Federation of Ethnic Communities' Councils of Australia

Submission to the Productivity Commission's final review of the National Mental Health and Suicide Prevention Agreement

14 March 2025

FECCA pays its respects to Aboriginal and Torres Strait Islander Elders past and present and recognise the land we live and work upon was never ceded. FECCA proudly supports the Uluru Statement from the Heart.

FECCA acknowledges that our work on behalf of multicultural Australia has learnt from and been enriched by First Nations peoples and organisations. We are committed to continuing to listen, learn and support First Nations peoples in the journey to a more inclusive soc

Who We Are

The Federation of Ethnic Communities' Councils of Australia (FECCA) is the national peak body representing people from multicultural communities and their organisations across Australia. Through the membership of state, territory, and regional councils, we represent over 1,500 community organisations and their members.

What We Do

For over 45 years, FECCA has proudly worked alongside culturally and linguistically diverse communities, the broader Australian society, and government to build a successful, productive and inclusive multicultural Australia where everyone, no matter their background or how long they have lived in this country, can belong equally and reach their full potential.

FECCA draws on the lived and intergenerational experiences of those who have migrated to Australia and the expertise of its extensive and diverse membership to develop and promote inclusive, innovative and responsible public policy that reflects the needs and perspectives of multicultural Australia. We are committed to building a strong, innovative, and inclusive nation that harnesses its greatest strength: the diversity of its people.

The FECCA network is FECCA's greatest strength. Through our network, we can enhance the capacity of governments to strengthen public policy to meet the needs of the diverse Australian population. FECCA is a proven trusted partner to both communities and government, operating as a sophisticated conduit by mobilising communities to work with government to develop and enrich public policy through community-led expertise and action.

Foreword

The Federation of Ethnic Communities' Councils of Australia (FECCA) welcomes the opportunity to provide this submission to inform the Productivity Commission's final review of the National Mental Health and Suicide Prevention Agreement. For years, FECCA has highlighted the importance of improving the mental health and suicide prevention support system for multicultural communities, ensuring that cultural safety and cultural responsiveness are embedded as core components of how the system is designed and operates, from preventative interventions to service provision at different levels of complexity.

This submission would not have been possible without the contribution of FECCA's members and individuals in communities, multicultural community organisations, and specialised service providers who have shared their grounded knowledge and, at times, difficult personal experiences. We thank the Ethnic Communities Council of Queensland (ECCQ), Multicultural Communities Council of South Australia (MCCSA), Foundation House, and the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT), for the specific inputs and documents shared. We are particularly grateful to Perrin Abbas, and to the members of the Australian Multicultural Health Collaborative's Consumer and Carer Network, for their generosity and valuable personal inputs.

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Introduction

FECCA, as the national peak body for people from multicultural communities and their organisations across Australia, has a long-established history of working with as well as listening directly to its community members. For years, FECCA has engaged with the Commonwealth Government at all levels to ensure that Australian policies and services are fair and inclusive and reflect the diverse needs and strengths of our multicultural nation. As articulated in the *National Multicultural Framework,* coordinated by FECCA and supported by more than 100 multicultural organisations, we are dedicated to build: [1]

> *'A nation that actively recognises the value of its diversity and ensures that everyone, regardless of their culture, ethnicity, language, religion, gender, sexuality, disability, visa status, geography, class, gender identity, or age, has equal rights and opportunities is a nation that puts its best foot forward to being fair and inclusive.'*

Through its ongoing engagement with diverse ethnic communities and strong relationships with multicultural organisations across Australia, FECCA has heard multiple concerns about mental wellbeing in multicultural communities. This has become more acute after the COVID 19 pandemic, and particularly challenging is the fact that to date, there continues to be a gap in sustainable, tailored support for multicultural communities to understand mental health and mental health services in Australia, and to access a complex system. The challenges go beyond language barriers or stigma around mental health or suicide. Whilst those issues matter, we frequently hear of individuals in multicultural communities who actively seek access to mental health services, but these are either not available, not affordable, or are not culturally responsive. Negative experiences with mental health services often make them feel unsafe and unheard, consequently worsening their sense of social disconnect and isolation.

The *Multicultural Framework Review,* a historical process that resulted from ample community and sectoral consultations for a contemporary analysis of the status of multiculturalism in Australia, clearly emphasised the connection between sense of belonging and mental health outcomes. As the Review's report summarises:[2]

> *'The health and cohesiveness of a community transcends individual experiences, as it is shaped by shared histories and social interactions. Systemic issues, such as discrimination and the pervasive sense of being 'othered', can erode community cohesion, exacerbating collective psychological distress. Effective community health strategies must therefore address these broader social dynamics, fostering environments where diversity is acknowledged and respected.'*

This submission reinforces the findings from the *Multicultural Framework Review* and embeds inputs from communities and service providers. It is of particular value for the Productivity Commission's

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[1] FECCA (2023). *Submission into the Multicultural Framework Review*, 13 October, FECCA https://fecca.org.au/wp-content/uploads/2023/11/2023-10-FECCA-Submission-Multicultural-Framework-Review.pdf

[2] Australian Government (2024). *Towards fairness. A multicultural Australia for all*. Canberra, Commonwealth of Australia, p.45, https://www.homeaffairs.gov.au/multicultural-framework-review/Documents/report-summary/multicultural-framework-review-report-english.pdf

final review of the National Mental Health and Suicide Prevention Agreement ('the National Agreement') in its goals of assessing the effectiveness of reforms for 'culturally and linguistically diverse (CALD) communities and refugees' as an identified priority population, identifying **best practices** , and **improving the capacity of the mental health and suicide prevention services** to respond to the needs of culturally and linguistically diverse groups. It does not include reviews of bilateral agreements between the Commonwealth and States and Territories.

FECCA commends the Productivity Commission for the explicit inclusion of cultural safety and responsive for First Nations people within the scope of this review. This is a unique opportunity to learn **from and with First Nations**. However, for all the reasons outlined below, FECCA expects that the Productivity Commission will ensure that the principles of cultural safety and cultural responsiveness in mental health and suicide prevention services are adapted and extended to Australia's growing multicultural population.

Overall, the inputs from FECCA's members and individuals received for this submission reiterate that it is vital for the government, service providers and professionals to acknowledge that the highest benefits will derive from systemic reforms that address the interconnected social and economic determinants of mental health, and promote equitable access in a culturally safe and responsive manner.

Mental health and multicultural communities: A persistent gap

Cultural diversity is an important and defining aspect of the lived reality of the Australian nation. The 2021 Census shows that more than half of Australian residents (51.5 percent) were born overseas or have at least one parent born overseas; and over 5.5 million Australians speak a language other than English at home.[3]

Members of the multicultural communities in Australia can face greater challenges when navigating the healthcare system,[4] such as being met with cultural biases, racism and discrimination in healthcare services, language barriers, lower levels of health literacy, and difficulties navigating unfamiliar systems.[5] This puts people from culturally and linguistically diverse backgrounds at greater risk of poor health care and health outcomes, with refugees and people seeking asylum being the most vulnerable group.[6]Further, the challenges faced by multicultural communities are multilayered and may be compounded by other factors such as trauma, financial hardship,

[3] Australian Bureau of Statistics (2022). 2021 *Census: Nearly half of Australians have a parent overseas,* 28 June, https://www.abs.gov.au/media-centre/media-releases/2021-census-nearly-half-australians-have-parent-born-overseas

[4] Georgeou N, Schismenos S, Wali N, Mackay K, Moraitakis E. A scoping review of ageing experiences among culturally and linguistically diverse people in Australia: towards better ageing policy and cultural well-being for migrant and refugee adults. Gerontologist. 2021;191:1–18.

[5] Australian Institute of Health and Welfare (2025). *Culturally and Linguistically diverse Australians.* Australian Government, https://www.aihw.gov.au/reports-data/population-groups/cald-australians/overview (accessed on 25 March 2025)

[6] Hadgkiss Emily J., Renzaho Andre M. N. (2014) The physical health status, service utilisation and barriers to accessing care for asylum seekers residing in the community: a systematic review of the literature. *Australian Health Review* 38, 142-159. https://doi.org/10.1071/AH13113

uncertainty associated with migration status, experiences of racism and other forms of discrimination.[7]

The effects of these barriers are amplified when it comes to addressing mental health issues and support. Stigma in some CALD communities may prevent them from recognising mental health issues and seeking professional help. The dominant Western framing around mental health, which are more individualistic, can be unfamiliar or even threatening to certain communities.[8] Different beliefs and explanatory models of mental health and illness within different cultures and communities mean that help-seeking efforts can be met with hostility and stigma from within the community. According to the *National Stigma Report Card*, participants who had been most affected by mental health stigma in their cultural, faith, or spiritual practices or communities had either voluntarily avoided engaging with their own community or were isolated by their own community and met with a lack of understanding.[9] Further, cultural beliefs about mental health, family dynamics, and communication styles can significantly impact CALD women's willingness to seek help and engage with services.[10]

It must be highlighted that whilst in much of the conversations around mental health in Australia, cultural beliefs are framed as 'barriers', research has found that strong community ties, family bonds and religious traditional values are all positively associated with lower risks of suicide.[11]Migrant and refugees often demonstrate courage, resilience and social ties that are all sources of strength. Unfortunately, these features are not properly acknowledged or well used in the design of mental health services.

To date, lack of affordable, culturally responsive services remains a significant impediment for individuals from multicultural communities to access to mental health services. It is important that the responsibility to address this gap is not transferred to communities and community leaders, but remains with governments, in its duty to ensure a fair and inclusive mental health and suicide prevention system for all.[12]At the national level, there is limited monitoring and reporting on the status of mental wellbeing within CALD communities, the level of service access, or mental health outcomes.[13] People from CALD backgrounds are often not included in national mental health research,[14]and there is a persistent lack of good quality, disaggregated data for different cohorts

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[7] Shepherd, S. M., & Masuka, G. (2020). Working With At-Risk Culturally and Linguistically Diverse Young People in Australia: Risk Factors, Programming, and Service Delivery. *Criminal Justice Policy Review*, *32*(5), 469-483. https://doi.org/10.1177/0887403420929416 (Original work published 2021)

[8] Kleinman, A. and Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. PLoS Medicine, 3(10), 1673-1676

[9] Groot, C., Rehm, I., Andrews, C., et al. (2020). "National Stigma Report Card". *National Stigma Report Card*. https://nationalstigmareportcard.com.au/sites/default/files/2021-05/NSRC_Report_Summary.pdf

[10] Satyen, L., Piedra, S., Ranganathan, A. *et al.* Intimate Partner Violence and Help-Seeking Behavior among Migrant Women in Australia. *J Fam Viol* **33**, 447–456 (2018). https://doi.org/10.1007/s10896-018-9980-5

[11] Morrell, S., Taylor, R., Slaytor, E., & Ford, P. (1999). Urban and rural suicide differentials in migrants and the Australian born, New South Wales, Australia 1985-1994. Social Science and Medicine, 49(1), 81-91.

[12] Kleinman, A. and Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. PLoS Medicine, 3(10), 1673-1676.

[13] Mental Health in Multicultural Australia. (2014). *Framework for Mental health in Multicultural Australia: Towards culturally inclusive service delivery.* MHIMA. https://www.mentalhealthcommission.gov.au/sites/default/files/2024-03/framework-for-mental-health-in-multicultural-australia---towards-culturally-inclusive-service-delivery.pdf

[14] Garrett, P., Dickson, H., Whelan, A., & Whyte, L. (2010). Representations and coverage of non-English-speaking immigrants and multicultural issues in three major Australian health care publications. Australian and New Zealand Health Policy, 7(1), 13.

within this highly diverse and significant part of the Australian population. This is reflected in the lack of specificity and targeted efforts for multicultural communities at both the federal and state government mental health and suicide prevention strategies.

The National Agreement includes 'culturally and linguistically diverse communities and refugees' amongst priority populations (Clause 111.c), but it does not acknowledge the needs of people seeking asylum, and who are known for experiencing higher risk factors to their mental health, including suicide. The *National Suicide Prevention Strategy 2025-2035* explicitly mentions the disproportionate impact of suicide on certain groups within the CALD population:[15]

> *'People who enter Australia as humanitarian entrants have nearly twice the rate of suicide as other permanent migrants to Australia. Research shows that suicide rates of Australian-born people and migrants from English-speaking countries are similar, but migrants from Oceania countries and African countries have some of the highest suicide rates and these are increasing.'*

Still, ongoing investment in initiatives and programs that ensure specialised services, and coordination with the broader settlement sector, are missing. In addition to the National Agreement, each state and territory has its own mental health and suicide prevention plan, and the consideration and mention of support specifically targeting people from culturally and linguistically diverse backgrounds differs.[16] The state and territory level responses and capabilities in mental health and suicide prevention for CALD people lack specific and measurable actions, demonstrating considerable varying degrees of commitment between states and territories.

In the next section, we highlight priority areas and recommendations for systemic reforms that have been called for during the *2020 Productivity Commission's Inquiry into Mental Health*, and that continued to be urgently needed to ensure Australia's mental health and suicide prevention system is inclusive, culturally safe and culturally responsive.

Recommendation 1: Embed intersectional analysis as a core feature of the system

Whilst intersectionality has become a more accepted term in policy language, its actual application into policymaking has been slower. An intersection lens requires policy makers to examine how gender, sexual identity, age, ethnicity, geographical location, socioeconomic status, disability, and migration status, amongst other characteristics, can operate as sources of discrimination, cumulative barriers to access to services and lead to unequal outcomes for specific population groups.

In mental health and suicide prevention, settlement organisations and specialised service providers, for instance, have for long emphasised the importance of addressing differentiated drivers of mental health deterioration for refugees and those seeking asylum, including factors such as previous

[15] Australian Government. National Suicide Prevention Office (2024). *National Suicide Prevention Strategy 2025-2035*, p.15, https://www.mentalhealthcommission.gov.au/sites/default/files/2025-02/the-national-suicide-prevention-strategy.pdf

[16] Vayani, H (2017). *Background Briefing: Multicultural Mental Health & Suicide Prevention.* Report to the National Mental Health Commission, https://www.mentalhealthcommission.gov.au/sites/default/files/2024-04/background-briefing-multicultural-mental-health-suicide-prevention.pdf.

traumatic experiences, trauma acquired through the asylum-seeking process, and discrimination in their new context.[17]

Similarly, there has been considerable evidence on the need for more attention to gender differences, especially for women and members of the LGBTIQA+ community, from migrant and refugee backgrounds. In cases of family, domestic and sexual violence, women who are dependent on perpetrators financially and who are temporary visa holders, may experience additional challenges to access safe support services, for themselves and for their children. FECCA's work with SSI and faith and community leaders around family, domestic, and sexual violence, has reinforced the need for an intersectional lens, which places overlapping forms of disadvantage at the centre of system re-design, including in the areas of mental health and suicide prevention.

Individuals from culturally and linguistically diverse background who do not identify with the traditional binary classifications of sex and gender identities, are also more likely to experience intersecting forms of discrimination, within and outside their communities. Moreover, when accessing services, they often find more difficulties to identify providers who make them feel safe, both in terms of their cultural background and their gender identity.

FECCA has, through its relationships with older members of the multicultural communities and organisations serving older people, become aware of growing concerns with the mental health of older people in multicultural communities. The invisibility of older people in public discussions, and the specific challenges migrant background older people are experiencing, mut be addressed when considering system design and investment.

FECCA recommends that the final review of the National Agreement clearly frames intersectionality as more than a principle to be an essential consideration in design of services, programs and definition of priorities, to address inequities of access and outcomes in the current system.

Recommendation 2: Improve data and research on mental health and suicide prevention for multicultural communities

This includes:

> *2.1. Investment in migrant health studies, including longitudinal studies and surveys, to fully understand the short- and medium-term mental health experiences and support needs of CALD populations.*
>
> *2.2. Investment in better data collection around suicide, including through police and coronial reports, and targeted research, to build a robust evidence base around suicide, for specific cohorts within CALD communities, particularly refugees and people seeking asylum, with a gender lens.*[18]

[17] See, for instance, Foundation House and Victorian Refugee Health Network (2023). *Insights from community advisory groups: Improving access to mental health support for refugee background communities in Victoria*. Online, https://foundationhouse.org.au/wp-content/uploads/2024/03/VFST-VRHN-Community-Advisory-Groups-Insights.pdf; and Foundation House and Victorian Refugee Health Network (2023). *Key issues in access to mental health care for refugee background communities.* Online, https://foundationhouse.org.au/wp-content/uploads/2024/04/VRHN-VFST-Sector-Consultation-Report.pdf

[18] See FASSTT (2024). *Response to the Consultation for the Draft Advice on the National Suicide Prevention Strategy*, November 2024.

A recurring issue that has been raised time and again during FECCA community consultations is the lack of comprehensive research, reporting and robust data collection on the mental health of CALD communities in Australia, which in turn, remains a significant barrier to effective policy development. While the National Agreement emphasises data collection (part 7, p. 19), it does not explicitly require disaggregated data within mental health services to track outcomes, identify disparities, and inform targeted interventions.

The broad categorisation of individuals under the 'CALD' label oversimplifies the complexities of their unique circumstances and the vast diversity within and across these communities. A 2023 study examining the availability and quality of data related to CALD in the Victorian Suicide Register[19] identified the two most frequently used CALD indicators to record information: country of birth and year of arrival. The study also found that there was less information pertaining to citizenship, residency/visa status, preferred language, English language proficiency and religious affiliation.

This overgeneralisation often leads to conclusions that do not accurately represent specific subgroups. More importantly, incomplete and unrefined data hampers the ability to fully understand and analyse the intersecting factors affecting mental health, including migration pathway and visa status, refugees and people seeking asylum, women experiencing family, domestic and sexual violence (FDSV). Relying on overgeneralised data poses a significant risk, as it can limit governments' capacity to undertake informed policy, program and service planning.

The lack of disaggregated data also hinders the ability to monitor progress, identify unmet needs, and evaluate the effectiveness of programs for CALD people. A study examining mental health research and evaluation in multicultural Australia[20] found that while there is policy intent and positive statements in relation to migrant and refugee communities in national mental health policies and strategies, there is virtually no reporting by Commonwealth or State and Territory governments of whether these policies are effectively implemented.

To address the CALD mental health data gap, data collection methods need to ensure oversampling of the CALD population, including different CALD cohorts such as refugees and people seeking asylum. Recognising the ongoing challenges migrants face during the migration journey (including resettlement), it is important to include longitudinal studies and surveys to understand mental health experiences and service needs in the short and medium term.[21]

Equally, there is an urgent need for more robust data collection around suicide, as well as research, to strengthen the evidence base for interventions directed to specific segments within the highly diverse CALD population. Without adequate and consistent national data collection around suicide, the system will continue to operate based on the construct of a mainstream and 'diverse others', without solid evidence base or mechanisms for performance measure or accountability.

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[19] Truong, M., Dwyer, J., Chan, J., & Bugeja, L. (2023). Availability and quality of data related to cultural and linguistic diversity in the Victorian suicide register: A pilot study. *Australian and New Zealand Journal of Public Health*, 47, 100078. https://doi.org/10.1016/j.anzjph.2023.100078

[20] Minas, H., Kakuma, R., Too, L.S. et al. Mental health research and evaluation in multicultural Australia: developing a culture of inclusion. Int J Ment Health Syst 7, 23 (2013). https://doi.org/10.1186/1752-4458-7-23

[21] Orygen and CMY (2020). *Responding together. Multicultural young people and their mental health*. Melbourne, Orygen, https://www.orygen.org.au/Orygen-Institute/Policy-Areas/Population-groups/Responding-together/Policy-report?ext=

The Forum for Australian Services for Survivors of Torture and Trauma (FASSTT), in its response to the Consultation for the Draft Advice on the National Suicide Prevention Strategy,[22]noted that:

> *'there are significant gaps in the collection of migration-related data relevant to suicide risk, including ethnicity, visa status, and length of residence. These factors are well-established as influencing mental ill-health and acculturation stress, which can increase suicidality. Further, data collected by the Australian Institute of Health and Welfare (AIHW) on suicides among refugees and humanitarian entrants excludes people seeking asylum and refugees granted protection visas onshore. Without comprehensive data, it becomes difficult to accurately identify specific risk factors affecting different migrant communities and populations that are disproportionately impacted.'*

Recommendation 3: Invest in community-led preventative programs and mental health services

This includes:

3.1. Investment in support services delivered by multicultural organisations that have long established relationships with multicultural communities.

3.2. Funding for community-led prevention initiatives that help community and faith leaders to support their communities and link them to culturally safe and responsive services.

3.3. Funding for mental health first aid training for community and faith leaders, to enhance their capability to identify warning signs and to understand how to navigate the mental health system.

As highlighted in Recommendation 2, one of the greatest systemic challenges that permeate most policy areas in Australia, including mental health and suicide prevention. Orygen and CMY conducted a study on mental health related to refugee and migrant background young people. They have identified that beyond the specific stressors associated with dislocation and resettlement, young people who arrived as refugees might have been exposed to armed conflicts, protracted periods with high uncertainty in refugee camps, discrimination and loss of family and community members. Whilst young people often show great strength and resilience, they are under extreme pressure to adapt to a new context, in which their experiences of being racially discriminated continues to be an additional stressor. Whilst completed in 2020, the study's recommendations, listed below, are still relevant to guide systemic reform:[23]

- Address racism and discrimination and strengthen social and economic inclusion
- Proactive develop mental health literacy and resources with young people from migrant and refugee backgrounds
- Integrate cultural responsiveness across the whole service system, from training of professionals to diversity in workforce, language support and better engagement with young people and their families
- More research and tailored approaches to identification of risks and suicide prevention,

[22] FASSTT (2024), p.3.
[23] Orygen and CMY (2020), p.5.

particularly in refugee communities

- Trauma-informed care across the mental health service system

In 2021 *Shapes and Sounds*, an organisation established in Victoria to de-stigmatise mental health in Asian communities, conducted a survey with about 350 individuals from various Asian identities, with questions about their mental health and wellbeing. The findings from the survey were incorporated into a short guide to Asian Australian mental health.[24] The guide highlighted stoicism, internalised racism, and intergenerational trauma, as prominent factors that can impact the mental health of individuals from Asian backgrounds. They reinforce the importance of well- trained mental health professionals that can understand the effects of these variables on individuals' mental health, so that support can be tailored and culturally responsive. In addition, FECCA heard that many young people, despite being born in Australia, found that counsellors failed to understand their experiences and social and cultural contexts, and asked to be linked to Asian background mental health professionals for better support.

Trauma, and intergenerational trauma, were also mentioned in FECCA's consultations. Members from communities heavily affected by collective traumatic experiences, spoke of how collective experiences affect individuals, and highlighted the need to strengthen community resources to support each other.

Equally, experiences of racism in Australia have been commonly cited in association with mental health deterioration.[25] Interpersonal and systemic racism continue to affect the wellbeing of individuals and groups, particularly people of colour, and often manifest together with other forms of discrimination, such as religious or gender-based discrimination. Particularly concerning is the fact that schools are often mentioned as a major site within which racism takes place, with direct impacts on the sense of belonging and wellbeing of children, young people, and their families. As mentioned in the *Racism in Schools* report:[26]

'Mentally, I was very distraught as to why I didn't have any friends; like why doesn't anyone want to be my friend? Why doesn't anyone want to play with me? Mentally, I was feeling lonely… just because of the way I looked.' (Noella, Interview, 23 November 2023).

The case of international students during the COVID 19 pandemic

The mental health impact of the COVID-19 pandemic on international students provides a good example of how individual factors, when combined with systemic barriers, can increase the mental health risks for individuals.

[24] Shapes and Sounds (n/a). *Your Essential Guide to Asian Australian Mental Health.* Online, https://www.justshapesandsounds.com/

[25] For a report based on community consultations around racism, see Muralidharan, P., Hosseini, Y. and Arashiro, Z (2024). *An Anti-Racism Framework: Experiences and Perspectives of Multicultural Australia.* Report on the national community consultations. Commissioned by the Australian Human Rights Commission. Canberra, ACT: Federation of Ethnic Communities' Councils of Australia. https://fecca.org.au/wp-content/uploads/2024/10/FECCA-NARF-Report-V6-1.pdf

[26] John Bosco Ngendakurio (2024). *Report: Racism in Australian Schools*. ECCQ, Scanlon Foundation, Griffith Centre for Social and Cultural Research, p.21, https://eccq.com.au/wp-content/uploads/2024/02/Report-Racism-Within-Australian-Schools.pdf

During the pandemic, with the Commonwealth Government's decision to exclude international students from the emergency welfare assistance, many of them were left in lock down without financial support, unable to work or to travel back home. Social isolation, preoccupation with their safety in Australia and of their families overseas, and disconnection from the Australian social protection system meant that thousands of international students who lived in Australia had to find their own ways of coping.

A study with Latin American students in Sydney detailed how, despite being aware that they needed mental health assistance, many of those students did not access support. The two main reasons they cited were the cost of services, and lack of support in language.[27]

Moreover, cases of suicide of international students in Victorian universities during the COVID 19 pandemic further exposed the need for coordinated responses from governments and education institutions which included cultural awareness, but had to go beyond that to create a stronger mental health support system to be inclusive of young students from overseas. [28]

Recommendation 4: Improve culturally responsive training for mental health professionals

This includes:

4.1. Embedding cultural safety and responsive approach and practices as a mandatory part of mainstream training for mental health workers.

4.2. Investment in increasing formal training and education pathways and opportunities for people from CALD backgrounds to become mental health workers and practitioners.

4.3. Investment in a peer-support model of mental health service provision with knowledge from CALD lived experiences.

Mental health training in Australia predominantly reinforces Western perspectives, with minimal consideration given to alternative viewpoints beyond these frameworks.[29] The exclusive focus on Western practice models and frameworks in psychology and mental health approaches means that trainees do not develop the necessary skills to work with non-Western or diverse populations.[30] Despite the mention of cultural considerations throughout formal training and higher education, opportunities to engage with clients from diverse background typically occur only after completing training. This limitation restricts future practitioners to truly understand and develop culturally responsive practices. To help address this, it is essential to integrate culturally responsive service

[27] Fernanda Peñaloza & Gisselle Gallego (2023): I'm in a Dilemma of Coming Back, not Coming Back, What to Do, I'm a Bit Stuck: Exploring the Wellbeing and Mental-health of Latin American Students in Sydney During COVID-19, *Journal of Intercultural Studies* https://doi.org/10.1080/07256868.2023.2208540

[28] The Senior (2023). International students did not seek help before deaths, 2 October, https://www.thesenior.com.au/story/8371415/international-students-did-not-seek-help-before-deaths/

[29] Clark, Y., Hirvonen, T. (2022). Decolonising Australian Psychology: The Influences of Aboriginal Psychologists. In: Kessi, S., Suffla, S., Seedat, M. (eds) *Decolonial Enactments in Community Psychology*. Community Psychology. Springer, Cham. https://doi.org/10.1007/978-3-030-75201-9_11

[30] Darnett, E., Peters, A., & Thielking, M. (2024). Psychologists' experiences towards culturally responsive practices to strengthen social and emotional wellbeing with Aboriginal and Torres Strait Islander clients. *Australian Journal of Psychology*, *76*(1). https://doi.org/10.1080/00049530.2024.2356116

provision into formal training as a mandatory component, which should include exposure to diverse clients through placements with organisations working directly with people of diverse background and/or diverse communities.

The same can be said about mental health and suicide risk assessment tools. Suicide prevention strategies in Australia primarily employ Western mental health paradigms focusing on individual-level interventions. Research with diverse cultural groups has demonstrated that these strategies overlook cultural and other contextual considerations crucial to effective prevention and intervention.[31] Mental health and suicide risk assessments might miss important risk factors if they do not specifically address the unique drivers that shape the experiences of people from CALD backgrounds. During our consultations, we heard the suggestion to incorporate storytelling into assessments, allowing clients to share the more nuanced, collective aspects of their experiences that are often overlooked in traditional, individualistic approaches:

'The collectivist culture of some countries where young people and/or their family originated, can be at odds with an individualised and Westernised mental health service system. Additionally, multicultural young people, families and communities may hold understandings of mental health that are shaped by cultural and religious views which may differ to clinical approaches used in Australia.'[32]

Consistent with the joint submission by Mental Health Australia, FECCA and NEDA in 2020,[33]we urge the government to improve the cultural responsiveness of mainstream mental health services to meet the needs of the diverse Australia population by investing in the adoption of Embrace's **Framework for Mental Health in Multicultural Australia.**[34] The Framework is a free online resource, and includes a series of core service modules, two self-reflection tools and an entry-level cultural awareness module[35]. The Framework also includes self-assessment against cultural awareness standards along with implementation guidance and supporting resources.

Challenges around language are often identified as a barrier for CALD people to accessing mental health services. While language barriers are significant, cultural responsiveness goes beyond access to interpreters. In FECCA's consultations, individuals have indicated preference to engage with mental health services that are 'culturally aligned' to their own cultures, even when they are Australian-born. In Melbourne, one community leader noted that in the absence of CALD counsellors, community members would rather seek mental health services that is delivered by First Nations counsellors, which they see as better able to connect with their experiences, social and cultural systems. Unfortunately, this does not resolve the gap in services, as the majority of mainstream psychological services in Australia is currently delivered by non-CALD and non-First Nations psychologists.

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[31] Look, M. A., Maskarinec, G. G., de Silva, M., Werner, K., Mabellos, T., Palakiko, D. M., et al. (2023). Developing culturally-responsive health promotion: insights from cultural experts. *Health Promot. Int.* 38: daad022. doi: 10.1093/heapro/daad022

[32] Orygen and CMY (2020), p.4.

[33] Mental Health Australia, FECCA and NEDA. Productivity Commission Inquiry into Mental Health Draft Report. February 2020. https://www.pc.gov.au/__data/assets/pdf_file/0007/251962/sub1113-mental-health.pdf

[34] The Framework is available online at https://www.embracementalhealth.org.au/service-providers/knowledge-hub/framework-mental-health-multicultural-australia-action-plan

[35] Further background about the Framework and how it was developed is available online at https://embracementalhealth.org.au/sites/default/files/framework/overview_fact_sheet.pdf

While the National Agreement mentions workforce planning (clause 155, page 35), it does not explicitly address the urgent need for a more diverse mental health workforce that reflects the CALD population, including bilingual and bicultural professionals, as well as specific CALD domestic violence training. A lack of diversity in the workforce can create barriers to trust and effective communications between CALD people and mental health providers.

Recommendation 5: Invest in targeted suicide support services and suicide preventative initiatives

This includes:

> *5.1. Targeted, long-term investment in specialised support services to refugees and asylum seekers, addressing the specific and multifaceted risk factors each of these groups may experience.*
>
> *5.2. Investment in culturally safe and responsive grief and bereavement support, including bicultural/bilingual workers.*
>
> *5.3. Adoption of innovative methods to the identification of risk factors associated with mental health and suicide, such as narrative and 'story telling', to allow for different forms of expressing emotional distress and suicidal thoughts to be captured and improve the identification of warning signs.*

As the *National Suicide Prevention Strategy 2025-2035* acknowledges, prevention strategies around suicide must address the social and economic determinants of health and mental health, and acknowledge individual factors in direct connection with the broader systems within which individuals experience suicide risks.

Stigma and shame around suicide is common across various cultures, but they can be stronger when combined with factors such as language barriers, experiences of racism and other forms of discrimination, religious beliefs, and community negative attitudes. Suicide prevention requires, in addition to professional specialised kills, cultural and social understanding, as well as trust in those providing support.

The new National Suicide Prevention Strategy acknowledges the disproportionate impact of suicide on humanitarian entrants (nearly twice the rate of suicide as other permanent migrants to Australia), and the need for increased capabilities in specialised services. However, it is unclear how the needs of these higher risk groups, including asylum seekers, will be met.

The FASSTT response to the Consultation for the Draft Advice on the National Suicide Prevention Strategy emphasised the need for targeted interventions which speak to unique risk factors of people seeking asylum and refugees, as opposed to general acknowledgement of 'culturally and linguistically diverse' communities.[36] As mentioned previously, for these groups, multiple traumatic events pre arrival and when settling in Australia, experiences of discrimination and racism in Australia, can constitute cumulative risk factors that cannot be reduced to 'culture'. Moreover, people seeking asylum face particular risk factors related to prolonged uncertainty, and systemic barriers to employment and access to essential services. Both groups should be acknowledged and supported through tailored interventions and safe and specialised service providers.

[36] FASSTT (2024).

FECCA noticed that in the National Suicide Prevention Strategy, as well as in the Call for Submissions to this inquiry, terms such as culturally safe, culturally responsive or culturally appropriate are used in confusing ways, at times restricted to First Nations only. It is important that cultural safety and cultural responsiveness be also understood in relation to multicultural communities, reflecting the recognition that the wellbeing of individuals in multicultural communities is often directly impacted by cultural practices, attitudes and norms that emphasise collective considerations, as opposed to the more individualistic approaches.

A consultation participant from Adelaide, who identified as 'a committed advocate for mental health and suicide prevention, using professional as well as lived experience to guide positive community change,' described:

"In the Western context, it's a very individualistic approach, whereas in collective cultures, the idea of self is connected to the collective, the community, the family. So consider collective wellbeing alongside individual factors [is necessary]. In the forms we fill out, instead of rigid questionnaires, a narrative approach can be incorporated. Encourage story telling instead of tick marks to collect data."

In 2024, FECCA heard of two cases of suicide in multicultural communities:

- In a regional town, a man experiencing persistent unemployment, increased aggression from his wife, and who had been pushed to sleep in his car, committed suicide. Whilst there were warning signs, those who knew him mentioned that support services were extremely hard to locate. The only service which could have supported individuals from multicultural communities did not promote it actively, due to lack of capacity to serve more people.
- In another case, a young person committed suicide, but the parents could not accept it and denied that the death had been caused by suicide. Due to cultural and religious beliefs, they were experiencing extreme shame and sought the advice of a community leader, who were themselves unprepared to provide that type of support. They struggled to identify a culturally appropriate bereavement service to provide support to the parents.

Lack of culturally appropriate grief and bereavement support was also mentioned by the consultation participant from Adelaide. After her partner committed suicide, she sought support, but despite her high level of education, pro-active attitude and fluent English, she struggled to find it. When she eventually found an organisation, the main assistance consisted of a couple of phone calls, initially once a week, then fortnightly, then once a year.

Given the psychological impacts that suicide can cause on families and close community members, it is vital that support is provided to those experiencing loss and grief.