Ethnic Communities Council of Western Australia

Hi Julie

Ms. Vivienne Pillay the Executive Officer of ECCWA and I have discussed your request and the best that we can do under the circumstances are to provide you the following attachments and reiterate some important points most of which are made in them:

- ECCWA Media Release "Don't Coloured Australian Lives Matter Anymore?
- ECCWA Feedback on Suicide Prevention 2020.
- All Lives Matter- Suspected Suicides within Ethnic Communities in Western Australia (presentation made by Dr. Indira Pattni, Clinical Psychologist, MSC & Ramdas Sankaran, President, ECCWA, to the WA Ministerial Advisory Council on Suicide Prevention in September 2017.
- Research Report-"Still births in Western Australia, 2005 to 2013: Influence of Maternal Migration and ethnic origin"

The reiterate points we wish to reiterate are as follows:

1. **Suicide Ethnicity Data**

The following profile has been extracted from the Western Australian Suicide Prevention Strategy 2009 – 2013 report.

> "According to data from the Australian Bureau of Statistics, 23% of the Australian population was born overseas. A study by Kryios19 indicates that about 25% of suicides in Australia are by people within the migrant population, with 60% of these deaths occurring among people from a non-English speaking background.
>
> In general, suicide rates follow the country of birth rather than the country of settlement, with migrants from countries with high rates of suicide also experiencing high rates in Australia. This includes people from English-speaking countries; such as Western, Northern, Eastern Europe, and the former USSR. Migrants from countries with low rates of suicide generally have low rates in Australia, which includes people from southern Europe, the Middle East and Asia. Similar patterns are evident in Western Australia.
>
> Suicide rates among migrant groups in Australia are generally higher than in the country of birth. Migrants aged 65 and older have higher rates than the overall population."

These statistics are very disturbing especially when you consider the following:

- When suicide rates follow the country of birth rather than the country of settlement and the former is lower than the latter, it is important to note that the former applies to the "entire population" in the country of birth, whereas the latter applies to a highly "selective population", namely migrants have to meet very high standards of physical and mental health to gain permanent entry to Australia and generally they are at the higher end of the scale in terms of income, education, wealth, etc. So if the rates of suicides in the country of settlement is the same or similar to the country of origin, it is cause for concern.
- Non-reporting of suicides is arguably occurring frequently although there is no empirical evidence for the same. :
- Inadequate access to professional multicultural mental health services in most state and territories.

The data provided in All Lives Matter, (as attached) shows that suicides rates within CaLD communities remain of significant concern.

2. Misplaced Expectations

Ms Christine Morgan, the CEO of the National Mental Health Commission is absolutely right in stating that "The challenges with the current system are that it's an expectation that they [culturally and linguistically diverse people] connect with the system - we have to turn that on its head." Our Council has been emphasising this for many years with empirical and other evidence but sadly it has fallen on deaf ears of politicians and senior bureaucrats at the federal and state levels.

3. Woeful access to culturally and linguistically appropriate mental health services

WA was the first state in Australia to establish a Multicultural Psychiatric Centre but regrettably it no longer exists. Worse still access to culturally and linguistically appropriate mental health service is woefully inadequate. Pages 20 & 21 of Suicide Prevention 2020 outlines the stressors that impact CaLD communities and states that **"**Culturally appropriate mental health services and cultural competency training for workers providing support to people from CaLD backgrounds are **essential** to raise awareness of mental health and suicide prevention within CaLD communities"

Whilst ECCWA agrees that culturally appropriate mental health services and cultural competency training for workers providing support to people from CaLD backgrounds are essential to raise awareness of mental health and suicide prevention within CaLD communities, we wish to emphasise that culturally appropriate clinical mental health services are woefully inadequate. Agencies like MSC that offer such services are not funded and cannot access cost free interpreting services when required, as funding for the same is not provided by MHC or other bodies.

4. Importance of targeted programs within culturally and linguistically diverse communities'.

Ms Morgan's was spot on in stating that 'while no specific funding has yet been allocated for multicultural Australia, she does see a need for targeted programs within culturally and linguistically diverse communities'. ECCWA strongly believes that "for far too long, the state and commonwealth governments have been pursuing a policy of mindless mainstreaming as reflected by the following examples".

- "The Coalition government's tender ($1.3 million per year for three years) for a project titled 'Mental Health in Multicultural Australia' was restricted to three agencies and **ALL** were **mainstream** providers. Beyond Blue, which was one of them, to their credit did not bid for it."
- Other glaring examples include the fact that ethno specific and multicultural services providers have been receiving a **nanoscopic** portion of the millions of dollars of funding that the federal and state government have been expending on mental health and suicide prevention."

Principle 5 of **Suicide Prevention 2020 states "**Tailoring for diversity acknowledges the unique needs and circumstances of people from diverse backgrounds, including people from Aboriginal or from culturally and linguistically diverse (CaLD) backgrounds. It also states Responsive approaches will be co-produced with high-risk groups to appropriately meet their needs. Whilst such acknowledgement is important ECCWA is **not aware of any "Responsive approaches** that have been **co-produced with CaLD groups** to appropriately meet their needs.

Priority 6 Suicide Prevention 2020 states emphasises "Allocating resources where they are most needed and in a coordinated way and that actions and interventions to prevent suicide and self-harm will support the whole population, with targeted responses and

appropriate resources for high-risk groups." However MHC resources being allocated for targeted responses and appropriate resources for high-risk groups esp. **CaLD is very inadequate from absolute and comparative perspectives.**

5. Coordinated and targeted services for high-risk groups

"Suicide Prevention 2020 **(Page 35)** takes an evidence based approach to reducing suicide risk across the lifespan, which reflects current research by the World Health Organization. In the section that followed people from culturally and linguistically diverse backgrounds were recognised to be at greater risk of suicide than the general population"

However, there is **no mention of CaLD** in all six actions that are listed under, "ensuring that services are coordinated and targeted to high-risk groups and across the lifespan is essential to preventing loss of life to suicide", and how this action area will be achieved.
The 10 actions mentioned under "Early Priorities" also **makes no mention of CaLD. (Page 37)**

6. Perinatal Depression

As you will note from the attached Research Report-"Still births in Western Australia, 2005 to 2013: Influence of Maternal Migration and ethnic origin" that women of African background in Western Australia have post term pregnancy in much larger proportions compared to their counterparts in UK and USA. That increases still births significantly. The report acknowledges/emphasise "their suspicions about assisted birth and their belief in natural births not being disturbed" and therefore a proactive role is required to ensure that they accept ante natal care and arguably our hospitals need to more regularly monitor post term pregnancies in a timely way. Women of Indian background also figure prominently in this report. Despite the research being undertaken in 2015, ECCWA we understand that there have not been systemic changes to address this. It is our view that funding that Ishar receives for perinatal counselling is woefully inadequate and this needs to be addressed urgently.

7. Sustainable Health Review Final Report

Executive Summary mentions that "Not all people in WA have fair access to health care and some experience worse health outcomes because of social, economic and **cultural inequality**" but **does not specify CaLD**.

The Population health section of the report refers inter alia to the following:
* Chronic diseases are responsible for 73 per cent of deaths in Australia. $715 million of hospital costs in WA were attributed to chronic conditions in 2013.
* 69 per cent of WA adults aged 16 years and over were classified as overweight or obese in 2017; 26.5 per cent of children aged five to 15 years were classified as overweight or obese in 2017.
* WA's older adult population (people aged 65 years and over) is projected to rise by 50 per cent in the next 10 years.17 * The number of new cases of dementia in Australia is projected to increase to 451 people per day by 2036 and over 650 people per day by 2056.
* Up to 70 per cent of Australians prefer to die at home – but currently in WA, 61 per cent of people were in hospital on the last day of their life. In WA approximately one-third of people aged 16–44 years (35.7 per cent) drink at levels considered to be high risk for long-term harm.
*** The life expectancy for people with mental illness in WA, who often have multiple physical and mental health conditions, was 15.9 years lower for males and 12 years lower for females compared to the general population.**
* **WA's suicide rate was approximately 20 per cent higher than the national average in 2016 and has been consistently higher than the national average since 2007.22**
* Aboriginal Western Australians experience a significant gap in life expectancy; a gap of 13.4 years for males and 12 years for females compared to non-Aboriginal people.
But there is absolutely no mention about CaLD in the above.

Figure 1: Shaping a more sustainable health system
The above figure makes reference to "People and communities at the heart" but **again there is no mention of CaLD.**
Figure 2: The Panel's eight Enduring Strategies for sustainability
This figure also makes **no mention of CaLD.**

The **only** reference to CaLD in the report is under Recommendations
Strategy 1 (3 b): Commit and collaborate to address major public health issues
b) Culturally and Linguistically Diverse (CALD) people Priorities in implementation:
* Improved data and benchmarks of health outcomes of CALD people, with benchmarked training in cultural competence to ensure staff are aware, responsive and sensitive to cultural diversity.
* Evaluation and spread of a collaborative approach to providing support to the CALD community, guided by the approach in Mirrabooka.

We are unsure what is meant by the Mirrabooka approach and whilst improved data and benchmarks of health outcomes of CALD people are important **it is preposterous to suggest that just the above will address the many serious issues including mental health, self harm and suicides that impact CaLD communities. Incredibly an important report such as this makes no** reference to the Language Services policy let alone advocate its effective implementation. Most astounding of all, Strategy 4: "Person-centred, equitable, seamless access" also makes no reference to CaLD and thus makes a mockery of all three concepts.

Conclusion
Whilst the collection and collation of ethnicity date regarding serious self-harm, completed suicides and the postvention impact of the latter remain problematic, the cases of suspected suicides within ethnic communities in 2017 is extremely disturbing and cause for concern.

From the perspectives of "Tailoring for diversity" (**Principle 5**) and the "Allocation of resources where they are most needed and in a coordinated way" (**Priority 6),** ECCWA believes a well-resourced Multicultural Action Plan **should be developed as a matter of urgency** to cover prevention and all interventions mentioned in the report**.**

When you consider the proportion of the CaLD population in the context of the Health and mental health budgets, what multicultural providers like Ishar, MMRC, Multicultural Futures, ERC etc. (which were established to service CaLD communities) receive is a nanoscopic share of it!! It is obvious that CaLD W. Australians are not getting a fair share of the direct and indirect taxes that they contribute in the form of culturally and linguistically appropriate physical and mental health services and suicide prevention in particular. Accordingly our drawing the conclusion that their lives don't matter is not misplaced.

As an interim measure the next round of MHC funding for Suicide prevention should prioritise CaLD as a target group and agencies that have a track record in providing culturally and linguistically appropriate mental health and other services should be contracted to provide relevant suicide prevention, training and postvention services.

We trust that the WA Suicide Prevention Action Plan 2025 will take all of the above into account.

Vivienne and I will be happy to meet with you and relevant people within the MHC to discuss this submission further as required.

Yours Sincerely

Ramdas Sankaran