Multicultural Centre for Women's Health

Submission to the Royal Commission into Victoria's Mental Health Services

5 July 2019

Multicultural Centre for Women's Health is a national organisation run by immigrant and refugee women and dedicated to immigrant and refugee women's health.

This submission has been developed by the Multicultural Centre for Women's Health (MCWH). MCWH is a Victorian-based women's health service established in 1978 that works both nationally and across Victoria to promote the health and wellbeing of immigrant and refugee women through advocacy, social action, multilingual education, research and capacity building.

The core of MCWH's work is to deliver bilingual health education sessions and share multilingual health information with women in the community. The sessions build women's confidence and capacity: to make informed choices about their health and well-being; and to access services, including mental health services, in Victoria. We also undertake projects that can contribute to increasing migrant women's opportunities for health and wellbeing, across a wide range of health and wellbeing research, advocacy and education topics (Please see our Annual Report for more information about our recent work).

MCWH also works to provide evidence, expert advice, and professional development to key stakeholders on improving the health and wellbeing of immigrant and refugee women across Australia. It does this through research and publication, participation in advisory groups and committees, written submissions, training and seminar programs, and presentations of our work.

MCWH wants all Victorians to have access to mental health services and support. We support Aboriginal and Torres Strait Islander people's self-determination and control over how mental health services and support can be improved both for their communities and the wider community.

As an organisation with a specific focus on migrant women's health and wellbeing, our submission seeks to highlight the specific experiences and perspectives of women and people who identify as women and who also identify or are identified as coming from a refugee or migrant background. This includes women living in Australia temporarily or permanently, across diverse visa categories and conditions, as well as first, second and many generation citizens.

Our focus is to highlight the experiences that may be relevant to all migrant and refugee women, however we acknowledge that migrant and refugee women's experiences also cut across and include specific experiences of women that we may not capture in this submission, but should be considered and addressed. This includes the specific experiences of migrant women with disabilities,

migrant women who are sex workers, older and younger migrant women and girls, migrant women who identify as LGBTIQA+, migrant women living in remote and rural areas, migrant women experiencing homelessness, unemployment or particular financial disadvantage, and migrant women in detention, including asylum seekers.

Our submission broadly addresses four of the questions set out by the Commission:

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?
2. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
3. What are the needs of family members and carers and what can be done better to support them?
4. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

1. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

It is critical that the issues of race and gender inequality and discrimination, and violence against women are recognised as issues that significantly impact on migrant and refugee women's mental health. In addition, migrant and refugees experience settlement stress and trauma before and during the migration process, which affects mental health (Delara, 2016).

To improve the mental health of Victorians, it is important that the RCHMS extend its view beyond an exclusive focus on the mental health system. There are many social and economic issues that impact on mental health that need to be addressed at the same time as mental health services are improved.

A social determinants of health approach to mental health recognises that mental health is shaped by the social, economic, and physical environments in which people live. Social and economic inequalities are associated with increased risk of many common mental health conditions (World Health Organization and Calouste Gulbenkian Foundation, 2014). In this submission, we will focus on a few key social determinants of health, recognising that many other factors also impact on migrant women's ability to experience good mental health.

Race and gender inequality

Peoples' mental health is impacted by the social and economic context in which they live and by the inequality and discrimination that they face. Migrant and refugee women are impacted by race and gender inequality which in turn affects their mental wellbeing (Delara, 2016). A recent Victorian study found that racism is damaging to both the mental and physical health of Victorians. People

who frequently experience racism are almost five times more likely than those who do not experience racism to have poor mental health (Department of Health and Human Services 2017).

Gender inequality is also associated with poor mental health, with inequalities such as the gender pay gap and workplace discrimination putting women at higher risk of physical and mental illness. Two to three times more women than men experience depression and anxiety and women make up over 60% of reported cases of self-harm and attempted suicide (Department of Premier and Cabinet, 2016; Yu, 2018).

Migrant women experience intersecting discrimination on the basis of race and gender and have multiple and severe health disadvantages as a result (Department of Premier and Cabinet, 2016).

Violence against women

Violence against women leads to poor mental health for women and children. Intimate partner violence contributes approximately 2.2% to the burden of disease for all women and 5.1% to the burden of disease for women aged between 18-44 years. Depressive and anxiety disorders, suicide and self-harm are among the top ten leading causes of the overall burden in women aged 18-44. (Ayre et al, 2016).

Research has shown that Australian prevalence of violence against women is unacceptably high: one in three Australian women have experienced physical or sexual violence and/or emotional abuse in her lifetime. For migrant and refugee women, there is evidence that prevalence rates are even higher and that violence is more severe and prolonged (Lum On et al, 2016). This is also the case among women experiencing social and economic marginalisation (Sokoloff & DuPont, 2005).

For migrant and refugee women, the reported health impacts of family violence include reduced or impaired mental health and an increasing and persistent fear of the perpetrator committing further violence, returning after separation, or seeking retribution. A 2016 study found that for migrant and refugee women, health and wellbeing impacts of family violence occur across a continuum; women reported high levels of stress, fear and anxiety during the relationship, regardless of the frequency or severity of the perpetrator's violence. Many migrant women also reported feelings of isolation, depression, guilt and self-blame, low self-esteem, loss of confidence and suicidal thoughts (Vaughan et al, 2016).

> As soon as he hit me, everything changed. I no longer see anything positive and don't even know who I am anymore. (Sara)
>
> I said that I didn't want to live and suicidal thoughts were coming. I tried to cut my vein with a kitchen knife. So many marks were there but I didn't succeed. I was thinking that even my knife wasn't helping me. (Mannat)
>
> (cited in Vaughan et al)

Settlement stress and trauma

Settlement stress and migration-related trauma contributes to a higher likelihood of mental health conditions among migrants and refugees. Social isolation during the settlement period, lack of family and social support, discrimination, and longer length of migrants' residence in the host country can increase the likelihood of common mental health conditions. Traumatic events prior to migration, as well as forced or unplanned migration can also contribute to a higher risk of developing mental health conditions. In contrast, proficiency in the majority languages spoken in the host country, family reunification, and increased social support are factors that reduce risk (Jurado et al, 2017).

Older people from migrant and refugee communities have been found to be at greater risk of experiencing mental health conditions, such as depression and anxiety. Social isolation, loneliness and language barriers exacerbate this risk (FECCA, 2017). Migrant and refugee women, including older women, are at particular risk of social isolation and loneliness which contributes to their higher risk of mental health conditions (Delara, 2016).

Settlement stress impacts differentially on migrants depending on their region of birth (Jurado et al, 20217), their gender and their visa status (Jarallah and Baxter, 2019). A recent study found that on-shore asylum seeking women in Australia experience higher levels of psychological distress than women seeking asylum off-shore. This can be explained by the prolonged nature of their precarious visa status before being granted permanent residency. Financial stressors, housing stressors, loneliness, and getting used to life in Australia are all significant predictors of psychological distress for asylum seeking women (Jarallah and Baxter, 2019).

Perinatal mental health

It is critical that the issue of perinatal mental health is addressed by the RCMHS. Pregnancy and the postnatal period provide a window of opportunity during which migrant and refugee women have increased contact with health services, often for the first time after settling in Australia. This is an opportunity for health practitioners to identify migrant or refugee women at risk of, or with existing, perinatal mental health issues and/or other mental health conditions. At this time issues can be identified and women can be appropriately supported across the individual, family, community and societal spectrum (Fellmeth, 2018).

A recent study conducted by La Trobe University and commissioned by the Multicultural Centre for Women Health (Shafiei et al, 2018) has shown that migrant and refugee women are at higher risk of perinatal depression and anxiety and are more likely to experience postnatal depression Specific risk factors identified include:

- social isolation
- lack of social and family support
- family violence
- financial stresses
- trauma
- uncertainty of visa status
- unintended pregnancy
- pregnancy complications including pregnancy loss, and

- a history of mental illness.

The study found that migrant women tend not to seek help for perinatal mental health issues. Barriers to seeking assistance include:

- social stigma
- complexity of the service system
- limited transport options
- communication barriers, and
- the high cost of services particularly for women on temporary visas who are not eligible for Medicare.

However, the study found that the most significant barrier to service access for migrant and refugee women is a lack of availability of relevant or appropriate services. In most of Victoria there are simply no tailored or targeted services that can provide specialist expertise in perinatal mental health for migrant or refugee women.

The study mapped the available perinatal mental health services in the Northern Division of Victoria, finding that there are only two health services (Swan Hill and Yarra) across the whole Division that offered any perinatal mental health-related services that were specifically targeted to migrant or refugee women. One Banyule-based program provided their perinatal mental health services to African women. All other perinatal mental health services had limited capacity to provide a culturally and/or linguistically appropriate service. In some cases, specific inclusion criteria, such as the need for a diagnosis, can act as a barrier to access.

In addition, the services that were tailored specifically to pregnant or parenting migrant or refugee women did not have perinatal mental health programs.

There is significant evidence that migrant and refugee women fall through the gaps of existing services that are available to the community to address mental health in general and perinatal mental health in particular. Two service providers shared the following case studies which clearly illustrate that migrant women struggle to find an appropriate health service response to cater for their specific mental wellbeing needs as mothers and migrants, particularly when there are multiple other social issues they are facing such as family violence and/or homelessness. Without culturally and linguistically appropriate and accessible early intervention services, mental health issues that could be addressed at an early point are left to escalate to a crisis point.

> “We had one mum who was suicidal, who we had to go through the mental health triage with, and with the domestic violence - even with that going on, it still becomes about ‘Where can I sleep? Where can I go?’ You can have significant emotional and mental [health problems] but it still prioritises the physical over that.” (Health service provider)

> “I had a mum yesterday who had talked about suicide. She’d seen a GP the week before at a bulk billing clinic and the GP started her on medication. Didn’t do anything about the suicidal ideation or triage team etc. And then this mother was meant to go back to that GP yesterday. I said, ‘Can I ring the GP, talk to her?’ She said, ‘Yes’. I found out the GP was on two weeks’ holidays. So she was going to go to this bulk billing clinic and just see another person,

presenting. You know, she had a [suicide] plan, talked about hurting the child, suicidal thoughts for herself ... It's just such poor standard of care." (Health service provider)

(cited in Shafiei et al, 2018)

2. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

Provide culturally appropriate, evidence-based and community-led education and information about mental illness and health

Stigma and lack of awareness about mental illness and mental health exists across many migrant communities in Australia. Stigma and poor understanding can prevent migrant and refugee women from speaking openly about mental health and from seeking assistance from appropriate services at an early point, or at all. Stigma can also lead to a lack of understanding, support or empathy for migrant women experiencing mental illness from their families and communities. Research suggests that stigma around mental health can be heightened when it intersects with gender or race inequality, such as in the case of perinatal mental health (Shafiei et al, 2018).

The specific ways that mental illness is described, understood and experienced can be different across linguistic, ethnic and cultural communities, and can be shaped by shared beliefs about health, wellness and spirituality (Jiminez, 2012; O'Mahoney et al; 2007). However, the negative consequences of stigma and misinformation about mental health are universal.

Education about mental health and illness should be delivered to migrant and refugee communities, with an understanding of the specific cultural and gendered context of the specific mental health issue. It should also take into account varying culturally-bound understandings of mental health and illness in general.

Whenever possible, bilingual education around mental illness and stigma should be available for migrant communities from non-English speaking backgrounds. Education should be delivered by trained bilingual educators and community leaders who are supported, remunerated and recognised for their work. Similarly, campaigns or public information about mental illness, mental health and mental health services, should be developed in consultation with relevant communities, to ensure that both English content and translated content are widely accessible, appropriate and that content remains meaningful for all communities.

3. What are the needs of family members and carers and what can be done better to support them?

MCWH undertook a two-year project between 2015 and 2017 to support immigrant and refugee carers of family members or friends who are frail elderly, and/or living with a disability, chronic illness or mental illness called *Dealing With it Myself* (see report attached).

An extensive body of literature indicates that carers themselves suffer from higher than average rates of physical and mental health problems, particularly when they are undertaking their caring role with low levels of family, community and formal support. Immigrant and refugee seniors and carers in particular have smaller family networks and lower rates of service use compared to the Australian-born population, potentially placing strain on caring families and leaving complex health needs unmet (Cash et. al. 2013; CEPAR 2014 B; FECCA 2015; and Team et. al. 2007).

Through the *Dealing With It Myself* project, MCWH identified the needs of migrant carers and identified carers as a group who have a higher risk of experiencing poor mental health. A summary of our findings and recommendations follows (Full Report attached).

Addressing gendered assumptions about caring

Unpaid family caring (or caregiving) for elderly adults or people living with a disability or chronic or mental illness is one of several domains of both paid and unpaid caring work in Australia located within a highly gendered workcare regime (Pocock et. al. 2013).

Gendered assumptions and expectations about caregiving often determine how the labour of caregiving is distributed within families and how families access informal and formal support. Such assumptions also inform social policy, and may intentionally or unintentionally reinforce restrictive gender roles.

Although many men also become carers, women are often expected to be the providers of care while men are considered to be the recipients (Spitzer et. al. 2003). Our project found that this gendered assumption influenced the level of informal (from friends and family) and formal (from medical and other human services) support that migrant women are offered (See the Full Report for a more thorough analysis: http://www.mcwh.com.au/downloads/project-reports/MCWH-2018-Dealing-with-it-myself-Carers-final-report.pdf).

Removing barriers to support

Both international and Australian literature indicate that immigrant and refugee carers face multiple, intersecting barriers in accessing social and government support services in their caring roles, and are more likely to fall within lower socioeconomic brackets (Boughtwood and Wu 2010; Gupta and Pillai 2012; Katbamna et. al. 2004; Miyawaki 2015; Spitzer et. al. 2003; Taylor 2013; Team et. al. 2007). Similarly, all of our project stakeholders pointed to navigating the complicated (and currently changing) Australian healthcare system as a key challenge for immigrant and refugee carers.

The project found that aged, mental health and disability care and carer support services assumed that individual 'consumers and carers' can exercise 'choice and control' and effectively identify and advocate for their own needs. Such self-advocacy and planning within the health system can be difficult even for fluent English-speakers who are familiar with dominant individualised cultures of service provision and biomedical approaches to health, and more so for people from immigrant and refugee backgrounds who may have different understandings about healing, caring, wellbeing, government intervention and service provision. This applies, not only to carers, but to any immigrant and refugee woman seeking support and accessing services.

Addressing migrant carer's isolation

The nature of caring can socially isolate carers, and many carers we spoke to described feeling alone due to the demanding nature of their role, and stigma from family and community members about the health conditions of their care recipients. Such feelings of isolation are well-established in the literature. Team et. al. (2007) for instance, found that many Russian female carers felt isolated both from the general community and their Russian-speaking compatriots because of their caring responsibilities, meaning they did not have substantial social networks to call upon for information or support.

The Dealing With It Myself project found that immigrant and refugee carers are often isolated and have very few people to call for help, as their social and family networks are much smaller in Australia than in their countries of origin. Moreover, eligibility criteria in the community care market prioritises people with acute care needs and people without family to look after them. Such criteria limit the access of carers, who are usually women, to services which could ease their caring responsibilities and improve their health and wellbeing (Cardona et. al. 2005). The project supported caring families by developing and delivering culturally-tailored multilingual health information on available support services, and raising awareness about carer health and wellbeing amongst family and community members. It is an excellent model for supporting carers from migrant and refugee backgrounds. A full list of recommendations can be found in the full report.

4. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

Research suggests that verbal, same-sex, group-based, peer education sessions are a highly effective and supportive mode of health education for immigrant and refugee women. Research conducted in Perth, Western Australia (Lee et al, 2013), into the topic preferences and means of access to health information among newly-arrived women, found that mental health was ranked as a top priority along with employment advice and women's health issues. Preferred methods for receiving information were interactive talks with written materials. In addition, it was found that non-threatening, participatory processes encouraged women to prioritise sensitive topics such as family violence and highlighted the need for such topics to be incorporated within general health information.

A UK based study (Greenhalgh, 2009) of a peer model of health education also found that positive outcomes can be achieved through group participation (in addition to knowledge acquisition), as participants are able to negotiate meanings and make information meaningful for themselves.

For over forty years, MCWH has conducted evidence-based, bilingual, woman-to-woman, health education sessions in workplaces and across communities throughout Victoria, including health education sessions on mental health. More information about the MCWH bilingual health education program is available at this link: http://www.mcwh.com.au/bilingual-health-education/. Many migrant women have provided feedback that attending health education sessions has increased their understanding of mental health issues and increased their willingness to seek support.

> "After learning the relaxation strategies, I will try to practice them, and give myself a break, have a rest when I feel overwhelmed, stand for myself and avoid anything that could affect my mental health in a negative way."
>
> After today's session I have more confidence to differentiate between depression and sadness as I know now the symptoms of each one.
>
> "The session has explained the importance of recognising symptoms and getting the right treatment to prevent the condition getting worse. I will share this information with my community. I think this will help my community to have a better understanding about the mental health and seek out treatment."
>
> "The session provided me with important information. I think we need to change the way we think and talk more about mental health and confront problems, not avoid to talk about them will not make problems go away. We all benefited from sharing experiences on how we can manage stress levels."

Although extremely important, health education and awareness raising is only one part of the picture. It is vital that in encouraging women to seek support for mental health issues, our organisation can be confident that the services to which we refer women will be culturally responsive to women's needs. Promoting mental wellness and preventing mental illness among migrant and refugee women and their communities requires a holistic approach to addressing mental health determinants at individual, social and institutional levels with respect to research, education, practice, advocacy and policy.

Recommendations

MCWH proposes the following recommendations:

1. Strengthening intersectional policy analysis: Embedding a gendered, intersectional framework to examine the impact of specific policy approaches on immigrant and refugee women and families. Analysis and evaluation of the mental health system and service delivery options should address the disproportionate amount of unpaid caring currently undertaken by women in Australia, as well as the multiple forms of disadvantage and barriers to accessing services experienced by immigrant and refugee families (including racism, discrimination, ethnocentrism in service delivery, and language barriers).

2. Co-designing future support services with immigrant and refugee women experiencing mental illness and their carers: Engaging immigrant and refugee women in the co-design of service options through active outreach and consultation by bicultural staff.

3. Developing innovative education and advocacy interventions that are specifically tailored for migrant and refugee women and involving representatives of migrant communities, and women in particular (Delara 2016; Fellmeth 2018). These could include programs that

promote gender and racial equality.

4. Develop community-based initiatives to promote social cohesion and the development of social networks within migrant communities. Community groups that are accessible to migrant women and responsive to their needs have been shown to reduce the risk of developing mental disorders (Fellmeth 2018).

5. Removing residency restrictions: Making support services available to migrant and refugee people on all visa categories in Australia to avoid a multi-tiered system in which certain groups of residents and citizens have access to more support than others.

6. Ensuring high quality and culturally appropriate service delivery by:

    - increasing funding for multicultural and ethno-specific organisations to increase understanding and decrease stigma around mental health;
    - providing sustainable funding for services to offer comprehensive, ongoing, in-person support and case management to immigrant and refugee families accessing their service,
    - recognising that many technology-based modes of service delivery exclude users of non-English speaking backgrounds from accessing timely early intervention services; and
    - ensuring immigrant and refugee clients do not pay for interpreting, translating.

7. Delivering cross-cultural training: Training mental health services staff and the interpreting workforce in gendered cross-cultural awareness

8. Facilitating community health education: Delivering bilingual health education sessions to raise understanding about mental health

9. Developing culturally-responsive peer support: Sustainably resourcing peer support-like activities co-designed with immigrant and refugee people.

10. Conducting further participatory action research to increase the evidence-base for migrant and refugee mental health and wellbeing in Victoria.

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