports and primary contact people to assist young people to negotiate their arrival and acculturation in a new society are self-evident.

HSYHS acknowledges that newly-arrived young people will obviously have the need for intensive support particularly in the areas of acculturation issues, language or when trauma has been experienced. It is equally important to consider other adolescent issues that may impact on a young person such as sexuality, developing social connectedness and self-identification.

Services targeting access of young people from cultural and linguistically diverse backgrounds should be aware of young people's potential cultural familiarity with the service and the 'stigma' and embarrassment of attending a service

Anecdotal evidence suggests that young people from culturally and linguistically diverse backgrounds are often hesitant to access services that are ethno-specific due to the issues of potential cultural familiarity and possible family connections within these services. Some young people



HSYHS embraces social justice principles and recognises the importance of a youth services that is inclusive of young people and their community.

have expressed concern that their confidentiality may be breached. This may be of particular concern for smaller ethnic communities where young people may believe that workers have links with their family members. The authors believe that some young people are often more comfortable accessing a worker outside of their cultural group, especially around sensitive issues such as abuse, sexuality, sexual preference and mental health.

Services should also be aware of the stigma often attached

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High Street Youth Health Service has a multi disciplinary approach to encourage creativity and innovation in all aspects of the service.

to attending a health service and work to promote the demystifying of health issues. Young people, regardless of their cultural and linguistic backgrounds are often reluctant to access health services. There may be additional issues around cultural beliefs and/or attitudes and knowledge levels.

Services targeting access of young people from cultural and linguistically diverse backgrounds should develop a youth service culture as a component of their services and programs

In order to acknowledge the fluidity of adolescent development in all young people (Taylor 2001) and to promote identity formation as a generic issue, the authors suggest that ethno-specific services develop a broad based youth service culture within their programs. In addition, the authors believe that broad based education programs should be developed for all young people and that the programs and activities promoted by these services provide a range of opportunities to assist young people with a wide range of health issues.

Youth health services, youth services and other services working with young people from culturally and linguistically diverse backgrounds should seek opportunities for collaboration and the establishment of working partnerships

Optimising young people's health depends on a broad range of social, economic and other environmental factors. Young people from culturally and linguistically diverse backgrounds need access to a range of health and other services. In addition, there needs to be a balance between public health interventions aimed at promoting the health of young people and treatment services for individuals for specific groups.

Mechanisms need to be developed to facilitate the effective coordination of individuals, organisations and agencies working to promote the health and well-being of young people from culturally and linguistically diverse backgrounds. Co-operative strategies within the health sector and between health and other sectors are required around the co-management of young people, consultancy and referral. Agencies should be encouraged to develop partnerships to develop projects, develop education and training packages and undertake research projects.

To this end, HSYHS values the importance of networking, supporting and collaborating with local ethno-specific and cultural organisations, workers and networks, in order to provide quality services to young people and their families from culturally and linguistically diverse backgrounds.

CONCLUSION

This paper highlights the need for social, health, welfare and political institutions and systems to create positive environments in which young people can develop, be valued and respected and where they are afforded equal opportunities and outcomes. These requirements are relevant to both mainstream and specialised services that are accessed by all young people regardless of their cultural and linguistic background. □

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Modification of FRIENDS Strategies for the Prevention of Anxiety in NESB Children and Young people

Paula Barrett & Robi Sonderegger

Griffith University and the State of QLD through the Queensland Transcultural Mental Health Centre (QTMHC), Division of Mental Health

The increasing number of Australian cross-cultural and acculturation research projects over the past few years has served to advanced knowledge about the difficulties faced by non-English speaking background (NESB) children and teenagers who migrate to Australia. It has recently been highlighted that migrant groups vary in their experience of cultural adjustment, emotional distress, and coping ability. Although it is broadly recognised that acculturative-stress is a major cause of internalising problems, and that culturally diverse groups have specific needs, strengths, and weaknesses, little work has been undertaken to synergise existing research efforts. Culturally sensitive psychological-practice recommendations have been proposed in the cross-cultural literature however, ethnically sensitive treatment programs for migrant groups, or even empirical trials of existing interventions for use with NESB youth, are virtually non-existent. To counter the NESB service paucity among Australian mental health professionals, Griffith University and QTMHC set out to develop anxiety prevention, emotional resiliency training (early intervention), and treatment programs that tap into the specific needs of migrant groups in culturally relevant ways.

Although considerable evidence purports that psychosocial treatments and prevention programs are effective in reducing a broad range of internalising problems (anxiety and depression) and promoting emotional resiliency in children and adolescents, the suitability of employing Anglo-Australian standardised therapeutic programs for use with NESB populations has been questioned. One of Australia's leading family and peer group based cognitive behavioral early intervention and treatment programs (The FRIENDS program; see www.australianacademicpress.com.au) has recently been the centre of much attention with its application to participants of diverse cultures, both nationally and internationally (having been translated and used by therapists and researchers in Holland, Germany, Belgium, Portugal and the USA). Having been clinically validated, FRIENDS has satisfied Australian Federal Government guidelines for evidence-based research through national and international studies.

The program name 'FRIENDS' is an acronym for the strategies taught: F-Feeling Worried?, R-Relax and feel good, I- Inner thoughts, E-Explore plans, N-Nice work so reward yourself, D-Don't forget to practice, and S-Stay cool and calm because you now know how to cope. FRIENDS is specifically designed for school age children, featuring two parallel programs for primary school and high school, each consisting of 10 weekly sessions. A group leaders manual clearly describes the activities that therapists need to implement in each session, and children work through their own personalised workbook detailing the strategies discussed in each session. Lessons include learning how to practice relaxation exercises, thinking helpful thoughts, changing negative thoughts to positive thoughts, graded exposure to difficult situations, problem-solving strategies, recognising feelings in yourself, recognising feelings in others, and helping both oneself and others to feel good. The manuals permit flexible implementation to allow for cultural individuality and the needs of any specific group.

The recent trial of the FRIENDS program in Australia with clinically anxious female refugees from former-Yugoslavia, revealed that while the program was effective in reducing clinical anxiety from pre- to post-intervention, the efficacy of the intervention may have been enhanced by tailoring the program to the specific migration issues presented by the participants. The authors concluded that there was not only a need to modify some of the existing activities to make them more culturally sensitive, practical to administer, and easier for NESB participants to understand, but also to allow for specific examples that addressed relevant migrant needs (e.g., cultural adjustment difficulties).

In order to evaluate the efficacy of FRIENDS in reducing anxiety and building emotional resiliency among NESB students, and gather practical suggestions on how FRIENDS activities could be culturally modified to better meet the needs culturally diverse youth, more than 200 NESB primary and high school students from Brisbane and the Gold Coast participated in a year long research program.

At different stages throughout 2000 and 2001, students of former-Yugoslavian, Chinese, and mixed ethnic

Continued Overleaf

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backgrounds participated either in the FRIENDS program, or a parallel 10 week wait-list condition. All students were administered a comprehensive assessment package (differentiated by primary and high school) at pre-condition, post-condition, and at 6 months follow-up, using the same administration procedure for all school and cultural groups. Although participants could read and write basic-English, group assessments were conducted verbally in ESL classrooms, providing both an English and native cultural language (Mandarin, Cantonese, and former-Yugoslavian) interpretation of each question by trained bilingual Mental Health Professionals. Mixed-ethnic participants were administered the assessment package in English only (with the exclusion of Samoan and Arabic speaking students who also received interpretations).

A total of 10 FRIENDS intervention groups were run in six different schools. All participating schools were recruited from analogous socio-demographic regions. Both primary and high schools were of similar size, and were all operating under the Queensland state education system. Four high school treatment groups were run ($n=50$), comprising one former-Yugoslavian group ($n=12$), two Chinese groups ($n=22$), and one Mixed-Ethnic group ($n=15$). Six primary school treatment groups were run ($n=71$), comprising three former-Yugoslavian Groups ($n=28$) and three Chinese groups ($n=37$). Each FRIENDS group featured between 6 and 17 students. All remaining participants (matched for school level, gender, and cultural background) participated in the three assessment phases of the program, without having participated in FRIENDS.

The outcome of the project was overwhelmingly positive, with School Principals, Deputy Principals, ESL coordinators, and Bilingual teacher aids, acknowledging positive in-class and playground behaviour change among NESB students who participated in FRIENDS. Based on pre-post quantitative measures, students who participated in the FRIENDS program showed significantly greater improvement on self-esteem (primary students only), level of anxiety, and future-outlook, than NESB control students (matched for culture, gender, and age) who did not participate in the program.

The program itself received considerable feedback from group leaders, NESB student-participants, ESL teachers, ethnic community members, project management staff, and independent psychologists, which directly contributed to the development of a culturally sensitive resource specifically targeted for NESB migrant students. Social validity data and independent interviews with participants and program facilitators aided this process by gathering valuable information on the strengths and weaknesses of administering existing activities to NESB participants.

The general consensus from facilitators and participants

was that the program would benefit from flexible open forums for group discussion on topics of cultural concern and interest, as well as the incorporation of music, art, and creative stories that are personally relevant to young NESB migrants. Over a series of months, changes were made to existing activities featured in the FRIENDS program, culminating in a brand new Group Leader's Universal NESB Supplement to FRIENDS (UNSF) Manual. The new supplement follows the same 10 sessions of the original FRIENDS program, providing both detailed process instructions for facilitators and alternative culturally sensitive/aculturative-relevant activities. Although now ready for administration, the UNSF Manual will continue to evolve and be modified over the coming months following eventual validation trials with NESB students around Australia. □

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MENTAL HEALTH RESOURCES IN THE WORLD

Initial results of Project ATLAS World Health Organisation

For the full report go to www.who.int

Though considerable information has recently become available on epidemiology and burden of mental disorders, very little is known about the resources available for mental health care within countries. Accurate information is crucial for programme development and serves as a baseline for monitoring changes.

Project ATLAS aims to meet this need by collecting basic information on mental health resources from all Member States to construct global and regional databases, maps and profiles. Preliminary analysis of information collected during the initial study, from October 2000 to March 2001, from 181 countries covering 98.7% of the world's population is now available. The information was collected using a questionnaire completed by the mental health focal point within the countries.

Of the countries studied 43% have no mental health policy; 23% have no legislation on mental health; 38% have no community care facilities; in 41%, treatment of severe mental disorders is unavailable in primary health care; and more than half of the beds for mental health care are in mental hospitals.

Serious disability caused by mental disorders is often not considered for state disability benefits. Out of the 174 countries where information about disability benefits is available, more than a quarter do not provide state or public disability benefits for mental illness.

MENTAL HEALTH IN PRIMARY CARE AND COMMUNITY CARE

While it is agreed that most mental disorders are best managed at the primary care level, this has proven difficult to achieve in practice.

Eighty-five per cent of countries report that mental health services are available at primary health care level, but actual treatment is reported to be available only in 59%.

A national therapeutic drug policy or a list of essential drugs is present in most countries however, in many countries, policies have been developed in the last 5 years, hence the benefits of this policy have not fully filtered down to the consumer level. More than 25% of the countries do not have the most commonly prescribed antipsychotic, antidepressant, and antiepileptic drugs considered essential for the treatment of common mental and neurological disorders at the primary health care level.

Community-based care is not available in 38% of the countries. Even in countries that have community care, the coverage is far from complete.

HUMAN RESOURCES AND INPATIENT FACILITIES

About 71% of all people in the world have access to less than one psychiatrist per 100,000 people. Access to psychiatric nurses is also poor; 46% have access to less than one nurse per 100,000.

While the countries in the African region of WHO have only about 1,200 psychiatrists and 12,000 psychiatric nurses for a population of about 620 million, the European region has more than 86,000 psychiatrists and 280,000 nurses for a population that is only about 36% more (total population 840 million).

Though mental hospitals with a large number of beds are not recommended for mental health care, a certain number of beds in general hospitals for acute care is considered essential. There is a wide variation in beds available for mental health care. Nearly two-thirds of the world's population has access to less than 1 bed per ten thousand population. Even more disappointing, more than half of all the beds are still in mental hospitals. These often provide custodial care rather than mental health care.

MONITORING AND DATA COLLECTION SYSTEM

More than 27% countries have no system of reporting mental health data in their annual health report. Those who have such a system often lack any meaningful information. Often only the number of admissions and discharges from mental hospitals is recorded. This lack of monitoring makes detecting changes almost impossible.

PROGRAMMES FOR SPECIAL POPULATIONS

Programmes for special populations are present in a small number of countries. Programmes for minorities and indigenous populations are not present in the majority of the countries. Programmes for the elderly and for children are present in only 48% and 59% respectively.

Overall, the mental health resources in countries present a dismal picture of severe shortage, neglect and apathy. However, there are some rays of hope. A large number of countries have established policy, programmes and new legislation in the last 5 years. NGOs have also started becoming active. These include consumer groups and family groups that have the capacity to bring about a change in the system. A concerted action by governments, professionals and the community is needed to improve the mental health resources situation in the world.

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AFRICAN COMMUNITIES AND SETTLEMENT SERVICES IN VICTORIA: TOWARDS BEST PRACTICE SERVICE DELIVERY MODELS

This report includes maps and analyses of the African Australian population in Victoria based on the 1996 Census and DIMA Settlement Database statistics. The literature review, outlines African perceptions of settlement services and of a range of settlement services including. The principal findings demonstrate the diversity and fragmentation of African communities in Victoria.

Apollo Nsubuga-Kyobe and Liz Dimock
La Trobe University, 2000

CARE-GIVING AND THE SOCIAL CONSTRUCTION OF "MENTAL ILLNESS" IN IMMIGRANT COMMUNITIES

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

Eastern Perth Public & Community Health Unit &
Murdoch University, 2001

A STUDY ON THE MENTAL HEALTH NEEDS OF THE SOMALI COMMUNITY IN TORONTO

The objects of a meeting and partnership between York Community Services & Rexdale CHS raised several objectives in relation to the mental health needs of the Somali Community. These objectives are discussed in more detail in the report.

Abdullahi S. Elmi
York Community Services & Rexdale CHS 1999

SETTLEMENT EXPERIENCES OF SOMALI REFUGEE WOMEN IN TORONTO

This paper reports on a qualitative research project that outlined the perspectives of Somali refugee women and their resettlement in Toronto and considers aspects of their integration into Canadian society.

7th International Congress of Somali Studies York
University, Toronto, Ontario Canada 1999

PATHWAYS AND BARRIERS TO MENTAL HEALTH CARE FOR ETHIOPIANS IN TORONTO

This report is derived from a survey research that has been partially funded by the Centre Of Excellent for Research in Immigration and Settlement in Toronto. The focus of this study was to determine the prevalence of such major mental disorders as depression, anxiety, Post Trauma Stress Disorder (PTSD) and somatization. The study also describes the utilization rates and patterns of diverse health care services.

Cultural Community and Health Studies Program, Centre
for Addiction and Mental Health and Department of
Psychiatry, University of Toronto, 2001

THE PSYCHOLOGY OF CULTURE SHOCK

This book will prove an essential reference and textbook for courses within sociology, psychology and business training. It will also be a valuable resource for professionals working with culturally diverse populations and acculturating groups such as international students, immigrants or refugees.

New York : Routledge 2001
ISBN 0415162343

RELIGION & CULTURE IN ASIA PACIFIC: VIOLENCE OR HEALING?

This collection of essays brings us to accumulated wisdom of some of the most important theorist and practitioners of conflict resolution in Asia Pacific. It paints a daunting picture of the great challenge ahead, but at the same time conveys an empowering sense of the enormous resources, which the spiritual and ethical traditions of the Asia Pacific can bring in response to that challenge.

Melbourne : Vista Publications 2001
ISBN 1876370025

PSYCHOSOCIAL AND TRAUMA RESPONSE IN WAR- TORN SOCIETIES, THE CASE KOSOVO

This notebook is a compilation of papers presented at the First International Seminar on Psychosocial and Trauma Response in Kosovo, which was held at IOM Geneva, Switzerland, from 8 to 10 March 2000.

Psychosocial Notebook Vol.1, November 2000

Events Calendar

2001

August

29-31

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29-1Sept

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23-26

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24-25

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26-29

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www.menshealth.uws.edu.au/mfa1.htm

November

11-13

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30-2Dec

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December

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For information on transcultural mental health issues contact the ATMHN or your local transcultural mental health service. For those living in the Northern Territory or Tasmania contact your local Department of Health.

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 Parramatta BC NSW 2150 Fax: 02 9840 3388
 Email: atmhn@wsahs.nsw.gov.au

Transcultural Mental Health Services

ACT Transcultural Mental Health Network	02 6207 1066
NSW Transcultural Mental Health Centre	02 9840 3800
QLD Transcultural Mental Health Centre	07 3240 2833
SA Transcultural Mental Health Network	08 8243 5613
Victorian Transcultural Psychiatry Unit	03 9417 4300
WA Transcultural Psychiatry Unit	08 9224 1760

Other Contacts

Aust. Mental Health Consumers Network	07 3394 4852
Carers Association of Australia	02 6282 7886
Federation of Ethnic Communities	
Councils of Australia	02 6282 5755
Mental Health Council of Australia	02 6285 3100
National Ethnic Disability Alliance	02 9891 6400
National Forum for STARTTS	02 9794 1900

Government Mental Health Services

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ACT Dept. of Health and Community Care	02 6205 5111
NSW Health	02 9391 9000
Territory Health Services, NT	08 8999 2400
QLD Health	07 3234 0111
Dept. of Human Services, SA	08 8226 8800
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