DOCUMENT RESUME

ED 477 918 CG 031 946

TITLE	Synergy, 2003. Australian Transcultural Mental Health Network.
INSTITUTION	Australian Transcultural Mental Health Network, Parramatta.
PUB DATE	2002-00-00
NOTE	42p.
AVAILABLE FROM	Australian Transcultural Mental Health Network, Locked Bag 7118, Parramatta BC, New South Wales 2150, Australia.
PUB TYPE	Collected Works - General (020)
EDRS PRICE	EDRS Price MF01/PC02 Plus Postage.
DESCRIPTORS	Acculturation; Community Health Services; *Cultural Pluralism; Foreign Countries; *Health Promotion; Immigrants; *Mental Health; *Public Health; Refugees; Second Languages; Social Support Groups; Well Being
IDENTIFIERS	Australia

ABSTRACT

Each issue in the 2002 edition of the Australian Transcultural Mental Health Network (ATMHN) newsletter represents a theme critical to mental health practitioners. The Winter 2002 issue features articles on the psychological consequences of interpreters in relation to working with torture and trauma clients, addressing language issues on mental health, and specialist advocacy services for people from culturally and linguistically diverse backgrounds. The Autumn 2002 issue focuses on promoting well-being in multicultural communities and presents an article on the "New Arrival Refugee Women, Health and Wellbeing Project," The issues contain reports on current ATMHN-funded projects, book reviews, and lists of additional mental health resources. (Contains 25 references.) (GCP)

Synergy 2003

Australian Transcultural Mental Health Network Newsletter

Australian Transcultural Mental Health Network

Synergy

Winter 2002

WORKING WITH INTERPRETERS

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Diversity in Health 2003
INNOVATION... CREATIVITY... HARMONY...

Diversity in Health 2003
Innovation... Creativity... Harmony

Following the outstanding success of the first Diversity in Health Conference, Sharing Global Perspectives, held in Sydney in 2001 readers will be excited to learn that* Diversity in Health 2003: Innovation... Creativity... Harmony *will be held on October 27-29, 2003 at the Sydney Convention and Exhibition Centre.

Diversity in Health 2003 will concentrate on new and innovative approaches to health and well-being and will showcase creative solutions to health service delivery. It will focus on the cultural, spiritial and emotional aspects of health, stressing the importance of a whole of life approach to physical health and psychological well-being in a harmonious community.

Almost one thousand people attended "Diversity in Health" over three days in 2001. International keynote addresses by speakers from Malaysia, the USA and New Zealand complemented presentations by invited guests from the UK, South Africa, India, Malawi and Zimbabwe and eminent experts from around Australia. Symposia, a hypothetical on men's health, moderated by ABC Science commentator, Robyn Williams, lunchtime "Meet the Expert" informal discussions, the "Great Diversity Debate" and a film festival highlighting multiculturalism as it is portrayed in Australian television and cinema, made Diversity in Health an overwhelming success with delegates. One participant asked *"How can you top this? What next one wonders?"*

Scenes from Diversity in Health 2001

Once again eminent international and Australian speakers will join delegates in a meeting designed to facilitate learning, networking and exchange of experience and information, as well the chance to catch up with colleagues and make new contacts.

Mark the date today, join the Diversity 2003 mailing list, and be part of the most innovative and exciting multicultural health and well-being conference in Australia -

Diversity in Health 2003
Innovation... Creativity... Harmony

Call for papers - early 2003 Registration Brochure - mid 2003
See page 7 for more information

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

The Australian Transcultural Mental Health Network
Locked Bag 7118
Parramatta BC
NSW 2150
Australia
Telephone: 02 9840 3333
Facsimile: 02 9840 3388
Email: atmhn@wsahs.nsw.gov.au
Website:
www.atmhn.unimelb.edu.au

Correspondence with the Editor
Tel: 02 9840 3333 or email:
atmhn@wsahs.nsw.gov.au

The ATMHN is an initiative supported by the National Mental Health Strategy and funded by the Commonwealth Department of Health and Ageing.

national mental health strategy

ATMHN

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Anyone interested in contributing to future issues of Synergy please contact The Editor at: atmhn@wsahs.nsw.gov.au or phone 02 9840 3333

The Psychosocial Consequences Experienced by Interpreters in Relation to Working with Torture and Trauma Clients: A West Australian Pilot Study

GEORGE LIPTON[1], MARIE ARENDS[2], KERRY BASTIAN[2], BERNADETTE WRIGHT[3], PETER O'HARA[1]

[1]Mental Health Division, Department of Health, Western Australia; [2]Multicultural Access Unit; [3]West Australian Transcultural Mental Health Centre

As Australia continues to become an increasingly multicultural society, the services of trained language interpreters will also increase in demand. Against the background of continuing refugee migration, bringing an influx of people who have experienced torture and trauma prior to arriving here, who are more likely to subsequently present with mental health problems. Therefore, the need for interpreters specifically trained for the mental health setting (ie. 'mental health-trained interpreters'), will continue to increase. This WA study presents the case that interpreters working in a mental health context are not necessarily trained to implement strategies to deal with highly sensitive material that may potentially be psychologically detrimental to them.

The difference between interpreters and other professionals is not only the level of training that is provided to the workers, but also the difficulties imposed on the Interpreter due to the nature of the work. In addition to language skills, awareness and ability to deal with difficult material and 'maintain appropriate boundaries' are also important professional requirements of an interpreter (Tribe, 1999). However, little has been done to examine the stress engendered by a work environment that exposes mental health interpreters to detailed descriptions of torture and trauma that may necessarily emerge as part of the therapeutic process (Figley, 2001, *personal communication).* As language interpreters, the job requires recounting these incidences in a different language, without adequate time for emotionally processing the details. Their anxiety is further compounded by their concern for accurately representing the client in terms of 'semantic and emotional content' (Tribe, 1999).

Negative emotional aspects of interpreters' work are often not, if at all, addressed appropriately within the workforce. In her study, Tribe (1999) found that the feeling of being overwhelmed by the material they must translate in the context of an interpreting session, or that fear of becoming overwhelmed by the content of a session, are significant issues confronted by interpreters.

The mental health system within Australia therefore has a 'duty of care' towards the interpreters. This 'duty of care' is necessary to ensure that interpreters are given adequate support and supervision in order that their own mental health does not deteriorate; and, in the interest of the client, to maintain the quality of the interpreting work. However, the lack of research into the effects of vicarious traumatization on bicultural interpreters has resulted in a relative lack of knowledge about the psychosocial consequences experienced by interpreters resulting from vicarious traumatization. As a result, the following literature review is based on literature available regarding various other professions that have been instructed through training and supervision to encourage professional boundaries and recognition of self. Bicultural interpreters practicing in Western Australia do not receive training in this area.

In the early 1980s attention to the effects of traumatic information

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and events on professional helpers became a focus for investigation (Figley, 1995). It has been recognized in the literature that the demands on professional helpers of empathic listening when working with clients whom have experienced torture and/or trauma, requires sufficient absorption of the information to allow for a greater understanding of the clients experience. This level of empathic listening and absorption of information have been found to confront the psyche of the professional and become a source of change to the worldview of that person. Little information is available surrounding the issue of interpreters confronting situations that could lead to traumatic stress in their daily work. The majority of the literature has focused on tertiary trained professionals (Hudnall-Stamm, 1995; Figley, 1995; Clark & Gioro, 1998; Alexander, 1990; Black & Weinreich, 2000; McGorry, 1995; McCann & Pearlmann, 1990). These cohorts of professionals are provided training throughout their education and professional practice, through supervision, boundary setting, debriefing and peer support. This type of support provides the professional with objective support in working through the issues of distressing information. Interpreters, on the other hand, are often only trained to pass on information that is given to them, and generally only provided training in mental health terminology, and other basic skills, with little or no training in boundary setting, and little or no supervision. This situation may leave interpreters open to traumatisation either via revisiting their personal past experiences or through the transmission of information that is familiar to others they have known, or their inability to integrate the information appropriately.

The double bind that interpreters may experience, is the necessity to not only listen empathetically to information that may be distressing, but they are also required to repeat it, often finding it necessary to locate language that will appropriately transmit the clients meaning. (Tribe, 1999). This assertion appears to be based on the expansion of the Diagnostic Statistical Manual, 4th Edition (American Psychiatric Association, 1994), where it is recognized that direct exposure to torture or trauma is not a necessary factor of traumatization, but that fear for another is sufficient to cause post-traumatic stress disorder. Vicarious traumatization is a response to ongoing exposure to traumatic information (Pearlmann & Saakvitne, 1995, p. 280). This type of traumatization does not necessarily require somebody to have directly experienced the exposure to violence or trauma, but occurs due to the long term effects of exposure to the distress of others, and the necessity to empathize with the clients' therapeutic content. Pearlman and McCann (1990) and Figley (1995) suggest that any professional working directly with clients suffering from torture and/or trauma over a period of time, are at risk of developing some kind of psychological trauma in relation to the constant barrage of distressing information to which they are exposed.

Pearlman and Saakvitne (1995) assert that time spent with family was seen to be very helpful in coping with personal and professional self-care. Other workers were reported to have described disruption to family life as they became isolated, distant or angry within the home environment as a result of empathic listening and engagement with traumatized clients.

Another area that may be interrupted in the everyday life of the traumatized professional is that of personal safety and connection to the known. Various authors have indicated that areas of personal safety have often been reported by traumatized professionals as being effected to the exposure to traumatic descriptions over time (Black & Weinreich, 2000; Clark & Gioro, 1998; McCann & Pearlman, 1990).

Interpreters in Western Australia are governed by a set of professional ethics that requires total confidentiality. Roberts-Smith, Frey & Bessell-Browne (1990, p.24) clearly define the role of interpreters as '... *being complete once the interview is over.*' They further confirm that it is inappropriate for interpreters to receive debriefing after an interview, and that the interpreter and client should leave the office at the same time. This issue raises serious questions about the needs of professional interpreters and how they are addressed.

Throughout the literature it is clear that peer support, supervision and debriefing are major tools in the reduction of traumatization on professionals working with torture and trauma clients (Tribe, 1999; Black & Weinreich, 2000; Figley, 1995; Pearlman & Saakvitne, 1995; McCann & Pearlmann, 1990; Clark & Gioro, 1998). The literature clearly identifies that through the use of these strategies, professionals can reduce the likelihood of not only traumatization, but also the extreme effects of burnout, where professionals can no longer work within their professional environment.

Within the literature there is some debate as to the efficacy of debriefing workers who have experienced traumatization through exposure to crisis situations. Kenardy et al (1996, p.37) argue that through their research into the effects of exposure to traumatic events in Newcastle, Australia, of 195 helpers, 'there was no evidence of an improved rate of recovery' after workers received debriefing. However, this is countered in many other readings (Dyregrov, Kristofferson & Gjestad, 1996; Alexander, 1990) where the delivery of debriefing after a traumatic even has provided significantly perceived assistance to workers.

This pilot project informs the development of debriefing intervention workshops, which will provide support and supervision to mental health interpreters who are affected by stress, related to exposure to torture and trauma details divulged by their clients. This study aimed to gain a greater insight into the difficulties that interpreters face when working with traumatic information, with particular emphasis on those working with torture and trauma clients. The objectives of this study were therefore to determine the psychological coping mechanisms utilized by language interpreters to cope with work-related stressors (e.g., graphic details they must interpret relating to torture and traumatic experiences) particularly working with refugees. We further aimed to gather data surrounding the psychosocial effects of interpreting for torture and trauma survivors within the refugee population. A better understanding of these psychosocial issues impacting on language interpreters when working with refugee clientele would inform the development of appropriate debriefing/supervision intervention that would be required to minimize the adverse impact of working with torture and trauma survivors.

METHODOLOGY

This research, cross sectional and retrospective in nature, utilised the ethnographic interview style as devised by Spradley (1979). This style of research was also considered the most likely method to provide the 'in-depth' information necessary to ascertain the needs of interpreters in relation to debriefing requirements given the varying cultural practices, religions, and beliefs that must be considered.

The primary form of data gathering was conducted through in-depth interviews with 15 (mixed gender) language interpreter informants during February,

Continued overleaf

Guidelines on working with interpreters

The Victorian Transcultural Psychiatry Unit has produced a manual on how to work effectively with interpreters in a clinical mental health setting.

It outlines possible structures for establishing and operating an interpreter service and provides information on factors which need to be considered when working with interpreters. Section include assessing the need for an interpreter, crisis situations, booking an interpreter, steps to take before, during and after the interview and unsatisfactory practices.

The Guidelines can be accessed on the VTPU website, www.vtpu.org.au Just click on to "Programs" , and then on "Service Development" and scroll down. The document can be downloaded in its entirety.

For any queries or more informtion contact Malina Stankovska on (03) 9411 0311.

Queensland Transcultural Mental Health Centre (QTMHC) Glossary of Mental Health Terms

The Qld Transcultural Mental Health Centre (QTMHC) has developed the *Glossary of Mental Health Terms* for use by interpreters and translators working in mental health settings as well as for bilingual mental health workers. The glossary contains key terms used in mental health care and an explanation of those terms in various community languages.

Glossary of Mental Health Terms I
English – Chinese, Italian, Spanish & Vietnamese

Glossary of Mental Health Terms II
English – Arabic, Bosnian, Croatian, Farsi, Samoan, Serbian & Tagalog.

To order a copy of the above publications, please contact the QTMHC on (07) 3240-2833 or by email penny_d'ath@health.qld.gov.au

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2001. All interviews were taped and subsequently transcribed to further gain an understanding of each informant's personal experience with distressing information they encounter when interpreting for refugees who relate details of torture and trauma. Question items were developed by a Steering Committee with expertise in psychiatric concepts and extensive knowledge of interpreter and refugee issues within transcultural mental health. Questions were constructed to be generally worded to facilitate informants to steer the interview. Interview topics were not restricted to set protocols as informants were given the opportunity to initiate topics they felt to be relevant. Hence grand and mini tour questions were posed (Spradley, 1979). In addition to those items that specifically elicited issues relating to working with survivors of torture and trauma, questions were also posed about the extent to which work related stressors, originating from exposure to torture and trauma details, impacted on their personal relationships and/or family dynamics. The end result of this strategy highlighted the informants' own understandings of the situations they have experienced

Question items were then piloted on interpreters to ascertain their appropriateness and pertinence to the area of investigation. NUD.IST Ethnographic Software (QSR, 1995) was utilized to enable recognition of patterns, themes and comparisons within the data.

Interpreters over the age of 18 years, working with refugee survivors of torture and trauma, were accessed by utilizing a snowballing selection method. All interpreters who participated are contracted by the Translators and Interpreting Service of the Commonwealth Department of Immigration and Multicultural Affairs and have also undergone a course in mental health interpreting.

Ethics approval for this research was obtained through the University of Western Australia. All informants were provided full information on the purpose of the study, and signed a written consent form prior to commencing the interview. Furthermore they were notified of their right to withdraw from the study at any time. All informants were asked to provide a pseudonym at the time of signing the written consent form. This pseudonym has been utilized throughout the study, both during the taped interviews and at the point of transcription to ensure confidentiality of that informant. All tapes used in the interview process were erased as soon as they were transcribed to hard copy. All informants were provided a copy of the transcript of their interview to ensure that information has not been lost, confused, or altered in any way.

Given the sensitivity of the information accessed, informants were invited to utilize debriefing with a senior Clinical Psychologist, provided by the Steering Committee, on an 'as required' basis.

RESULTS

Consistent with the qualitative nature of this study, and the subjectivity of the data collected, the results have been written in a 'verbatim' narrative manner, where appropriate.

Issues surrounding empowerment, information gathering, employment, perceived outcome of working within the profession, emotional response pertaining to their role of interpreters and the psychosocial impact that the task of hearing and interpreting torture and trauma details has on their functioning were derived as themes or commonalties which emerged from the transcribed interview data.

The interview responses revealed that, at the outset of their careers, interpreters have an altruistic perception about their work. This revolves around an expectation that the work would 'empower' them to not only assist their own settlement process in a new country but also would 'help others' particularly fellow expatriots who have left the same country of birth to settle here in Australia. A consistent pattern emerges for each interpreter interviewed where the profession they have entered sets them on course on a continuum beginning with high aspirations through to a realization that the sense of fulfillment they had hoped cannot be achieved in their professional role.

Assisting 'own people'

Indeed, for many of the interpreters interviewed, the perception of 'helping others' from their own country of origin was the primary reason for becoming professional interpreters. Several interpreters felt they were able to provide some assistance by providing a *'voice'* for their *'own people'* and by doing so, would fulfil their own need to actively *'help'* fellow migrants. The term *'my people'* was a common phrase used by informants and suggested a sense of responsibility and duty towards those coming from their homelands.

Information gathering

At a more practical level, respondents considered their work as an avenue for accessing a wealth of information that would otherwise not be available for them. The information inadvertently gathered through their

work with many agencies was then utilized to assist themselves and other members in their ethnic community to further familiarize themselves with the customs of the host society.

Empowerment

Other interpreter respondents perceived their profession as providing them a sense of empowerment through achieving professional status: '*over there* [country of birth], *this profession is very much respected.*' * or as a means of gaining a sense of belonging: '*... you are regaining your confidence... part of the healing process... letting go of fear*'.

Employment

They all acknowledged the role of employment and income as a reason for occupational choice but for many these appeared to be secondary to the other factors. Many of the interpreters who were interviewed had tertiary qualification or were professionals in other areas in their country of birth but were not able to continue in that profession due to qualifications not being recognized in Australia.

Perceived outcome

The subsequent perception that develops as the interpreters continue to interpret for ex-patriots – particularly refugees who divulge torture and trauma details for which the interpreters must interpret – is one of disempowerment and frustration. It transpired that interpreters generally become progressively aware that they actually have a limited capacity for completely assisting their fellow ex-patriots.

In addition to the tendency to experience distress about the content of the information, interpreters may also become distressed by the perceived or actual inappropriate behaviour(s) of the professional who conducted the session.

The reported sense of 'powerlessness' is also associated with the service provider's perception of their role and the perception that they are not regarded as 'professionals' in their own right, but merely as an 'adjunct' or an 'instrument' compounds the sense of disillusion interpreters experience about their profession. The original ideal goal of using the interpreting profession as a vehicle to 'help' fellow ex-patriots becomes progressively an illusion. One respondent described her feelings as follows: '[Other professionals] *treat you as a second rate employee*', clarifying that she did not '*feel like a second rate employee*!' but very much felt like she was treated that way.

Statements such as this raise the question about how practitioners perceive the professional status of interpreters.

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....voices with no feelings...a discussion of the role of interpreters in psychotherapy

in

Diversity and Mental Health in Challenging Times

edited by Beverley Raphael, AM and Abd-Elhasih Malak

"INTERPRETERS' EXPERIENCE OF WORKING IN A TRIADIC PSYCHOTHERAPY RELATIONSHIP WITH SURVIVORS OF TORTURE & TRAUMA: SOME THOUGHTS ON THE IMPACT ON PSYCHOTHERAPY" by Rise Becker and Robin Bowles, forms just one chapter of this new publication about the relationship between culture and mental health.

This chapter deals with debriefing of interpreters involved in counselling, particularly psychotherapy, with non-English speaking background survivors of torture and trauma. It includes an international literature review, material obtained from a "psycho-educational debriefing day" held with experienced health care interpreters who have worked closely in a counselling relationships with psychotherapists and clients of STARTTS (NSW), and a discussion of some theoretical ideas around the interpreting process within psychotherapy in bilingual settings.

Issues raised during the debriefing day included

- interpreters' experience in general
- their relationships with torture and trauma clients and with the psychotherapist
- supervision and debriefing, and
- psychotherapy and boundaries

Becker and Bowles conclude that interpreters are still often seen as voices with no feelings and ideas of their own, and advocate for increased understanding of the importance of the complex and vulnerable role that interpreters may play when working with counsellors in a psychotherapeutic setting.

Addressing language issues in mental health in Queensland

Rita Prasad-Ildes
Queensland Transcultural Mental Health Centre

The Queensland Transcultural Mental Health Centre has implemented a number of strategies to address language issues within mental health services in Queensland. Strategies are based on providing both mental health workers as well as interpreters with information and resources to ensure consumer's language issues are addressed in the provision of mental health care. Following are some examples of this work.

TRAINING MODULE "LANGUAGE MATTERS IN MENTAL HEALTH CARE"

Incorporated in the eight module training program "Managing Cultural Diversity in Mental Health" is one module "Language Matters in Mental Health Care". This one-day workshop focuses on the role of language in regard to the expression of mental health and mental illness from the perspective of both the consumer and the service provider. The difficulties in acquiring a second language and meaning attributed to a consumers language by clinicians is particularly addressed with a focus on clinical issues that may arise during assessment and treatment phases. The workshop also provides skills in communicating with people with language barriers, including working with professional interpreters. This training is usually delivered as part of QTMHC's training program across the state but is also able to be delivered as a stand alone module on language matters.

INTERPRETING IN MENTAL HEALTH SETTINGS COURSE

QTMHC developed a specialised training course in partnership with Southbank Institute of TAFE for interpreters focusing on key issues in interpreting in mental health care. Topics in the course included processes used within mental health services, eg. mental state assessments, information about mental illnesses and their impact on communication and interpreting, site visits to various mental health facilities and skills in mental health interpreting. QTMHC has recently reconvened the reference group that was involved in the development of the original course to review and update the course in order to develop a new format which can also be taken to other locations around Queensland to train interpreters outside Brisbane.

THE INTERPRETER'S PERSPECTIVE: INTERPRETER FOCUS GROUPS

As part of its review of the *interpreting in mental health settings course* QTMHC recently conducted two focus groups with interpreters who completed the course to not only obtain their feedback but to also hear from interpreters directly about current issues in interpreting in mental health settings. The response to the training course was overwhelmingly positive and interpreters requested ongoing refresher courses. They particularly found information about the various mental illnesses and their impact on communication processes and the interpreting interview, information about the Mental Health Act, and information about cultural perceptions and mental health valuable. Interpreters nominated the two key issues in interpreting in mental health settings as the need for debriefing and personal safety issues. They indicated that the course had increased their awareness of the importance of debriefing although it is not always provided by service providers even if they request it, and many had examples of where their personal safety issues had not been taking into consideration by mental health service providers.

GLOSSARY OF MENTAL HEALTH TERMS

QTMHC has produced this resource publication as an aid for interpreters and bilingual mental health workers which provides not only an overview of the

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NATIONAL NOTICE

Queensland TMHC Mental Health Project for refugees on TPVs

In response to high numbers of refugees on TPVs arriving in Brisbane over the past 2 years, and the subsequent need to respond to mental health issues in this group identified by refugee support agencies in Brisbane, QTMHC has initiated an innovative project in partnership with a number of mental health services and the Qld Program of Assistance to Survivors of Torture and Trauma (QPASTT). A QTMHC worker is based at QPASTT focusing on outreach and early identification in order to improve the mental health of refugees on TPVs. The project also aims to increase the capacity of the participating services to respond appropriately to the mental health needs of refugees.

For further information please contact Simone Bell 07 33931621 or simone_bell@health.qld.gov.au

Telstra Community Development Fund & Telstra's Kids Fund

Telstra recently announced the formation of the Telstra Foundation, a philanthropic initiative that will strive to improve the lives of Australia's children and young people. The Telstra Foundation is interested in supporting projects that develop innovative solutions and new approaches to issues affecting children and young people and are based on sound research and have strong likelihood of meeting their objectives.

The Foundation includes two main grant giving programs: the Telstra Community Development Fund and Telstra's Kids Fund.

The Telstra Community Development Fund supports not-for-profit organisations that focus on helping Australian children and young people to overcome challenges and make the most of their lives. The fund will support cultural, health, education, research and disability programs and address important social issues affecting young people. These may include youth homelessness, cultural diversity and tolerance, substance abuse, youth suicide and self-harming behaviour and personal safety.

The Telstra's Kids Fund provides smaller grants to support local organisations and activities in which the children of Telstra's staff are involved. This fund provides grants for recreational, education, sporting, cultural, social and environmental projects.

More information is available from the Telstra Foundation on 1800 208 378 and on http://www.telstrafoundation.com

Children, Youth, and Families Network

The Children, Youth, and Families Network is a research and government advisory body, which focuses on health inequalities in Australia. Established in April 2002, the Network's first newsletter, focused on poverty and health outcomes amongst Australian families. The next newsletter will focus on migrant health in Australia, and in particular, how migrant health compares with the health of the rest of the Australian population, evaluating the variables that have been researched and established as being contributing factors to poorer health outcomes for migrant and refugee groups.

For more information contact:

Julie-Anne Carroll, Coordinator,
Children, Youth, and Families Network

Ph: (07) 3864 5611

Fax: (07) 3864 3369

Email: jm.carroll@qut.edu.au

Qld Health and Wellbeing competition in ethnic schools

In the lead up to Mental Health week this year, QTMHC is organising a poster competition through ethnic schools. Class discussions on health and wellbeing will be held and students will create posters of artistic expressions of health and wellbeing. The awards ceremony for participating schools will be held on World Mental Health Day.

For further information please contact Elvia Ramirez 07 32402833 or elvia_ramirez@health.qld.gov.au

BOARD

To place items on the noticeboard please contact the editor: atmhn@wsahs.nsw.gov.au or tel: 02 9840 3333

New CEO for Mental Health Council of Australia

John McGrath, Chair, Mental Health Council of Australia recently announced the appointment of Ms Grace Groom as the MHCA's new Chief Executive Officer. Grace commenced full time with the MHCA on Monday 15 July 2002.

beyondblue & Centre for International Mental Health Depression Study

The Centre for International Mental Health, The University of Melbourne, in conjunction with the Victorian Transcultural Psychiatry Unit is undertaking a project with *beyondblue*: the national depression initiative, to examine the issues of depression in ethnic monority groups across Australia. This project will provide an Australia-wide 'snapshot' of the state of current practice and research in the area of depression and ethnic minority groups.

For more information contact Renata Kokanovic ph (03) 9411 0305 or Steven Klimidis ph (03) 9411 0306

Older people's support groups

Support groups aimed at improving older people's mental health are to be established in five culturally and linguistically diverse communities in NSW. Facilitators will be trained to run the groups and a best practice self-help model will be developed and evaluated.

The project, funded by the Commonwealth Department of Health and Ageing, is being carried out by the NSW Council on the Ageing, the Mental Health Association NSW, and the NSW Transcultural Mental Health Centre. It is part of the National Suicide Prevention Strategy Program.

For more information contact: David Meadows. Phone: (02) 9840 3763 Email: David_Meadows@wsahs.nsw.gov.au

FECCA Conference to focus on social determinants of physical and mental health

The 2002 Federation of Ethnic Communities Councils of Australia National Conference, in Canberra in December, will include the social determinants of physical and mental health as one of six key themes. Under these themes issues for priority populations groups, youth, women, people with disabilities and senior citizens will be discussed.

For more information contact FECCA on (02) 6282 5755

Australian Society for Traumatic Stress Studies Annual Awards for Traumatic Stress Research

ASTSS, an organisation of over 500 professionals across the Australasian region dedicated to the prevention and treatment of trauma, will reward academic excellence for research in the field of traumatic stress. The awards are designed to acknowledge and encourage relatively new researchers and are open to all research disciplines.

The Awards are at two levels: the Annual Academic Prize of $1000.00 and Chapter /State Awards of $250.00. Each State or region where ASTSS Chapters exist, currently ACT, NSW, SA Vic and New Zealand will award an annual prize. All entries for the Chapter /State Awards will also be considered for the Annual Academic Prize. Entries will consist of a research study which has not been published, or accepted for publication, presented as a stand-alone paper no longer than 7500 words. Entries will be assessed primarily for their contribution to traumatology. Students, practitioners, and researchers up to and including recently completed PhDs, MDs or other professional doctorates (no more than 2 years post-completion) of any discipline are invited to enter. The closing date for entries is 1 December each year and the winners will be announced on 1 February of the following year.

For more information and further details, go to www.astss.org.au

New Internet Directory of refugee sites & support groups

Refuges Australia has launched a new directory to support refugee groups working in Australia. The web site has been designed to help Internet users quickly find the refugee information they need. The directory includes quick facts, taking action links and a contacts page with email addresses and phone numbers of groups in Australia.

More information at www.refugeesaustralia.org

Development of Guidelines for Translated Mental Health Information in WA

At the launch of WA's very first Transcultural Mental Health Policy, *'A Transculturally Orientated Mental Health Service for Western Australia'*, held in May 2002, the WA Minister for Health officially announced a statewide strategy to develop Guidelines for translating mental health information as a strategic initiative for enhancing cultural-sensitivity in mental health service delivery in Western Australia.

The aim of this initiative is to improve the availability and quality of culturally appropriate forms of information about mental illness, mental health issues and services to the increasingly multicultural population of Western Australia. The Policy identified that one of the priority needs of people from varying cultural groups is for accurate information about the mental health system and its services. It is acknowledged that the high level of stigma surrounding mental illness in some cultures serves to limit factual knowledge about mental health issues, the relevance of available services and intervention approaches. A lack of understanding about the Western Australian mental health system may also be further compounded by a language barrier.

Appropriate pathways taken by people of CALD background to timely access and utilization of mental health services are often influenced by the amount of relevant or suitable information available to CALD communities about these services. In light of this, it is important to ensure that such information is translated into languages relevant to the ethnic community demographics in Western Australia and made widely available. Although there is an existing range of translated mental health-related material available, relatively very little originate from Western Australia, hence the target languages and cultures of available resources may not be relevant to the ethnic community demographics in our state. Furthermore, much of the material was developed in the eastern states and do not include the appropriate contact numbers of relevant agencies here in Western Australia. There is also a lack of uniformity in what material is translated, its quality, and the range of languages covered.

The Guidelines to be developed will address the need for a set of criteria for selection of languages into which new or existing mental health related material should be translated and how this material should effectively be distributed. Recommendations for which languages are to be considered as standard priority languages for translation will be based on demographic and service usage data. It is important for the message contained within the information to be conveyed in a manner that is culturally-sensitive, taking into consideration a given culture's attitudes and beliefs about mental illness and its disorders. The Guidelines will thus ensure that translated information is culturally relevant for the target audience and that cultural concepts surrounding specific disorders are accurately and sensitively interpreted in order to promote acceptance of mental health service assistance. The Guidelines for translating mental health information will improve the consistency in what information about the mental health system and its services is translated, and the range of languages covered.

Work on this initiative will commence later this year. It will be conducted in joint partnership between the West Australian Transcultural Mental Health Centre, the New South Wales Transcultural Mental Health Centre, the Multicultural Access Unit (Western Australia) and the School of Public Health at Edith Cowan University (Western Australia). Our collaboration with the New South Wales Transcultural Mental Health Centre will facilitate the exchange of knowledge and of their expertise in this area. The Guidelines generated from this initiative may also facilitate the subsequent development of national standards for the translation of mental health information.■

For Further information contact

Bernadette Wright
West Australian Transcultural Mental Health Centre on (08) 9224 1760.

Kerry Bastian
Multicultural Access Unit on (08) 9400 9504

Specialist advocacy services for people from culturally and linguistically diverse backgrounds with a disability

Barbel Winter, Executive Officer, Multicultural Disability Advocacy Association Of NSW

In a recent announcement the NSW Government has made resources available to the Multicultural Disability Advocacy Association of NSW (MDAA) to provide advocacy services to people from a non- English speaking background with disability (including people with psychiatric disabilities).

Several weeks later the NSW Upper House Parliamentary Inquiry heard that 4 out of 5 people from culturally diverse backgrounds with disability are currently missing out on disability services.

For a long time the Multicultural Disability Advocacy Association of NSW (MDAA) has argued that in order to make a difference for people from NESB with disability and their families and friends, a three pronged approach was needed. Such an approach needs to entail:

- work with individuals and communities
- work with the bureaucracies and policy makers
- work with the service delivery system.

To this end, MDAA received funding to provide:

INDIVIDUAL ADVOCACY

Together with the funds received from the Commonwealth government MDAA will be able to provide individual advocacy across NSW. In addition to workers being located in Sydney, three part time individual advocates will be located in three regional areas (Hunter, Illawarra and Riverina areas) with advocacy/ disability/ community agencies.

SYSTEMIC ADVOCACY

In acknowledgement of many of the systemic barriers experienced by people, work will be undertaken to articulate policy positions in the key areas affecting people from a NESB with disability and to lobby for better outcomes.

ADVOCACY DEVELOPMENT

This joint initiative together with the Physical Disability Council of NSW (PDCN) and the NSW Council for Intellectual Disability (NSWCID) will develop and run education and advocacy training sessions, as well as set up and support advocacy networks across non- metropolitan regions.

This project aims to break down barriers across disability and cultural groups and the service will be delivered to people with all sorts of disabilities from NESB and Anglo- Australian backgrounds.

INDUSTRY DEVELOPMENT

In acknowledgement of the need of the disability services sector to enhance their cultural competencies, MDAA will develop programs and project in collaboration with disability services which are designed to increase the capacity of the disability services sector to provide services for a culturally diverse communities.■

For more information contact

MDAA on 02 9891 6400 or
www.mdaa.org.au or
email: mdaa@mdaa.org.au

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Addressing language issues in mental health in Qld

Queensland mental health system but also key mental health care terminology in English with explanations in the following community languages: Italian, Chinese, Vietnamese, Spanish, Bosnian, Croatian, Serbian, Farsi, Arabic, Samoan and Tagalog.

PARTNERSHIPS

QTMHC recently conducted a workshop for the Australian Institute of Interpreters and Translators (AUSIT) for its members on Interpreting In Mental Health Settings. QTMHC recognises that partnerships with professional bodies representing interpreters and training organisations are another important avenue to partner with in order to provide training to interpreters.■

For further information contact Rita Prasad-Ildes or Greg Turner at the QTMHC on 07 3240 2833 or by email rita_prasad-ildes@health.qld.gov.au or greg_turner@health.qld.gov.au

WEB NEWS

http://Auseinet.flinders.edu.au/journal/
New Australian electronic Journal for the Advancement of Mental Health. Vol 1. Iss 2 includes "Islamic Community Worker Training Program for the Management of Depression" - by Tina Tse.

www.HealthPromotionGlobalPerspectives.com
New address for Global Perspectives, the Newsletter of the International Institute for Health Promotion Network (IHPN).

www.mhca.com.au
MentalHealth Council of Australia's relaunched, new look website.

www.fcs.wa.gov.au/_content/parenting_information/factsht/multi/factsht.htm
Factsheet on parenting in a multicultural society. Also available in WA in Chinese, Arabic, Indonesian, Farsi & Vietnamese from WA Parenting Help Centre Mt Lawley, tel: (08) 9272 1466.

www.apo.org.au
Australian Policy Online, a new website giving quick access to latest material on Australian social, economic, cultural and political issues.

Continued from page 7

Psychosocial consequences for interpreters

Emotional response

The majority of interpreters stated that they were not 'briefed' at the beginning of an assignment to emotionally or mentally prepare them for any unpleasant information that might be divulged during the interview. Many reported of interpreting situations which leave them feeling quite distressed invariably arose. These situations would generate an empathic emotional response as they either reacted to, or related with the 'emotional content' rather than the actual experiences being conveyed by the client. Some interpreters reported feeling empathy with client's distress and have requested time from the practitioner to help clients calm down during sessions.

Incidences of clients pleading for help, clients' rich narratives of events in homelands or their experiences on their illegal journey to Australia, and other similar experiences reportedly cause distress for interpreters. This was particularly emphasised among those interpreters who had come from war-torn countries.
It became clear that interpreters who came to Australia from war torn countries reacted differently from those who were not. Among the former group, common words or phrases - at times quite dramatic, were used to describe their emotional reactions to distressing information; *'you kill it or it kills you'* . In contrast, those who did not come from war torn countries described their reactions to distressing information in relatively moderate terms e.g., *'I was a bit shaken'* .

A closer examination of the language or expressions used by the two 'subgroups' of interpreters highlighted a continuum between vicarious emotional connections to an experience of sympathy. Empathic responses to stress, particularly those from war torn countries appeared to be a significant reaction to exposure to torture and trauma details.

When respondents discussed unpleasant information to which they were exposed, they were inclined to connect these unpleasant events with other situations that raised the same or very similar emotions. *'..it's replicating bad memories and bad experience.'*. When this particular respondent described his 'worst' incident, he stated that he had experienced the same emotions he had encountered in his homeland.

'Coping strategies'
Of the interpreters interviewed 46% had no knowledge of how to unwind or reduce stress. *'... we weren't taught at school how to do it, get rid of the stress.'* . 53% described coping strategies they used, for example:

> *'... If you feel like, um, you got something here (indicating the heart area) then it's good to go around with the case officer.'*

Common coping strategies included finding somebody to talk to, taking time out, or doing something that takes their mind off their feelings. Impromptu activities were reported as common ways to forget the emotions they experienced. One respondent felt the necessity to lie to his family, mainly because of 'confidentiality'. Others engage in denial of the information they hear, lying to themselves as a means of coping: *'I tell myself they are lying to cope.'* . Clearly these forms of coping strategies are dysfunctional.

It became evident that the majority of interpreters often had no training and little understanding of how to maintain confidentiality while accessing appropriate assistance that might facilitate their ability to cope with highly emotive information and their own empathic emotional response. Only 46% recognised the need to de-stress or unwind in some way after interpreting for clients who divulged horrific life experiences related to torture and trauma.

An 'at risk' group
Many respondents reported that until they had completed the training course relevant for mental health interpreting, they were unaware of the emotional and psychological dangers that could arise from their work situations.

As interpreters are often required to travel from assignment to assignment, those who work with distressing information have little or no time available for appropriate unwinding between interpreting assignments, therefore placing themselves 'at risk' of physical harm. One interpreter commented on the emotional ramifications her work which have caused her to lose concentration on the road:

> *'I'm not concentrating on the road and I'm tired, I'm exhausted and my head is full – I'm just not there.'*

Debriefing
None of the respondents reported practitioner awareness of the adverse emotional effects the interpreters may have experienced resulting from interpreting distressing information. This strongly suggests that practitioners are not aware of the professional needs of these 'co-workers'.

Only two respondents were able to articulate the type of debriefing or assistance received from a practitioner. These two interpreters described a relatively better level of rapport that developed between the practitioner and themselves. Such rapport was thought to provide the practitioner with sufficient insight into the distress being experienced by the interpreter during interviews where details of torture and trauma need to be interpreted. 87% of those interviewed described feelings of either powerlessness or extreme emotions towards their work. Of this particular group, 53% described experiencing both powerlessness and extreme emotions.

'Ethics'
The trends described by the interpreter informants suggested there was a strong ethos of confidentiality that inhibited accessing help when needed. One respondent disclosed his feelings about why interpreters do not access debriefing:

> *'But I think, er generally speaking people they intend to be secretive and not to talk much about their feelings to support, to complain about their feelings because they are very much concerning of losing their jobs...'* .

This statement indicates the sensitivity and complexity of the concerns expressed by interpreters. It further highlights the necessity to educate interpreters in the need and purpose of debriefing or ventilating and, more particularly, the requirements to maintain confidentiality when debriefing.

DISCUSSION

It is acknowledged that this study is a pilot and as such it has limitations. The extent to which an interpreter is deemed 'highly' experience as correlated by length of service as a formally accredited interpreter, and able to deal more effectively with details of torture and trauma could not be investigated in this study. Due to the minority languages selected for the study, there was a mixture of experienced, and newly accredited interpreters who participated. This variation reflects the different level of training that the informants have had and therefore, the level of competency in the delivery of services. In spite of these identified flaws, however, the data derived from this investigation has

Continued overleaf

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provided insight into the potential psychological harm when the mental health system overlooks the impact of work-related stressors on interpreters.

Individuals who enter this work do so with the intention of 'helping' their fellow country people, believing that they maintain a professional position. The Code of Ethics for Translators and Interpreters (2000) established by the Australian Institute of Interpreters and Translators Inc – 'AUSIT' - are those which are adhered to by interpreters. The Code of Ethics describes interpreters as 'professionals' with professional standards required of them. Yet many service providers or practitioners do not uphold this belief. This in turn affects interpreters' perception of the significant input they may have in the helping process, often resulting in a sense of powerlessness and inability to achieve their goals. At the outset their altruistic aspirations for choosing their profession are therefore sabotaged by the lack of recognition given to them by practitioners who need their interpreting skills and services and the lack of structure inherent within their profession that would otherwise ensure 'duty of care' to the interpreter as well as continuing professional development. With reference to the former, health practitioners need further training to work with interpreters as team members and to establish appropriate professional boundaries, and facilitate rapport between the health practitioner and the interpreter.

As debriefing is not widely offered, and training to recognize the need for debriefing or ventilating of emotions is not provided in their early training, many interpreters experience distress caused through frustration and a perceived sense of powerlessness. At this point the term 'at risk' should be further clarified. There is at least two forms of 'at risk' situations faced by interpreters: physical harm and psychological distress where interpreters experience possible harm by renewed distress over previous experiences. Generated by interpreting assignments that are associated with details of torture and trauma related information.

There needs to be recognition of the risks involved in interpreting. The data derived from this study clearly suggests that interpreters who are exposed to torture and trauma details are at risk of psychological harm. Moreover, the potential relevance of these early findings to issues of occupational health and safety is obvious. Particularly considered as highly 'at risk' are those interpreters who have experience in a war-torn country and are required to work with survivors of such experiences.

In light of this pilot study, the recommendation is made that interpreters are trained to comprehensively and accurately understand confidentiality requirements and to acknowledge when to access debriefing. It is recommended that these issues be addressed as fundamental training components at the outset of interpreting training.

The issue of confidentiality seems to be open to wide interpretation and according to the reports provided by participants, is more than likely to be grossly misinterpreted. The understanding about confidentiality may be influenced by the interpreter's culture or merely lack of knowledge about the boundaries of confidentiality. Irrespective of what could promote this misinterpretation it is evidently a barrier to accessing appropriate support.

The need for providing interpreters with debriefing after a stressful session is one preventative strategy that could ensure the well-being of interpreters. However, the problem lies with promoting access and utilization of this debriefing intervention. The misinterpretation of confidentiality seems to be the gate that would prevent seeking debriefing, as and when required. The general intention of confidentiality is to respect the privacy of an individual/group by ensuring that personal information is not intentionally divulged that may expose and/or identify the individual or group. The Code of Ethics for Translators and Interpreters (AUSIT, 2000, p. 3) does allow for ventilating or debriefing after stressful sessions. However, this presents a dilemma for interpreters and raises the question of why the interpreters in our sample did not seek debriefing. With specific reference to the issue of 'confidentiality' it states: '*...information shared in interpreting and translating assignments is strictly confidential...*'.

If the literal meaning of the Code of Ethics is to be adhered to, then interpreters could be correct in their assumption that they should not discuss any information, including personal emotions about sessions, with others. This however conflicts with the *'Working with Interpreters: Guidelines for staff providing services to people who require assistance in English'*, provided by the Office of Citizenship and Multicultural Interests (2000). These guidelines recommend that interpreters are provided with the option of debriefing although

case histories should not be discussed and that assistance should be offered by the practitioner for whom the interpreter was interpreting if it is evident that the interpreter has been affected by a stressful situation.

This leads to confusion, leaving interpreters in a difficult situation as they try to deal with some very distressing information and confidentiality. The issue of 'confidentiality' therefore needs to be explored not only with interpreters but also health professionals in order that a uniform understanding and adherence to confidentiality is applied. It is recommended that health and mental health practitioners who are likely to utilize the services of an interpreter be provided appropriate training in the skills necessary to deliver structured debriefing to interpreters, when the need arises after stressful sessions. Protocols should be put in place where, as part of the process of utilising interpreter services, debriefing becomes a part of the normal process of completing an interpreting assignment. It is argued that if structured debriefing is provided to interpreters at the point of distress, potential harm to the individual can be minimised.

This study highlights the lack of monitoring of standards and codes of professional practice which, as evidenced by the derived data, are wide open to neglect. This is a fundamental deficit in entering the interpreting profession in Western Australia. One approach that would address this gap is to establish a professional body. Such an entity would assist in appropriately managing issues arising within the profession. Furthermore, it would serve to facilitate implementation of occupational health and safety measures in order to safeguard the psychological well-being of language interpreters working with an increasingly refugee population within the mental health context. ■

For further information please contact: ***Kerry Bastian on (08) 9400 9504 or email:***
Kerry.Bastian@health.wa.gov.au
or Bernadette Wright on (08) 9224 1760 or email:
Bernadette.Wright@health.wa.gov.au

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Synergy Index 1999-2002

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Events Calendar

2002

September
29-2 Oct

Mobilising Public Health
34th Public Health Association of Australia Annual Conference
Adelaide Festival Centre
Tel: 02 6285 2373
Email: conference@phaa.new.au

October
10-11

Healthy Justice for Children and Young People
AWCH 9th National Conference
Menzies Hotel, Sydney
www.conferenceaction.com.au

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The Power of Family: Catalyst for Change
5th Conference for Carers of People with Mental Illness
Carlton Crest, Melbourne
Tel: 03 9417 0888
www.carersconference.info

27-30

Maturity Matters
International Federation on Ageing
6th Global Conference & Expo
Burswood Convention Centre, Perth
www.congresswest.com.au/IFA

November
14-15

Are we on the right wavelength? Clinician & Consumer Perspectives
3rd Annual Conference, Illawarra Institute for Mental Health
Novotel NorthBeach, Wollongong
Tel: 02 4221 8095
Email: james_cook@uow.edu.au

December
2-4

Cultural Diversity in Alternative Health Care & Nursing Therapeutics
5th Nursing Academic International Congress, Thailand
http://www.fnaic.org

5-6

Mental Health from a Lifespan Perspective
Annual Conference of the Australasian Society for Psychiatric Research
Australian National University, Canberra
www.anu.edu.au/aspr

December
5-7

Setting the Agenda
2002 FECCA National Conference
National Convention Centre, Canberra
Tel: 02 6285 1336
conference@conlog.com.au

2003

February
23-28

The 27th World Congress of the World Federation for Mental Health
Melbourne Convention Centre
Email: wfmh2003@icms.com.au
www.icms.com.au/wfmh2003

March
1-4

7th National Rural Health Conference
Hobart, Tasmania
Tel: 02 6285 4660
Email: conference@ruralhealth.org.au
www.ruralhealth.org.au

27-29

Boys to Fine Men: School & Community Partnerships Conference
Newcastle, NSW
Email:
men-and-boys@newcastle.edu.au

May
22-25

VIII European Conference on Traumatic Stress
Berlin
http://www.trauma-conference-berlin.de

August
27-30

International Internet, Media & Mental Health Conference
Brisbane Conference & Exhibition Centre
Email: g.martin@uq.edu.au

October
27-30

Diversity in Health 2003 Innovation... Creativity... Harmony
Sydney Convention & Exhibition Centre
Tel: 02 9280 0577
Email:
diversity2003@pharmaevents.com.au

Contacts

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Address

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Please return to:
ATMHN
Locked Bag 7118
Parramatta BC
NSW 2150
Australia

WINTER 2002

ISSN 1442-7818

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

Locked Bag 7118		02 9840 3333
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
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SA Transcultural Mental Health Network	08 8243 5613
Victorian Transcultural Psychiatry Unit	03 9417 4300
WA Transcultural Mental Health Centre	08 9224 1760

Other Contacts

Aust. Mental Health Consumers Network	07 3394 4852
Carers 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 9687 8933
National Forum of Services for Survivors of Torture and Trauma	02 9794 1900

Government Mental Health Services

Commonwealth Dept. of Health and Ageing	1800 020 103
ACT Dept. of Health and Community Care	02 6205 5111
NSW Health	02 9391 9000
Mental Health Services, NT (Dept. of Health & Community Services)	08 8999 4988
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

Australian Transcultural Mental Health Network

Synergy

Autumn 2002

PROMOTING WELL-BEING IN MULTICULTURAL COMMUNITIES

Inside This Issue:

Embracing Diversity in Mental Health: Breaking New Ground

A Tasmanian Forum on Transcutural Mental Health

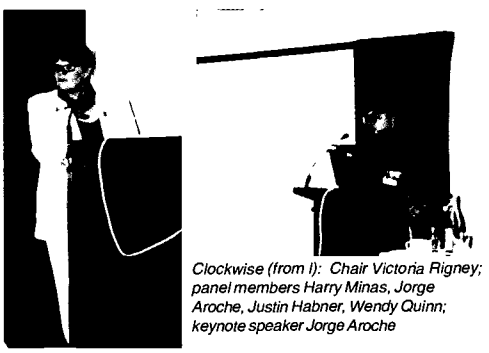
Over 180 people from across the health and welfare sector in Tasmania attended *Embracing Diversity in Mental Health: Breaking New Ground*, a free forum organised by Mental Health Services, Tasmania and the Australian Transcultural Mental Health Network in Hobart on Harmony Day, March 21, 2002. A growing interest in transcultural mental health issues in Tasmania and the difficulties Tasmanians experience attending national conferences meant that people from around the State supported the Forum.

Embracing Diversity in Mental Health took advantage of the wealth of knowledge and experience in Tasmania for the ATMHN Advisory Group meeting on March 20, and invited Emeritus Professor Beverley Raphael, Mr Jorge Aroche and Associate Professor Harry Minas to present keynote addresses. The forum opening ceremony included Ms Wendy Quinn, State Manager, Mental Health Branch, and Mr Julian Jocelyn, Manager, Health & Well-being Population Groups Unit, Dept. of Health & Human Services, Tasmania and Mr Dermot Casey, Assistant Secretary, Mental Health & Special Programs Branch, Commonwealth Dept. of Health & Ageing.

Keynote speakers explored a range of issues including changing trends in mental health service provision, how torture and trauma services relate to mainstream mental health services and the availability and usefulness of cross cultural assessment tools. Delegates discussed the local situation in a series of workshops on consumer and carer issues, mental health promotion, clinical issues and issues for refugees.

A feature of the Forum was a special Harmony Day Celebration during the lunch break. The inaugural meeting of the Tasmanian Transcultural Mental Health Network was held at the conclusion of the Forum.

Thanks to everyone who contributed to *Embracing Diversity in Mental Health*, particularly the Hobart Organising Committee for their enthusiasm and commitment.



Clockwise (from l): Chair Victoria Rigney; panel members Harry Minas, Jorge Aroche, Justin Habner, Wendy Quinn; keynote speaker Jorge Aroche

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

The Australian Transcultural Mental Health Network
Locked Bag 7118
Parramatta BC
NSW 2150
Australia
Telephone: 02 9840 3333
Facsimile: 02 9840 3388
Email: atmhn@wsahs.nsw.gov.au
Website:www.atmhn.unimelb.edu.au

Correspondence with the Editor
Tel: 02 9840 3333 or email: atmhn@wsahs.nsw.gov.au

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The ATMHN is an initiative supported by the National Mental Health Strategy and funded by the Commonwealth Department of Health and Ageing.

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Anyone interested in contributing to future issues of Synergy please contact The Editor at:
atmhn@wsahs.nsw.gov.au
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One NESB size does not fit all! What makes a health promotion campaign "culturally appropriate"?

Margo Moore, South Western Sydney Area Health Service
Di Lane, South Western Sydney Area Health Service
Anne Connolly, NSW Department of Health

In 1987 the Office for the Status of Women reported that one in three people thought violence against women was acceptable. By 1995 there was far greater understanding of the nature of domestic violence following a series of media campaigns.

However people from culturally and linguistically diverse backgrounds were less well informed and few preventive campaigns had targeted this group.

This paper, presented at the "Diversity in Health" Conference in 2001, describes a campaign targeted specifically at awareness raising and attitude change in multicultural communities.

Since the late 1980s there have been a number of media campaigns that have played a role in increasing awareness within the general population about the issue of violence against women. When the Office for the Status of Women (OSW) first surveyed community attitudes about domestic violence in 1987 it reported that one in three people believed assaulting a partner was acceptable behavior.

There followed a series of media campaigns, for example, "Domestic Violence. Break the Silence", "Wife bashing is a crime", "Domestic Violence... you can live without it" and "Real Men don't Bash or Rape Women". These raised the issue of domestic violence with the Australian public, emphasised the use of violence as a control mechanism with the family and helped shift opinion towards the view that violence against women is intolerable and should be publicly opposed. The follow-up National survey conducted by the Office of the Status of Women in 1995 showed that there had been a considerable broadening in the understanding of the definition of domestic violence beyond its physical forms. The 1995 study investigated the current awareness and understanding of, and attitudes towards violence against women in comparison to the 1987 survey. It found that there was a far greater understanding of the nature of domestic violence, that domestic violence is a criminal offence (93% agreement) and domestic violence is not a private matter (80% agreement). There was less tolerance of excuses for domestic violence (94% agreement that alcohol is not an excuse). Some population groups were better informed than others – people from higher income households were consistently more knowledgeable than the average and those born in non-English speaking countries were generally less well informed. [1] Although a great deal of work has been done on addressing the effects of violence against women, an extensive literature review showed very little evidence of any relevant preventive campaigns around domestic violence within culturally diverse communities.

It was evident from the 1995 survey that the promotion campaigns run in the mainstream media had not been successful in reaching non-English speaking background (NESB) populations. Clearly domestic violence is a crime that occurs across all cultural groups [2-7], however, the research reflected a poor level of awareness about the issues amongst non-English speaking background communities. A number of initiatives designed and implemented by non-English speaking background groups have emphasised the need for broad, community

Continued Overleaf

Continued from page 3

based, multicultural preventative campaigns.[8-11] The emphasis on community involvement was seen to be critical in the success of the campaign if the messages were to be culturally and linguistically relevant to the target audiences.[12]

BASELINE RESEARCH

In 1997, the South Western Sydney Area Health Service (SWSAHS) and the Central Sydney Area Heath Service (CSAHS) joined together on a community campaign to raise awareness and address attitudes about domestic violence in culturally diverse communities. Four communities were involved in the campaign – Vietnamese, Chinese, Arabic and Tongan speaking.

A random telephone survey of 425 people from the four communities was conducted. The survey was based on the 1995 National survey and examined knowledge about and attitudes towards domestic violence, its perceived causes, and the best ways to deal with it.

There were some significant differences between the National survey and the pre- campaign survey. Compared to the National survey, respondents were less well informed about domestic violence and the seriousness of its effects. Only 40% of people identified domestic violence as the main form of violence experienced by women compared to 60% in the National survey. In the pre-campaign survey more than half the respondents identified relationship problems as the main cause of domestic violence compared to only one fifth of the National survey. Respondents in the pre-campaign survey were much less inclined to strongly agree that domestic violence is a criminal offence. Fifty-eight percent of respondents agreed with the statement domestic violence is a private matter best handled in the family, compared to 18% in the National survey. These, and other differences, highlighted the contrasts in thinking between non-English speaking background groups and the general population. The contrast was even stronger within the more recently arrived groups like the Chinese. The findings showed that non-English speaking background groups - notably women (59% women compared to 41% men) - acknowledged the occurrence of domestic violence within their community, but that generally the response was to keep it private. The other important finding was that fewer people knew that domestic violence is a crime in Australia, only 63% compared to 83% in the National survey.

IMPLEMENTING A "CULTURALLY APPROPRIATE" CAMPAIGN

A partnership approach was developed with community representatives participating in designing and developing culturally and linguistically accurate campaign materials. Community members of the Tongan working party spoke to church congregations about the issue of domestic violence and the Vietnamese working party became key decision-makers in how the campaign was run. Members of the working parties and the steering committee provided the expertise on panels at community information forums. Key community and religious leaders also had a high profile, giving interviews to ethnic media, being on panels at information sessions with the public, speaking at the launch of the campaign and promoting it through their own networks.

Some of the issues raised in the working parties included: the gender imbalance between men and women; the role of women in their community; the role of religion in challenging or upholding ways of thinking; the power dynamics within communities, and the difference between the cultural mores and laws of their country of origin and Australia. Given the challenging topic, community cooperation was outstanding.

DEVELOPING CULTURALLY APPROPRIATE MEDIA MESSAGES - ONE SIZE *DOESN'T* FIT ALL

Separate focus groups with men and women followed the initial research to extend the understanding of issues raised in the baseline survey. Results of the focus groups highlighted the need for a different approach in non-English speaking background campaigns. In contrast to the images frequently used in English speaking campaigns, the communities clearly did not want to see images of battered women and distressed children. They wanted to build on the positives – strong family unit, strong community, strong social ownership of the issue. Peace and harmony in the family were developed as challenges to domestic violence. Images of happy families were chosen to highlight the importance of the children's future and the desire to maintain domestic harmony.

In addition to highlighting the difference in attitudes that exist between the general population and non-English speaking background populations, the research also showed the differences between each of the four communities. The research findings proved to be a vital tool in assisting the working parties in understanding their community's attitudes and perceptions to domestic violence. The research offered working party members an insight into their communities' current attitudes about domestic violence and became a valuable resource to draw on to ensure slogans and messages were pitched at a realistic level. It was important to meet with community and religious leaders early on in the process

in order to brief them and keep them informed, so that they were prepared for the campaign.

The project management team decided from the outset that the campaign material would not be based on a "translation model" where material is written in English first then translated. Instead, a "first language first" model was adopted, which allowed the working parties to develop messages in their first language using the vernacular and culturally specific expressions unique to each group. The time that would have been spent in translations and back-translation was instead invested in community consultation which resulted in the creation of specific messages that had substance and meaning within each cultural context.

One of the techniques we used in developing the campaign messages was borrowed directly from advertising. It built up a picture or "profile" of the person we were addressing. Each "person" had a name and a set of personal characteristics and experiences based on what we found out from our earlier research and on cultural input from bilingual workers. Rather than asking what messages we wanted to convey we asked each "person" what messages they wanted to hear about domestic violence. The profile was a very useful tool when it came to writing the radio ads – we developed eight characters, a husband and a wife's story for each of the language groups and incorporated specific messages that these characters would be open to hearing.

THE MEDIA CAMPAIGN

The campaign ran over a period of two months from November 1997. The intention was to draw attention to the issue of domestic violence prior to and during the Christmas period as this is traditionally the time when the incidence of domestic violence rises.

The multi-media campaign consisted of radio (SBS and community radio), ads and articles in ethnic newspapers, community forums and billboards at four railway stations. The artwork for the billboard was matched in posters and bookmarks.

The ethnic press strongly supported the issue, particularly the Tongan, Chinese and Arabic press. In addition to the paid advertisements placed in newspapers, the campaign received coverage of the community events and accompanying articles about domestic violence, which exceeded initial expectations. For example, the Chinese "Independent Daily"

Continued overleaf

WEST AUSTRALIAN TRANSCULTURAL MENTAL HEALTH CENTRE

The WA Transcultural Psychiatry Unit will now be known as the **West Australian Transcultural Mental Health Centre,** to better reflect the broad range of services the Centre delivers, as well as its statewide function. The new name also brings WA into line with counterparts in New South Wales and Queensland.

The name change was announced in March 2002 by Dr Aaron Groves, Chief Psychiatrist, and A/General Manager of the Mental Health Division, Department of Health, WA.

The Centre is funded to engage in activities aimed at enhancing mental health service access and utilisation by WA's CALD population; and promoting a better understanding of mental health issues among CALD communities.

The Centre has, and will continue to
- provide direct clinical services
- develop and deliver mental health promotion programs among WA's ethnic communities
- undertake collaborative research with other stakeholders, including universities
- undertake service development initiatives in partnership with other mental health service providers
- develop and deliver education and training programs for staff of community-based services on transcultural mental health issues
- provide a resource and consultancy service.

For more information contact
(08) 9224 1760

Continued from page 5

reproduced the entire Domestic Violence Workers Directory in a four-page supplement it produced in a weekend edition newspaper. The Tongan newspaper carried an article about one aspect of domestic violence in every edition throughout the campaign period. The Arabic newspaper "An Nahar" carried a piece about domestic violence in its look back over the year of 1997 signifying that the issue had a prominent position in the the Arabic speaking community.

TAILORING THE MESSAGES, IMAGES AND COMMUNITY EVENTS TO BE CULTURALLY APPROPRIATE

The survey results were integral in informing the way the messages were devised and the "look" of the campaign. A principle of working with the communities was that survey results would not be used to single out or stigmatise any of the four communities. Under the direction of the working parties and the bilingual workers, images were created which appealed to the target audience and which could be seen and understood regardless of literacy.

The resultant billboard covered the four language groups and English. The overall English slogan says "Domestic Violence hurts everyone in the family... and it's a crime". The billboard was divided vertically into four panels, representing the four communities. Each panel depicts a family scene portraying the importance of the family unit and the extended family. To show family conflict each panel has symbolic representations of unease and trouble. For example, under the family portrait in the Vietnamese panel a vase has been tipped over and the flower snapped. As the rose represents woman in Vietnamese culture a Vietnamese person could read that all is not well in this family. The individually devised slogan is written as a poem and says, "Love builds harmony. Violence destroys everything." The Tongan panel has the portrait hanging over the "tapa", the traditional ceremonial cloth worn by women. The tapa is highly regarded as an heirloom and is often displayed on the wall. In this case the tapa has a corner pulled down off the wall, signifying to a Tongan reader that the family is in trouble. The Tongan slogan on the panel is " Domestic violence against women affects the whole family". The Chinese panel has the portrait reflected in a cracked mirror (very bad "feng shui") and the Arabic photo itself has been smashed and is falling off the wall. The Chinese slogan is "Build up family respect and harmony. Speak out against domestic violence" and the Arabic slogan is "Domestic violence causes family destruction".

Similarly, the radio ads were designed to target each audience. There was a gender-specific radio ad for men and one for women for each of the four language groups. An innovative approach to writing the ads was trialed in the project. A "profile" was worked up which gave the working parties a method of synthesising all the information they had into one female and one male character. The method developed a profile of a person with a name, a suburb, relationship to family, whether working or not and a description of the conflict situation.

Specific messages were designed for the four groups. The Chinese community was most worried about bag snatching and attacks on the street as the main form of violence against women, so this perception was addressed in the radio ads. The last line is "Physical assault is a crime, whether it happens in the home or on the street." In the Arabic focus groups, there was a prevailing attitude that a woman should stay with her abusive husband "for the sake of the children". These and other negative perceptions were challenged in the script writing. The phrase was turned around and the woman says "now when I look back on it, I can see that I should have sought safety and protection earlier – "for the sake of the children".

Three of the working parties held community events – the Chinese held a "Information day", the Arabic an "Awareness Day" and the Tongan a "Song Festival". Even these differed from each other in the format and delivery of information. The community events became a major vehicle for directly reaching people, capturing the spirit of the campaign and providing a forum for community members to talk about the issue in their first language. The working party members and community and religious leaders provided the expertise on discussion panels at each of the forums.

Each event had its own cultural perspective. For example, the Tongan Song Festival tapped into a culturally appropriate way of talking about sensitive subjects in a non- threatening setting. The Tongan community was asked to write and compose original songs promoting the message of peace and harmony in the family and opposition to domestic violence. The songs were performed before a panel of judges and prize monies awarded. On the night of the song festival, there were sixteen contestants and over five hundred in the audience. All the songs created for the night are now part of the oral history of the Tongan community. The songs were recorded live by SBS and continue to be played on community radio. The sacred songs will also add to the repertoire of songs that are sung in Tongan

churches across the State. The Tongan Song Festival is an example of how community members can participate in defining the shape and feel of a project and how culturally specific campaign messages can add value to the culture rather than take something away.

The Vietnamese working party worked differently again by choosing not to hold a community event and instead concentrated on making resources. They made a TV ad, a fridge magnet and a pamphlet. All the resources produced by the campaign have been highly utilised by the communities.

RESULTS: POST CAMPAIGN SURVEY

Following the media campaign and community development events there were significant changes in knowledge about and attitudes towards domestic violence across all communities. The post campaign random telephone survey (of 412 people from the four language groups) showed that people were more likely to identify domestic violence as the main form of violence experienced by women (51% compared to 40% pre campaign). There were significant differences between the proportion of people identifying different forms of violence as domestic violence and also in the numbers of people reporting the various forms of domestic violence to be very serious. Seventy-five percent of respondents in the post survey strongly agreed that domestic violence is a criminal offence compared to 63% of respondents in the pre-campaign survey (a 20% increase from the baseline), and 46% of respondents disagreed with the statement domestic violence is a private matter best handled in the family compared with 39% in the pre-campaign survey.

CONCLUSION

The success of this campaign has highlighted the importance of "cultural tailoring" to ensure campaign messages have resonance with the target audience. The cultural and linguistic skills of the four working parties were an invaluable resource to draw on and maximised the potential of the campaign. Utilising community knowledge and involvement at every stage of the project development ensured community ownership of the issue and built sustainability. The cultural specificity of the message and images meant that they were well accepted and recalled. The model has since been adopted by other communities wanting to work around this sensitive issue.

ACKNOWLEDGEMENTS

This project was supported by grants from the Department for Women, the South Western Sydney and the Central Sydney Area Health Services. It was a joint collaboration between SWSAHS, CSAHS and the University of NSW (Department of Community Medicine). We gratefully acknowledge the support and work of the Steering Committee and Working Parties. The project has been awarded a prize and Certificate of Merit from the Australian Violence Prevention Awards, and a Certificate of Commendation from the 1999 NSW Premier's Public Sector Awards. ■

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Are you a person from an ethnic background who is living with a mental illness?

The Australian Transcultural Mental Health Network (ATMHN), the National Ethnic Disability Alliance (NEDA) & the Australian Mental Health Consumer Network want to find out how people from non-English speaking backgrounds can become partners in the management of their own mental health.

WOULD YOU LIKE TO SHARE YOUR STORY WITH US?

Take this opportunity to participate, speak up about the issues that affect you or your family and assist us to develop strategies for the future to help make sure your voice is heard.

INTERESTED?

Over the next month NEDA will be conducting forums around Australia. For more information on your local forum, please contact

Lou Anne Lind
National Ethnic Disability Alliance (NEDA)
Phone: 02 9687 8933 or e-mail: llind@neda.org.au

www.neda.org.au

New Arrival Refugee Women, Health and Wellbeing Project

Daniella Costa and Jan Williams

In recent years South Australia, like other Australian states, has witnessed a constant flow of new arrival refugees seeking humanitarian protection from situations of oppression, persecution and the antecedents of poverty and war.

Amongst these are women and children who are in great need of physical and emotional care and support. This article describes the experience and aspirations of women, gathered through the " New Arrival Refugee Women, Health and Wellbeing Project". The project builds on the longstanding collaboration between the Migrant Health Service (MHS) and Women's Health Statewide (WHS).

The multidisciplinary team at Migrant Health has been involved in the clinical, social and emotional assessment and treatment of new arrival refugees for several years. Since 1994 a women's health clinic, run by medical and nurse practitioners, has provided assessment and treatment for women of recent arrival. This has been operating as a joint initiative between WHS and MHS.

Recent research conducted through the women's health clinic, looked at the presenting health concerns of new arrival refugee women (Costa. 2001). The study indicated a strong correlation between women's emotional symptoms and their perceived state of health. For example, the experience of physical pain, a common presenting problem, was often a powerful metaphor for past traumas and losses.

The findings of the research and the clinical experience of the staff at MHS, have highlighted the need to offer avenues for refugee women to explore, in their period of resettlement, the source of their physical and emotional suffering and to reconnect with their identity. It is within this context that the "New Arrival Refugee Women, Health and Wellbeing" project was conceived.

THE PROJECT

This project consists of two stages. The first stage, which this article addresses, was a community consultation with new arrival refugee women and service providers. The second stage, yet to be funded, is to develop a resource in collaboration with other service providers, which is a manual of information about a wide range of topics concerning new arrival women.

The aim of the community consultation was to gain a deeper understanding of women's experiences and determine the scope of existing support programs. A project team of community health nurses, social workers, bicultural workers and a medical practitioner were involved in the planning of the project strategies and the conducting of focus group sessions.

This community consultation project had two components:

- Consultation with service providers through informal interviews

- Focus groups conducted with three main groups of refugee women;- women from Former Yugoslavia, Sudan and the Middle East.

THE INTERVIEWS

The service provider interviews involved workers from key agencies, ranging from health and counselling, to education and resettlement support. There were two main aims to the service provider interviews. To find out from service providers what they consider the main issues are affecting new arrival refugee women and to ascertain the range and type of support programs currently available for new arrival women.

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NATIONAL NOTICE

Healthy Kids: A Parents' Guide NSW Child Mental Health Project

The NSW Child Mental Health Project is a collaborative project between the Department of Psychological Medicine at the Children's Hospital at Westmead and the NSW Transcultural Mental Health Centre.

The Healthy Kids: A Parents' Guide project involves the development of a series of four fact sheets, which have been developed as part of a resource kit for families. The fact sheets provide information about and improve people's awareness and understanding of children's mental health issues. The four fact sheets that have been developed are:

- Anxiety in Children
- Disruptive Disorders in Children
- Depression in Children
- Anorexia Nervosa in Children

The fact sheets have been translated into nine community languages and will be broadcast in these languages on SBS. The radio programs will be produced as CDs for distribution following the broadcast. Subsequent fact sheets will be developed and translated over the duration of the Child Mental Health Project.

For more information contact Michelle Azizi, Child Mental Health Project Officer
Ph: (02) 9840 3764 (Tue, Thurs & Fri) (02) 9845 2198 (Mon, Wed)
Email: Michelle_Azizi@wsahs.nsw.gov.au

Free public lecture *"Seeking asylum in Australia: mental health and human experience"*

The Hawke Institute, in conjunction with the Division of Education, Arts and Social Sciences, University of South Australia, is offering "Weaving the Social Fabric", a series of free public lectures.

As part of this series, Associate Professor Nicholas Procter, from the School of Nursing and Midwifery, will present "Seeking asylum in Australia: mental health and human experience". Each lecture in the series includes community commentators who form part of the program. At Professor Procter's lecture the discussant will be journalist Peter Mares.

This presentation examines the lives and experiences of people seeking asylum as they impact upon mental health and human experience. Inspired by his work with refugees and asylum seekers, Associate Professor Procter takes up the challenge of taken-for-granted assumptions surrounding the mental health and well-being of people seeking asylum. The presentation interweaves thinking about human experience with the wider picture of worldwide people movement. It will be of particular interest to people working in health and human services as well as the general public in search of more informed discussion of Australia's treatment of asylum seekers.

Full Details: http://www.hawkecentre.unisa.edu.au/institute/events.htm
Monday 3 June 2002, 6.00-7.45pm,The Atrium, Ground Floor, Yugondi Building, City West Campus, 70 North Tce, Adelaide.
Register by contacting The Hawke Institute on (08) 8302 4369 or e-mail sanjugta.vasdev@unisa.edu.au

Queensland Refugee Mental Health Project

Queensland Transcultural Mental Health Centre, in partnership with the Prince Alfred Hospital Division of Mental Health, the South Brisbane Child and Youth Mental Health Services and the Qld Program of Assistance for Survivors of Torture and Trauma, have commenced a collaborative project to address the mental health needs of refugees on temporary protection visas.

The early intervention and clinical care project will particularly focus on outreach and early identification and focus on facilitating access to mental health care within the participating agencies.

For further information please contact Rita Prasad-Ildes ph 07 3240 2835 or by email rita_prasad-ildes@health.qld.gov.au

BOARD

To place items on the noticeboard please contact the editor: atmhn@wsahs.nsw.gov.au or tel: 02 9840 3381

W A Directory of Bilingual/ Bicultural Mental Health Practitioners - 2002 Edition

The West Australian Transcultural Mental Health Centre recently launched the 2002 edition of the Directory of Bilingual/ Bicultural Mental Health Practitioners. This is the third edition that the Unit has produced, the inaugural edition was launched in 1996. Since that time, a wide range of service providers have found the Directory to be a valuable and useful tool for facilitating culturally and linguistically appropriate services for CALD background clients presenting with mental health problems. The Directory's value is even more pertinent given the geography of Western Australia and the vast spread of its people in metropolitan and rural areas.

To ensure a reasonable level of currency and in response to a continuing strong demand for culturally-responsive services for people from culturally and linguistically diverse backgrounds, the Centre is committed to revising the Directory every two years. The Directory costs $10.00 + GST per copy, with $3.00 postage which only partly covers production costs.

To place an order, please contact ValzaThomas at the West Australian Transcultural Mental Health Centre on 9224 1760 or via email: Valza.Thomas@health.wa.gov.au

Community participation in mental health

As part of a long term commitment to establishing effective mechanisms for consumer participation, the QTMHC and the Ethnic Mental Health Program have been working together to develop and implement a community development project, which works with bilingual community development workers to undertake outreach and education on mental health and community participation issues in ethnic communities.

For further information please contact Rita Prasad-Ildes ph 07 3240 2835 or by email rita_prasad-ildes@health.qld.gov.au

Managing Loss and Grief- free information for carers

Carer Resource Centres have two new fact sheets: *Loss and Grief* and *Palliative Care*, and a booklet, *Supporting Carers in their Caring Role* to assist carers experience loss and grief, understand palliative care and accept support.

These resources are free and have been developed with funding from the Commonwealth Department of Health and Ageing.

Carer Resource Centres are a part of the Carers Association in each state and territory and provide carers with referral to services and practical information to support them in their caring role.

Carers and service providers can call their Carer Resource Centre on 1800 242 636 (freecall).

National Research Project on Remuneration of Consumer Consultancy and Advocacy in Mental Health

Auseinet, in collaboration with the Australian Mental Health Consumer Network, is undertaking a national research project on "Remuneration of Consumer Consultancy and Advocacy in Mental Health".

The aim of the project is to obtain a national picture the pattern of remuneration that is present for mental health consumers who are involved in the work of advocacy, education, peer support and committee work. It will also endeavour to ascertain how much work is done and how it is valued. The data collected will enable Auseinet and AMHCN to look at the trends, similarities and differences within and between the states and territories. This information will be correlated to form a national overview. The project will seek to compile helpful guidelines for and models of paid service delivery by mental health consumers.

Surveys of consumers and agencies form the first part of the research. This will be followed by focus groups in each state and territory to further explore issues that arise from this data.

For more information see **www.amhcn.com.au** or **http://auseinet.flinders.edu.au**

Domestic Violence and Disability in Western Australia

In 2000, in Western Australia, an interagency consortium (which included the Ethnic Disability Advocacy Centre, and the West Australian Transcultural Mental Health Centre) was convened to look at the alarming issue of the neglected combination of domestic violence and disability (psychiatric, physical, intellectual).

A forum subsequently took place which provided a better understanding of the extent of unmet needs, identified strategies for enhancing services within existing resources, and generated ideas for promoting awareness of the domestic violence and disability issue among funding agencies and relevant peak bodies.

A preliminary report was prepared and widely distributed. The recommendations contained in this preliminary report, called for service providers and policy makers to acknowledge the difficulties experienced by the target population in question. The report further recognized that people with disabilities are three to four times more likely to experience domestic violence. (In this context, the term 'disability' refers to sensory, psychiatric and/or physical disabilities). Yet, little research has been conducted to identify the special needs of those who fall into this category, or the gaps in services in catering for this group. The added factor of being a migrant, with a disability and living in a domestic violence situation is also a circumstance about which many service providers fail to acknowledge or understand the special needs of the person.

In 2002 the consortium aims to

- ascertain the nature and extent of domestic violence against women with disabilities in WA including those from CALD backgrounds;
- identify unmet needs; and,
- develop realistic strategies for raising community awareness and effective interventions about domestic violence, in general, among ethnic communities in Western Australia.

Work is underway in collaboration with the Multicultural Women's Advocacy Centre, Canning Division of General Practice and several ethnic communities to address these issues.

For further information please contact:
Ms Jenny Au-Yeong at the Ethnic Disability Advocacy Centre on (08) 9221 9921 or
Dr Bernadette Wright, West Australian Transcultural Mental Health Centre on (08) 9224 1760.

Multicultural mental health promotion on the Queensland air waves!

Queensland Transcultural Mental Health Centre has became a regular presenter on the Brisbane-based ethnic radio station 4EB promoting mental health.

The partnership with 4EB follows a successful interactive media workshop facilitated by the Australian Transcultural Mental Health Network, in conjunction with QTMHC, in December last year.

The workshop brought together service providers and ethnic media representatives to discuss how to effectively communicate mental health issues to Queensland's diverse communities,

For further information contact

Rita Prasad-Ildes ph 07 3240 2835
or by email rita_prasad-ildes@health.qld.gov.au
or
the ATMHN on (02) 98403333 or by e-mail
atmhn@wsahs.nsw.gov.au

Book Review

Promoting Health in Multicultural Populations

Hurr, R. and Kline, Michael

Review: Elvia Ramirez, Mental Health Promotion Coordinator, Queensland Transcutural Mental Health Centre

This rare book provides the foundations to work on health promotion and disease prevention (HPDP) in multicultural society and assumes that a health care practitioner also provides HPDP services. It details planning and implementation strategies and barriers and potentialities of specific populations, some relevant to the Australian context: Asian, Pacific Islanders and Latin American.

The book establishes that cultural aspects are one of the key social determinants of health and that culture is everywhere and is used by everyone to construct reality, incorporating aspects passed down through generation, as well as aspects from any given society. It explains that cultural differences between health promoters and clients may be viewed as barriers, but ones that must be overcome if the goal of uniform health delivery to a multicultural population is to be attained. This goal must then be worked for disregarding the antiquated notions of acculturation and assimilation, where the dominant society's culture engulfs minority cultures, but through cultural competence and ethno-sensitivity.

These concepts emphasise a culturally sensitive discourse between the health practitioner and the client; for example, the health practitioner should demonstrate a genuine interest and respect for cultural differences. Where these cultural variations create barriers, ethno-sensitivity should be put into practice on the part of the health practitioner by learning from clients and taking the time to explain Western perceptions of health and illness and health care practices thus optimising cross-cultural communication.

The reader is reminded that aspects of the client and target group are as important as own socio-cultural orientations and organisational aspects in the achievement of health outcomes. The way in which the organisation perceives the target group, how it prepares to deliver culturally competent services, and how it is oranised physically and in it policies plays as great a role as the demographic characteristics of the group, its epidemio-logical and environmental influences, health beliefs and practices and general and specific cultural characteristics such as communication patterns, perceptions of self and community, time orientation and world view.

The book distinguishes the frameworks for *cultural tailoring* and *targeting* HPDP interventions to diverse cultural groups. The latter merely ensures exposure of the target group to the intervention whereas cultural tailoring takes into account the specific cultural factors that influence behaviour related to health and disease.

This book is a useful tool for those working on HPDP of people with a cultural other than their own.

Promoting Health in Multicultural Populations: A Handbook for Practitioners, Huff, R. and Kline, Michael. Sage Publications: Thousand Oaks (CA) 1999

Review reprinted with permission from · "Translink", the Newsletter of the Queenlsand Tanscultural Mental Health Centre, Issue No 21, March 2002

NSW TMHC focuses on Mental Health Promotion, Prevention and Early Intervention for all

NSW Transcultural Mental Health Centre has recently released two new reports focusing on mental health promotion, prevention and early intervention. The first, *A Better State of Mental Health For All*, describes a state wide multilingual multi-media community awarenes campaign targeting families, while the second, *Mental Health Promotion, Prevention and Early Intervention for All*, reports on the third Transcultural Mental Health Promotion Forum.

A BETTER STATE OF MENTAL HEALTH FOR ALL:

A multilingual multi-media community awareness campaign promoting the mental health and wellbeing of children, adolescents, young people and families

The community awareness campaign detailed in *A Better State of Mental Health For All: A multilingual multi-media community awareness campaign promoting the mental health and wellbeing of children, adolescents, young people and families* focuses on building bridges between families from culturally diverse backgrounds and the NSW health system and the Transcultural Mental Health Centre.

The reports focus is on promoting the mental health of children, adolescents and young people from culturally and linguistically diverse backgrounds. This overall aim was achieved by implementing a state wide, population-based approach, multilevel community awareness campaign targeting 15 community language groups. The project entailed:

- the production and dissemination of a culturally and linguistically appropriate Family Help Kit, (The Multilingual Family Help Kit) covering nine mental health issues in 15 community languages;

- the production and dissemination of audio tapes based on the Multilingual Family Help Kit in 15 community languages; and

- the coordination and evaluation of a state wide radio campaign on nine mental health issues in 15 community languages.

This report outlines in detail the key processes that were followed during the planning, development, implementation and evaluation stages of a culturally and linguistically appropriate and sustainable mental health promotion/early intervention initiative. The processes that contribute to building positive mental health for culturally diverse populations, both within individual communities and networks and across a range of communities are explored. The partnerships that were essential in achieving these key processes were those between the NSW Health Department's, Centre for Mental Health, the Transcultural Mental Health Centre, the Special Broadcasting Service (SBS), Bilingual Consultants and the 15 selected communities.

The report details practical insights on how to successfully develop multilingual health messages for multiple NESB communities and highlights the barriers and facilitators to developing culturally and linguistically appropriate resources.

This report is an essential resource for mental health promotion staff, mental health and community health service providers, managers, community members, policy makers and planners. The report will be of benefit to anyone with an interest in improving the quality of mental health and community health services for NESB children, adolescents and young people and for developing mental health promotion initiatives generally.

For more information contact the Resources Officer NSW Transcultural Mental Health Centre on Tel: 02 9840 3800

Continued next page

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Third Transcultural Mental Health Promotion Forum: MENTAL HEALTH PROMOTION, PREVENTION AND EARLY INTERVENTION FOR ALL

This report of proceedings of the *Third Transcultural Mental Health Promotion Forum: Mental Health Promotion, Prevention and Early Intervention For All* held on the 20th September, 2001 contains useful information that builds on previous Forums coordinated by the Transcultural Mental Health Centre (TMHC) and addresses issues of culture and mental health promotion, prevention and early intervention.

The proceedings records the:

- objectives of the Forum, workshops and consultations that occurred during the day;
- details the key points raised by the respective speakers;
- a synopsis of the panel discussion;
- comprehensive workshop and consultation summaries; and
- recommendations for future action.

The report also sets out in detail the current ideas and concepts of mental health promotion, prevention and early intervention in a transcultural setting and particularly how it relates to young people, adults and older people.

The report is an essential resource for mental health promotion staff, mental health and community health service providers, managers, policy makers and planners. The report provides the theoretical/policy context of mental health promotion and practical insights on how to successfully develop mental health promotion, prevention and early intervention strategies for people from culturally and linguistically diverse communities. ■

Tasmanian Transcultural Mental Health Network re-established!

The Tasmanian Forum " Embracing Diversity in Mental Health: Breaking New Ground" held in Hobart, Tasmania 21st March 2002, saw the relaunch of a revitalised Tasmanian Transcutural Mental Health Network (TTMHN) . Membership of TTMHN consists of many government and non-government organizations, communities and individuals interested in multiculturalism and mental health care across state.

The original Tasmanian Transcultural Mental Health Network was established as an organization in Launceston, in 1996 and represented migrant service organizations, ethnic community groups, mental health service providers and university staff. With support from Australian Transcultural Mental Health Network (ATMHN), the TTMHN encouraged, promoted and supported the development of cross-cultural training to the staff of services. This was aimed at developing a greater level of reflectivity and responsiveness to the multicultural nature of the Tasmanian community and to facilitate better access from people of culturally and linguistically diverse backgrounds.

The Tasmanian Transcultural Mental Health Program, a two years project, was funded by the Commonwealth Department of Health & Ageing through the ATMHN and the Tasmanian Government in 2000. The Program's aims were to facilitate better access to and quality of the existing mainstream mental health services for people from culturally and linguistically diverse backgrounds who have a mental illness and their carers. And to reestablish the Tasmanian Transcultural Mental Health Network .

Membership of TTMHN is free and open to anyone concerned with the needs of people from culturally and linguistically diverse backgrounds and the influence of language and culture in mental health areas.

For more information contact Zhen Xiao, Project Officer Phone (03) 6331 2300
Fax (03) 63342660
Email: Zhen.Xaio@mrcltn.org.au

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The interviews highlighted four common themes. These included:

· Practical issues of resettlement, such as housing, transport, language problems, education and finances.

· Challenges, arising from the cultural difference between country of origin and Australia, commonly experienced through values and beliefs systems, norms regarding social behaviour and through the role of men and women in society.

· Physical and emotional health issues which present as both a symptom and a cause of distress, within the resettlement period. Pre migration experiences such as war, torture, trauma, family separation and lack of access to adequate medical care, often compound physical and emotional health symptoms.

· Women's sense of self, which represents an array of personal and emotional issues many refugee women find difficult to articulate. Feelings of loss, loneliness, belief in ones self, hopes and dreams for the future and personal goals, are often obscured by the practical issues of resettlement. Implicit in the expression of sense of self, is the need for women to be understood within the context of complex, rich and diverse cultural stories.

This information, combined with the outcomes of the research (Ibid.2001), was used as a basis for the construction of a focus group format with the community women.

THE FOCUS GROUPS

Focus groups, in both community consultation and formal research, have become an increasing popular and effective tool in exploring the views and experiences of community groups. For the purpose of this project, focus groups were used as a way of evoking personal responses, which reflect the experiences of refugee women in coming to a new country.

Many refugee women coming to Australia have lived through experiences of imprisonment or internment in refugee camps, separation from family and loved ones, torture, rape, famine and loss of property and livelihood.

There were two main aims to the focus group sessions.

· To produce a line of questioning which validated the baseline information, gained through the service provider interviews, about issues concerning new arrival women.

· To find out from women how we as service providers, could best meet their support and information needs, through the development of a course or a resource.

To minimize the effects of variation between groups, such as age and cultural background, each session was conducted in a consistent manner.

Continuity with the staff involved in facilitating each session ensured consistency and rigour with the format. Documentation of the discussion was both written and tape recorded. Each transcript was cross-checked and analysed by the project team. A system of sorting through common themes and issues was developed with particular attention to describing the mood of the group and identifying factions or divisions. A summary of the focus group transcripts was presented back to individuals from each group, to cross check for validity.

Considerable attention was paid to creating a safe environment for the participants. All of the women, who were involved in the sessions, were known by the project team, who in turn had an intimate knowledge of the kinds of experiences and issues faced by the community women. Sensitivity toward emotional issues such as unresolved grief and the potential for personal disclosure was acknowledged. Each of the facilitators had experience working therapeutically with new arrival refuge women. Each brought to the process a range of skills from the various professional backgrounds, which included social work, nursing and medicine. The aim of each session was to establish an atmosphere of trust, openness, safety and sharing in order to take women on a journey, beginning with an open discussion about non-threatening practical issues of resettlement and ending with an invitation to explore deeper meanings about sense of self.

It was anticipated by the project team, that engaging women in a discussion about the experiences and challenges of resettlement would be straightforward. Our collective experience told us that women share readily when asked about tangible issues concerning themselves and their families. Encouraging women to articulate beyond practical issues into the realm of personal goals, dreams and ambitions would not be as

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simple. For many women, pre migration experiences as a refugee and the process of beginning again in a new country have necessitated a pre occupation with survival and dealing with loss. Many have not had the luxury of time, or an environment in which they feel safe enough to look into the future with hope.

THE THEMES

There were a number of common themes across the three focus group sessions.

· The aspiration to create a safer existence for themselves and their families

For many, coming to Australia meant a chance of survival.

> *" When we were in Afghanistan we had no hope to be alive."*

Many women from Afghanistan spoke about *'fleeing for their lives'* with little thought about where they were going, or what was ahead.

> *" In my mind it was just to rescue my children and myself. I don't wish for my children to be like the Taliban."*

Even though they had taken enormous personal risks, they expressed tremendous gratitude for their new lives in this country.

· Expectations of a better life in Australia

Many of the women from the Middle East had high expectations based on what they perceived as Australia's high standing on human rights issues. They had not expected to be treated differently than other refugees. Women from former Yugoslavia spoke about the misinformation, which they received and how their expectations did not match their actual experiences in transit and on arrival to Australia.

· Lack of opportunities for employment and learning English

Language issues, together with dependency on the welfare system, represented common sources of distress for the women. As one woman put it: *" We are a Centrelink burden."*

Unemployment and the inability to communicate in English, deprived women of the means to connect with Australian society. For many women and their partners, the sense of social alienation and hopelessness had spiraled into a cycle of low self-esteem, depression and despair.

> *"I don't know what's wrong with me at this point. Psychological fatigue hinders my ability to achieve goals and any chance in this country. I don't know if it's because of being a stranger in this country or for being away from my relatives or being in Woomera for a long time."*

> *" I have a lot of stresses. I just want to cry all the time. I am tired all the time. If you want me to cry now, I can cry right now. I can cry right now ".*

· Sense of cultural dislocation.

Women who had spent a long time in refugee camps prior to coming to Australia, spoke of the profound sense of dislocation derived from the cultural leap from a third world environment, to Australia. All of the women described a sense of profound loneliness and being 'lost' within a new country, separated from family and community networks.

> *"Now I am in my house nobody, no one, comes and asks about me in my house. No one comes and talks to me. Because there is nobody who comes and talks to me I feel as though I am dead. Now that you are asking about me and when you called me to come here, then I knew that I was alive. No one asks my needs, no one talks to me here. They just left me. The Australian government people brought me here and just left me here".*

SUMMARY AND CONCLUSION.

The process of bringing refugee women together in cultural groups, to talk about specific themes, was at times very moving and extremely powerful. Women valued the opportunity to share their feelings, their views and aspirations for the future. More importantly, they wanted to be heard.

In terms of support and interventions some of the issues raised by the women include:

· The need to address physical and emotional health issues.

· A desire to meet other women and learn from their experiences of resettlement.

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- The need for community groups to work with service providers to form links and support.
- Access to language classes specifically for women.
- Sessions and groups that provide childcare and information about resettlement issues.
- Assistance in gaining job seeking skills and recognition of prior learning / qualifications.
- Information and support regarding the challenges of cultural change.
- A place of safety where women can express their cultural and religious beliefs.
- A group, which has a support and advocacy role, where women can voice their anger, concern and confusion about life in a new country.
- A group, which gives women the opportunity to explore creative outlets such as cooking and sewing.

The main recommendation, which emerged from the community and service provider consultations, was to use the focus group model as the basis for developing a program for new arrival women. This program will address the need for information, counselling and early supportive intervention.

A final project report detailing the community consultation outcomes and a course outline were completed in 2001. ■

Reference:
"Women's Health Clinics: the many faces of empowerment" 4th International Women's Health Conference Proceedings, Adelaide, 2001.

For more information contact:
Jan Williams, Community Health Nurse
Migrant Health Service
21 Market Street, Adelaide SA 5000
Ph: 08 8200 3912
E-mail: jan.Williams@dhs.sa.gov.au

Daniela Costa, Senior Medical Practitioner
Women's Health Statewide
64 Pennington Terrace, North Adelaide SA 5006
Ph: 08 8239 9600
E-mail: daniela.costa@dhs.sa.gov.au

Events Calendar

2002

May

13-15

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

Email: events@adf.org.au
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

16-19

Made in the Future
Australian Health Promotion Association 14th Annual Conference
Sydney Convention & Exhibition Centre

Tel: 02 9280 0577
Email:
healthpromotion2002@pharmaevents.com.au
www.healthpromotion.org.au

21-23

Quality of life for All of life
Suicide prevention-its social, political and developmental contexts
9th Annual conference of Suicide Prevention Australia Inc
Darling Harbour Convention Centre, Sydney

Tel: 02 9211 1788
www.suicidepreventionaust.org

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

There's no Health without Mental Health
TheMHS 12th Annual Conference
Sydney Convention Centre, Sydney

Tel: 02 9926 6057
www.themhs.org

September

15-17

A National Forum on Promotion, Prevention and Early Intervention for Mental Health & Well-being

http://auseinet.flinders.edu.au

29-2 Oct

Mobilising Public Health
34th Public Health Association of Australia Annual Conference
Adelaide Festival Centre

Tel: 02 6285 2373
Email: conference@phaa.new.au

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
Email: conference@ruralhealth.org.au
www.ruralhealth.org.au

Contacts

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Address

E-mail

Please return to:
ATMHN
Locked Bag 7118
Parramatta BC
NSW 2150
Australia

AUTUMN 2002

ISSN 1442-7818

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

Locked Bag 7118	02 9840 3333
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 Mental Health Centre	08 9224 1760

Other Contacts

Aust. Mental Health Consumers Network	07 3394 4852
Carers aAssociation 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 9687 8933
National Forum of Services for Survivors of Torture and Trauma	02 9794 1900

Government Mental Health Services

Commonwealth Dept. of Health and Ageing	1800 020 103
ACT Dept. of Health and Community Care	02 6205 5111
NSW Health	02 9391 9000
Mental Health Services, NT (Dept. of Health & Community Services)	08 8999 4988
QLD Health	07 3234 0111
Dept. of Human Services, SA	08 8226 8800
Dept. of Health & Human Services, TAS	03 6233 3185
Health Department of WA	08 9222 4222

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