National Suicide Prevention Taskforce

CALD Lived Experience Research Final Report

2 December 2020

Research prepared for the National Suicide Prevention Adviser and the National Suicide Prevention Taskforce, commissioned through the Suicide Prevention Research Fund, managed by Suicide Prevention Australia and through the Department of Health

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Developed by the Cultural & Indigenous Research Centre Australia 2019

All research conducted by CIRCA for this project was in compliance with ISO20252

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1. INTRODUCTION

1.1 The Lived Experience Research

The Cultural and Indigenous Research Centre Australia (CIRCA) was engaged by the National Suicide Prevention Taskforce to undertake research that will help to build a better understanding about the lived experience of suicide in Australia to inform recommendations to the government. The focus of this research piece was on people who have attempted suicide or experienced a suicidal crisis and who are from Culturally and Linguistically Diverse (CALD) backgrounds.

This research is important in providing the Taskforce with a broader diversity of experiences around suicide and suicidal crisis. A focus on the lived experience of people from CALD backgrounds also allows the consideration of immigration and its consequences as a factor in suicidal behaviour and crisis.

The research was undertaken in two stages to allow for early findings for consideration by the Suicide Prevention Taskforce in its preliminary reporting. The first stage of the research was undertaken through funding from the Suicide Prevention Research Fund, managed by Suicide Prevention Australia. The Stage 1 Report was delivered on 20 August 2020.

This final report incorporates the findings of Stage 1 with the addition of 5 further interviews, albeit with a more specific focus on the experiences of younger men from African, Pacific Islander and Asian backgrounds.

1.2 The Research Focus

The focus of the research was to understand the lived experiences of a range of diverse people who had either attempted suicide or who had experienced suicidal crisis. The approach adopted for this segment of 'lived experience' research reflected the focus applied to all other lived experience cohorts which was to consider the following questions:

- What factors contributed to a person's suicide attempt or crisis?
- What was helpful and not helpful to get them through the crisis?
- What supports were helpful and how did they find the supports?

For both research stages, CIRCA worked through existing community networks to provide information about the project and sought people from CALD backgrounds to volunteer for interviewing.

The research approach required narrow participant criteria, with a focus on young men. Given the difficulties around accessing respondents and the cultural sensitivities at play, the initial recruitment

processes resulted in several people outside these criteria respond, who wanted to tell their stories. These were accepted and made up the bulk of the Stage 1 analysis. In scoping the second stage CIRCA was able to benefit from the relationships and contacts it had already established at the start of the project and with the support of these intermediaries, was able to identify and facilitate the participation of young men meeting the initial criteria.

The interviews for Stage 1 were undertaken between 29 July and 14 August 2020. The interviews for Stage 2 took far greater time to identify and cover the period from late August to early November 2020.

2. METHOD

2.1 Participant Recruitment

2.1.1 The Recruitment Method

The initial recruitment task sought to find people from CALD backgrounds with a lived experience of suicidal crisis from the following demographic groups; self-identifying as male, aged between 18 and 35 years old; in recovery and not presently experiencing a crisis.

The Suicide Prevention Taskforce (based on existing information and a need to access the lived experiences of more recently arrived CALD communities) specified an intertest in finding respondents from the following language/cultural backgrounds; Chinese, Vietnamese, South Sudanese, Congolese and Maori/Pacifica. This CALD specific research is also seeking to complement other work being undertaken to understand the lived experience of people who have attempted suicide or experienced suicidal crisis.

The specificity of the recruitment criteria created an initial difficulty in identifying people given the significant cultural sensitivities across CALD groups around the issues of mental health and suicide. As such the approach was predicated on developing pathways through community engagement of organisations and structures who themselves would have contact with or access to people experiencing suicidal crisis. It should be noted that the research was facilitated by existing positive relations with CIRCA Research and its parent company Cultural Perspectives Pty. Ltd.

As such, CIRCA utilised a purposeful community engagement approach which included:

- Identifying key cross-cultural and transcultural mental health services and structures to gain access to networks of people with lived experience of suicide crisis.

  These included the NSW Transcultural Mental Health Centre, the Queensland Transcultural Mental Health Service, Embrace Multicultural Mental Health (Mental Health Australia) and STARTTS NSW (Refugee Torture and Trauma Service).This was an important component of the work as these organisations would have to both support the research and buy in to the recruitment process.

- Identifying multicultural community structures that currently provide mental health services to people in the initial target populations, especially given the narrow range of cultural and linguistic groups being sought. These included SydWest Multicultural Services (Sydney), Community and Cultural Connections Inc (Sydney) and Access Community Services (Queensland). These organisational opportunities were more limited as the few language or culturally specific services that exist (such as the Italian service Co.As.It.) fell outside the recruitment specifications.

- Broadening the search in Stage 2 to organisations that were both specific to the language groups being sought and were involved in issues and services related to mental health. These included Bridging Hope Charitable Foundation, and a number of Local Health Districts containing multicultural services.

- Engaging with these organisations to seek support for the distribution of information about the research to enable people with lived experience to self-nominate the participation in research. Initial feedback acknowledged the difficulty of the recruitment task and suggested that the most appropriate approach would be to distribute information about the research and request that people with lived experience directly contact the researchers.

- Developing a research flyer to provide consistent information to intermediaries and to be used for recruitment purposes (attached in Appendices).

The research flyer was effective in that it resulted in people coming forward wanting to share their lived experience stories and to help understand the nature of the research and their role within.

The methodological issue encountered during the process was that those coming forward did not specifically meet the recruitment specifications. Following discussions with the Suicide Prevention Taskforce it was decided that we would broaden specifications to allow their participation. A significant consideration at this time was the need to ensure that the lived experiences of people from CALD backgrounds could be included in the lived experience component of the interim report of the Taskforce.

As a consequence, the second stage of the research focused on achieving five further interviews (from the initial five conducted in the first stage) with young men meeting the criteria, which was able to be achieved. This resulted in a longer than expected time frame to identify and engage research participants and to overcome their reluctance to tell their stories. These included young men from Chinese, Vietnamese, Congolese, South Sudanese, and Maori/Pacific Island backgrounds.

CIRCA was unable to complete the 10th interview with a Chinese background person with lived experience within the allocated time frame. CIRCA's recruitment attempts to identify a potential candidate we substantial.

We contacted the following organisations seeking urgent support, and while we received important qualitative information no leads to potential respondents were identified.

The organisations we contacted included:

- Embrace Multicultural Mental Health

- Transcultural Mental Health Centre NSW (TMHC)

- Bridging Hope Foundation

- Southwest Sydney Health, Multicultural Program
- One Door Mental Health
- NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)
- Queensland Transcultural Mental Health Centre
- Chinese Lifeline Harbour to Hawkesbury

All intermediaries indicated active involvement in attempting to recruit a respondent but were not successful. These intermediaries were also willing to provide their perspective on this apparent failure. The reasons cited included:

- Not being able to find respondents that would match the narrow recruitment specifications.
- People from a Chinese background with lived experience being very uncomfortable in telling their stories and not wanting to come forward.
- The significant level of taboo and cultural sensitivity around suicide and suicidal crisis even when both those making the approach and those who would be undertaking the interview were themselves from a Chinese background (Section 2.1.2 refers).

While this result does represent a failure in hearing from a Chinese background person with lived experience, the lack of success of what should be considered an intensive outreach and recruitment approach, indicates the depth of sensitivity around suicide crisis within the Chinese community. This issue sensitivity is made even more significant given the overall size of the Chinese speaking community in Australia.

In order to minimise potential harm, CIRCA decided to exclude participants who were presently experiencing a crisis during recruitment. Only those deemed to be in recovery and who, with professional support, are effectively managing their mental health were recruited and assessed for participation.

All participants were assessed to be appropriate for interview.

2.1.2 Engaging appropriate research interviewers

An important consideration in undertaking the interviews was to ensure that the interviewers were themselves appropriate to and capable of undertaking the interviews with these participants.

As such CIRCA identified skilled research consultants with experience in trauma-informed practice and a knowledge of suicide prevention and mental health first aid. With respect to the latter, CIRCA developed a Distress Protocol to help researchers manage and mitigate any distress or anxiety that might emerge among participants during or following the interviews.

The second consideration was to ensure that the interviewer was both linguistically and culturally appropriate. An initial screening was conducted with each research participant to assess their linguistic needs and any other cultural considerations which needed to be accommodated by the research consultant.

This matching process was effective in ensuring that all participants felt culturally safe and were able to express themselves in their preferred language. As a result, three individual research consultants were contracted to undertake the interviews. Each of these research consultants were trained in trauma informed interviewing and were able to demonstrate capacity and willingness to deliver a culturally safe interview.

Where interviews were carried out in English, CIRCA research personnel sought permission to participate in interviews as an observer. Agreement was received in all but two interviews. Both interviews were conducted with participants from Vietnamese backgrounds. This response is consistent with the ongoing difficulty of recruiting men from Asian backgrounds for interviews. This is reflective of the significant cultural considerations and sensitivities surrounding both mental health and suicide crisis. The issue of culture and its impact is explored more fully in Sections 3.3 of this report.

In conducting the interviews, CIRCA allowed for participants' personal stories to be told by way of a 'semi-structured' approach. To allow for this, CIRCA co-developed both discussion guides with the Suicide Prevention Task Force. Each interview was sufficiently structured to address the research aims, while at the same time allowing space for participants to offer new meanings and tell their own story.

The storytelling approach was essential for this project as it is a proven and safe method of achieving qualitative understandings of the lived experiences of participants.

It should be noted that although the interview discussion guides were in English, the interviews themselves were conducted in each of the participant's preferred language. This allowed the research consultant's to convey questions in a culturally sensitive and appropriate manner.

Due to COVID-19, all interviews were undertaken via Zoom Video Conferencing platform, except for the Vietnamese interviews in which permission to use Zoom was not given. Phone interviews were conducted as an alternative for the remaining two interviews.

2.2 Participant Profile

Table 1: Overview of participants Phase 1

Participant	Gender	Age	Cultural/Migration Profile	Recency in Australia
Participant 1 Tasmania	Female	27	Mandarin Speaker from Taiwan initially coming to Australia as an International Student, now a permanent migrant.	5 years

Participant 2 Queensland	Female	50	English speaking South African Indian woman migrating as a child as part of family migration. The participant identified her religion as Muslim as it was nominated as being relevant to her suicidal crisis experience.	43 years
Participant 3 Australian Capital Territory	Female	>55	Vietnamese speaking woman coming to Australia as a refugee with her family in 1980 after spending 7 months in an Indonesian refugee camp.	40 years
Participant 4 Queensland	Male	72	Greek speaking background man migrating to Australia in 1981 from Greece after significant period of residency in the UK.	39 years
Participant 5 Queensland	Male	25	Congolese background man coming to Australia in 2016 as part of a refugee family (with 4 siblings) having spent 5 years in a refugee camp in Malawi.	4 years

Table 2: Overview of participants Phase 2

Participant	Gender	Age	Cultural/Migration Profile	Recency in Australia
Participant 6 Queensland	Male	39	Arrived as an international student from Zimbabwe in 2002. Future wife arrived 2 years after and they are now married with one child.	18 years
Participant 7 Queensland	Male	26	New Zealand born man from Niue/Fijian background. Arriving as a 6-year-old to live with estranged father on the Gold Coast. Only spoke Maori and unable to communicate with siblings in Australia. Experienced significant periods of estrangement from family and homelessness.	20 years
Participant 8 New South Wales Queensland	Male	28	South Sudanese man arriving in Australia as a refugee in 2006. Spent childhood in Kenya. Has lived in both Sydney and Brisbane.	14 years
Participant 9 New South Wales	Male	42	Vietnamese man coming to Australia in 2017 as a skilled migrant/spouse to live with Vietnamese Australian second wife. This relationship broke down due to debt and pressure to work (without regard to qualifications and skills).	3 years
Participant 10	Not applicable	Not applicable	After extensive efforts to identify and gain the participation of a younger	Not applicable

			Chinese background respondent this interview was not completed.	

2.3 Presentation of Findings

The results of both stages of interviews have been examined for emerging patterns and key themes. As well as reflecting the broader lines of enquiry consistent across all lived experience research being undertaken or commissioned by the Suicide Prevention Taskforce.

3. SUICIDE IS A COMPLEX BEHAVIOUR WITH MULTIPLE TRAJECTORIES

Caution should be exercised in applying the considerations and issues raised in these interviews to the broader CALD segment of the community. However, the life stories and information provided within these interviews do indicate a number of cultural and community factors that were identified by interviewees as significant to their suicidal crisis.

3.1 CALD Suicide (No one picture)

It is difficult to compile any specific patterns in terms of the nature of suicide crisis or suicide attempts from the interviews undertaken.

Each lived experience varied across individual considerations, which included the following:

- Age at which the person attempted suicide,
- Migration and refugee pathways,
- Family structures and relationships, and
- Issues relevant to settlement in Australia and the broader notion of 'fitting in' both within the host culture and the particular ethnic or religious culture specific to the participant's background.

3.1.1 Age Issues

The age at which participants attempted suicide varied significantly across the group. A particular pattern emerged around the experiences of young men who for almost every case had attempted suicide as a child. In nearly all cases these men as boys experienced some form of migration or family trauma.

Of particular interest is the implication that during the time of the suicide attempt there were few if any supports available to these children. Whether as a result of migration trauma, family breakdown, or stringent family expectations the suicidal experiences, mental illness and suicidality continued into adult life.

> *"In the African refugee camp right life was really hard. The treatment was inhuman. When you are young you don't have the necessary skills to cope. I saw no point in being alive." (Congolese man)*

"My first attempt was as a child of eight when I tried to stab myself of a serrated knife when I did something wrong as I was fearful of the consequences I would face from my mother. I felt I wasn't living up to expectations." (Zimbabwean man)

"As a child I was kicked out of home by my father and remained homeless for 12 months living rough suicide thoughts were constant." (Niue/Fijian man)

"there were thoughts coming into my head, I was tired all the time, I wasn't able to hold a conversation, they thought I wasn't there." (South Sudanese man)

In considering these experiences, a narrative emerges of young boys finding struggling to cope with their migration journey. This narrative is especially emphasised for the refugee journey and its related issues of settling into a new society.

Other age-related considerations included:

- A number of suicide attempts for people in their 20's associated with a range of young adult experiences including isolation, relationship issues, maintaining employment, accommodation and a broader 'fitting in' to Australian society. Of particular note within this is the experience of three participants who migrated to Australia as international students. The participants expressed feelings of vulnerability associated with succeeding academically and surviving economically as significant pressures which ultimately influenced their suicidal crises.
- A number of suicide attempts for people in their 40's associated with relationship breakdowns. Given the focus of the research being younger people from CALD backgrounds the issue of later life suicide attempts, there are only three participants who later life considerations apply to.

3.1.2 Settlement Issues

The experiences and issues around settling into Australia were a consistent stressor for all participants. Again, predominantly because of the sampling approach most of the settlement issues experienced were from the perspective of a child or young adult entering Australia and the schooling system.

The concept of 'fitting in' is consistent with all migration journeys and stories. What is important to note here is that the stressors associated with trying to gain language, fit in with peers and still meet parental and family expectations are significant and should not be underestimated.

The prevalence of migration trauma, family conflict and family breakdown are consistent themes in the stories shared by participants as the cause of their feelings of isolation, self-doubt, and inadequacies.

Equally the settlement experiences of participants coming to Australia as adults were also notable, especially around the issues of employment. This was linked with underemployment issues in terms of

not being able to access employment commensurate with either professional qualifications or skills, and family issues.

Section 3.1.3 below provides a focus on this specific consideration.

> *"The mental health journey of migrant children is very undervalued and there are two sets of considerations, the first is the issues and traumas that bring with this visit around the consistent view then they come to Australia, the second is the issues associated with trying to fit in here." (Congolese man)*
>
> *"Coming to Australia I experienced cultural shock. Being different from everyone as well as being a person of colour. I would ask myself 'am I not human enough' as everyone around me made me feel different." (Congolese man)*
>
> *"You feel you have to give up your own language so that you can be on the inside. I feel robbed." (South Sudanese man)*
>
> *"Coming to Australia was a huge decision for me. I would be living in an unfamiliar environment. Above all would have to quit my professional job in Vietnam… So, when you come to Australia and suffer this life you feel you're falling into a gulf from the top of the mountain." (Vietnamese man)*

3.1.3 Personal Relationship Issues

As mentioned previously family relationships and relationship breakdowns were evident in the stories shared by most participants.

Given the inherent stressors of migration and refugee journeys the importance of maintaining and being able to benefit from strong familial and personal relationships is a significant protective factor for both mental illness and suicide.

Younger participants referenced problematic family relationships as significant factors in their struggles through migration and settlement. Their stories referenced a lack of available support through significant family breakdown, parental and familial attitudes to mental illness that undermined the potential support that family could provide, and more generally parents and family being more concerned about cultural and community attitudes than the well-being of their children.

> *"My first attempt was at 14 resulting from multiple trauma but the main trigger was my conflict with my mother. Home life was difficult but outside of home I experienced racism and bullying and is Islamophobia." (South African Indian woman)*

Older participants spoke about relationship breakdowns as both causal to their suicidal crisis as well as a perpetuating issue affecting their feelings of self-worth and lack of success. Relationship issues in four of the interviews were associated with failed marriages. The circumstances in these relationships were as follows:

- In one story the responsibilities to care for a spouse who had suffered a brain injury exacerbated feelings of stress, especially given cultural expectations to provide care regardless of personal capacity.

> *"In 2012 I took a drug overdose. I was severely depressed due to marital issues which in my case were complicated because I had sponsored my husband to Australia as a senior religious figure."*
>
> *"His leaving me left me feeling betrayed, led to me losing family support and cost me my friendship networks."*
>
> "*My grief was enormous as all the blame was on me. As a woman I was expected to accommodate my husband which I had done for 14 years, it was traumatic to lose my friendships but as he was a religious leader, he got community support and I didn't.*" (South African Indian woman)

- In the second, a bad relationship was identified as the cause of an attempted suicide as a 25-year-old. The participant had migrated to England from Greece as a young adult on his own to be accommodated with family friends. He entered a married relationship with a much older woman who had two children. The nature of the relationship was traumatic and caused him to consider suicide.

- In the third, the cultural expectations of caring for not only immediate but extended family played a significant role in causing the trauma faced by the participant. In this story the participant's husband suffered brain damage following a vehicle accident which had left him paralysed ever since.

> *"I took care of him as well is his mother and stepfather, as part of our Vietnamese culture we would never leave our loved ones or other people who are in crisis or unfortunate." (Vietnamese woman)*

- The fourth participant had migrated from Vietnam with his son from a previous marriage to join his Vietnamese Australian spouse. The relationship was fraught and affected by significant debt carried by the spouse and the consequent pressure to earn money both to pay off the debt (from two unregulated lenders) as well as support the family.

> *"Due to the culturally negative perception about divorce we came to an agreement that we would separate but not divorce and still say under the same roof for the sake of our son." (Vietnamese man)*

The picture that emerges within these stories is of an apparent cultural straitjacket which both delivers a duty for caring within family situations, as well as a significant pressure to stay in relationships regardless of the pain or injury they cause.

The reluctance to leave a relationship based on cultural expectations is significant in considering factors leading to suicidal crisis.

3.1.4 Maleness

A key finding, from the interviews conducted in stage 2 was the prevalence of a concept of maleness within the participant's' stories. As a result, it precludes either acknowledging mental illness or suicidality or inhibited help seeking behaviours.

The following statements are typical of the inhibiting factor of cultural perspectives of maleness within the lives of people from a diversity of backgrounds.

> *"In our Vietnamese culture, the men should always put their faces up and keep their problems internal. As men, we don't feel good to seek help the, therefore we don't have skills to look for where to get help." (Vietnamese man)*
>
> *"In our culture there is a hierarchy … In our family unit I am the second oldest… Which means all my cousins look up to me as their older brother … Everyone has this expectation being the second oldest child and I have to live up to. In our society mental health issues are hidden… To be a man and say that you don't know what's going on and being emotional is a no." (Zimbabwean man)*
>
> *"As I got older, I continued to experience thoughts of suicide and most of the time I did not bring it up because of the perceived male persona of having to be unlocked off. I didn't want to be 'that guy'." (Niue/Fijian man)*
>
> *"there are preconceived cultural notions and behaviours… You never talk about what's wrong if you're a man." (Zimbabwean man)*

Maleness was demonstrated throughout the interviews by men as a significant cultural trait as well as an important determinant of behaviour. This applied to the following considerations:

- internalising stressors and mental health issues,

- giving priority to familial responsibilities over personal feelings,
- believing that the individual should be able to deal with their feelings rather than to seek help, and
- conforming to perceived cultural perspectives around men's roles and maleness especially with regards to mental illness and suicide.

In all these considerations there was a sense that these men assessed themselves as failures across a number of cultural and societal measures. Interestingly this perception resulted in a significant barrier to seeking assistance and the need for culturally appropriate approaches for successful engagement.

3.1.5 Employment

Employment was also a consistent issue impacting on the mental health of half of the participants interviewed. Within this a wide range of employment issues, identified as the following:

- The first of these were the range of stresses associated with either finding employment generally, finding relevant employment, commensurate with levels of overseas qualifications and skills or experience.

  In these cases, the employment experiences were considered causal to feelings of inadequacy or of failure which impacted on individuals mental health and considerations of suicide. Within this is the need to work and bring in an income, which dominated all other considerations. For interviewees who are international students, a failure to find employment would lead to added pressure from family to return to their country of origin. For professional migrants, a failure to gain relevant employment was seen as both demeaning and unfair.

- The second issue raised was specific to retaining employment during and post mental health episodes. The experiences of participants very much reflect experiences of the broader population with mental illness and suicidality in terms of maintaining safe and supportive workplace situations.

- Related to this was a stated reluctance to disclose mental health issues or suicide crisis behaviour in workplaces for fear that it would affect the ability to retain the job.

- Employers who are exploitative especially for vulnerable workers such as international students. In the experience of one participant, an international student, an undisclosed need for leave to accommodate mental health episodes led to her being dismissed.

> "*My suicide attempt followed my graduation. I found it hard to find a job. When I did find a job, I found I was not able to cope but I had not disclosed my mental health issues. I knew the workplace would not be supportive. When I asked for leave, I was told you better just quit. I will give you one week or just quit.*" (Chinese woman)

- Equally employers who are understanding and supportive of people with mental health issues or who have had suicidal crisis are essential in ensuring ongoing and supportive work situations.

> "*Having a job and a workplace that is supportive is very important. In my present position they know about my suicidal crisis and they support me by listening to me, giving me positive feedback, involving me in teambuilding as well is allowing me to work from home. I also receive regular supervision and positive support*." (Congolese man)

It can be assumed that negative employment experiences faced by migrants, failure to compete in the labour market (due to lack of English language skills or local experience), underemployment(due to skills and qualifications not being recognised), could all be considered issues that can increase anxiety, impact on mental health and be potential causes for suicidal ideation.

3.1.6 Housing/Accommodation

The issue of housing was not as significant as other issues canvassed above but was still referenced in three interviews. In two of these cases participant's identified housing vulnerability as a major factor in their suicidal crisis. In the third, homelessness was the result of a failed relationship but was not positioned as a significant cause for suicidal crisis.

Stress associated with housing availability and vulnerabilities for those in social housing is notable.

> "*I have witnessed this (forced evictions) happening in my community which had an impact on my mental health. The relocation of residents of the housing commission where I live triggered my fear of ending up like my neighbours. Thinking about this left me feeling that I would rather die*." (Vietnamese woman)
>
> *"I have been waiting for public housing for nine years. This has been a very difficult. And I'm close to homelessness. I have been bailed out by friends in the past but now I'm 101 days in arrears on my rent."* (Vietnamese woman)

For one participant, a failed relationship led to him and his son being evicted from the family home by his wife. He identified the subsequent homelessness as a significant trigger for his feelings of suicidality.

> *"My wife threw our belongings on the street to force me and my son to leave her house. We struggle to deal with homelessness, hunger, loneliness, and loss. I was living with an empty mind. I couldn't think of anything. For lots of time I didn't know where I was… I didn't feel like eating or sleeping, I couldn't control myself." (Vietnamese man)*

3.2 Mental Illness & Suicide as Cultural Taboos

A clear and consistent result across the research is the negative impact of cultural expectations and responses to both mental illness and suicide. Apart from providing the cultural context within which individuals experienced their mental illness or suicidality, the perception of prevailing negative community views and expectations acted to inhibit both perceptions of the mental illness and suicide crisis, as well as help seeking behaviour.

The consistent view was that there was minimal cultural understanding of mental health and indeed in most cases it was stigmatised and related to some form of behavioural retribution or punishment.

Each participant identified their ethnic culture as problematic in their experience of mental illness and suicidality. Each referenced cultural norms which framed mental illness as shameful, negative, and an issue that could impact on a family within identifiable CALD communities. The words used were extremely powerful such as 'taboo', 'shame', 'being possessed', "being a failure", and "being a failure as a man."

There was a sense in the research that the combination of cultural expectations around maleness and the negative perceptions and responses to mental illness and suicide worked together significantly impact on CALD men and their mental health outcomes.

"In my culture we don't deal with suicide that well, it is a shame to talk about it." (Vietnamese woman)

"The Congolese culture is very conservative. There are things not to be talked about. If you tell them about how you are feeling, they will suggest you are possessed, using terms like 'you have a witch attached to you or someone is jealous about your family and discussing you." (Congolese man)

"In my community mental health issues are problematic, there is stigma branding and spiritual abuse. Suicide attempts are frowned upon as it leads to an individual's religious observance to be questioned." (South African Indian woman)

"In our society mental health issues are hidden… If I spoke to my pastors about killing myself, they would lose their minds I would be afraid of their overreaction." (Zimbabwean man)

"In Greece, depression is like a door, once open it, you can't close it. "(Greek man)

"If we are forced to go back to Vietnam, we will face all the criticism, laughing at, judging and mocking from people without mercy." (Vietnamese man)

It can be argued that there is a lack of awareness in CALD communities about mental health which is rights based and positive. This is particularly due to the limited language and narrative available about the subject. The lack of community narrative serves to inhibit dealing with the issue or developing relevant services.

The practical reality of community perceptions and cultural taboos around mental illness and suicidality is that the community within which people from CALD backgrounds live, may not be the most appropriate place to position services. In large part, the lack of existing community-based services results in people having to move outside their cultural and linguistic group to receive support and services.

Once this occurs, there are a range of corollary considerations around the capacity of generalist or mainstream services to be able to deal with the needs of people from CALD backgrounds. This will be considered later in the report. The interview outcomes indicate that the individuals' agency to be culturally safe in accessing support services does not appear to be present.

Dealing with CALD community stigma around mental health and suicide is a particularly difficult issue but one which appears to be at the heart of the complexity of both causes and responses to suicidal crisis for these interviewees.

3.3 Family/community as stressor not helper

The consideration of the role of family for people with mental illness or experiencing suicidal crisis in CALD communities is a complex one. Given the prevailing cultural attitudes around these issues there is a strong likelihood that CALD families would reflect their cultural and community values in how they respond to family members with mental illness or suicidal crisis, especially within the early years of migration and settlement.

The issue regarding lack of family support (or even purposeful denial) was identified in a number of interviews. The following issues were both relevant and prominent.

- Interviews referenced problematic relationships with parents around the issue of mental illness and suicidal crisis. Families, especially parents, were seen to be reflecting prevailing negative community attitudes. Which as a result, meant the there was a reluctance in wanting to engage with or responding to the mental illness of a family member. In cases where this was mentioned the suggested preference of parents was to deny the condition or to keep it within the home environment. From the perspective of the individual, their needs were perceived as lesser and subservient to their parents need not to be shamed in their community.

The consequence of this cultural response is to minimise the level of support that parents may be able to provide either in a direct role or as the conduits to identifying and accessing services for their children.

This consideration speaks to a more general barrier in service access which is the relative absence of parents or family in the service or support seeking environment.

> *"In our setting you are compared to the neighbours kids." (Zimbabwean man)*

- There is a suggested lack of knowledge around mental health within CALD communities regardless of the socio-economic status of families. In three of the interviews, the parents of the participant were identified as professionals. From these, two cases were identified as medical professionals who demonstrated minimal understanding of mental health issues and how to deal with them, with cultural values overriding any clinical understanding of mental health conditions.

> "*They are really black-and-white; they don't understand mental health. The response was 'if you are upset because he can't get a job then just come home.*" (Chinese woman)
>
> "*I challenge them on their views I believe that having more space is good as they have their own beliefs and lifestyles and are far more likely to worry about what other people think about them. According to them if I do the wrong thing, they think it is their fault so having them overseas is easier.*" *(Chinese woman)*

- Family relationships and expectations were also seen as problematic in reinforcing the cultural 'otherness' of children in their relationships with their mainstream cohort. This was referenced by three participants who spoke about cultural differences and cultural clashes between their home environment (which is predominantly framed around cultural expectations and behaviours) and the out-of-home environment to which younger people aspire to be part of.

> *"I spend eight hours each day as white and Aussie as I can be and then I come home and expected to go back to Indian Muslim values and culture." (South African Indian woman)*

  In this way family relationships and cultural expectations may indeed be part of the stressors in and causes of mental illness and suicidality.

The discussion about the potential negative impact that families and parents might have suggests a counter narrative to the prevailing view of CALD families providing support for their children, which is often portrayed as a protective factor. When considering mental health, prevailing community norms, stigma and taboos can tend to override familial responsibilities and reduce help seeking external to the family.

One participant, who currently works with children with a disability describes situations in which she witnesses families from CALD backgrounds with children with disabilities exhibit shame and try to hide their children from both community and the outside world.

> *"I work in the NDIS with children with disability. I find it difficult when I encounter parents who want to hide the children away." (Chinese woman)*

3.4 Experiences of Racism & Prejudice

Experience of racism in Australia was identified by a majority of participants as being extremely relevant to their mental health and suicidal crises. This type of discussion fell into a number of streams.

- The first was that while the public narrative around Australian culture is that it is not racist and inclusive, the experiences of a number of interviewees indicated that their feelings of being victims of racism or not being accepted within Australia were more covert and operated 'under the radar'.

> *"When I came to Australia, I was in shock they spoke the same language as me, but it was different. It was like walking a minefield, standing on the landmine, and not knowing why." (Congolese man)*
>
> *"Racism in Australia is not in the open, it is under the radar, that's what hits me most. People just look at you." (Congolese man)*
>
> *"My mother is not fluent in English and she finds it hard to express herself which has contributed to her mental health issues. I believe that she receives poor treatment because she is black. This upset and frustrates me." (Congolese man)*
>
> *"I have suffered racism, is homophobia and the family difficulties are being Muslim. Some people say I am a role model because I have spoken but I feel that I am a damaged role model." (South African Indian woman)*
>
> *"People here view war and displacement as normal for Africans therefore they underplay the associated traumas that we carry." (Congolese man)*

One participant spoke at length about the ongoing negative impacts of experiences of discrimination affecting her feelings of identity, confidence, and self-esteem. She cited numerous occasions in which she had been directly discriminated against in service situations and referenced the general anti-Asian sentiment prevalent in Australia during the 1980's and 90's.

> *"During this time you could see writing on the walls in the streets with something like Asians go home', 'go back to where you came from' or when I passed someone on the street, I could hear them say to my face 'go home'. This is the kind of discrimination I've constantly experienced."*

- The second was more concerned with structural discrimination in which many available services failed to cater for the linguistic or cultural backgrounds of the individuals. This sense of not having needs met by mainstream structures, and not having bilingual and bicultural structures available to them impacted on feelings of isolation and lack of agency.

  Within this there was a strong current of opinion that services existed for 'other people' but not for them, and that their situations and needs were marginal to the mainstream population. Equally participants felt that there were few, if any, services that started from a cultural context in which their migration experiences and cultural norms and pressures would be understood.

> *"I wasn't a permanent resident at the time so I couldn't get services without paying for them which I could not afford. It was there very difficult as an international student in a place like Tasmania which I found very hard due to isolation." (Chinese woman)*

- The third notable stream was the combination of race and religion. The participant from a Muslim background identified Islamophobia as a constant presence in her life. In her case being from a Muslim background provided minimal solace or support and she deemed herself to be losing on both fronts. What concerned her most at this current time was the experience of her nieces and nephews who she identified as going through the same difficult social situations as she had. Similarly, the Zimbabwean participant spoke at length about the difficult relationship between him and his church over the issue of his mental health. As a community leader he did not feel that the church would provide him any support.

> *"Church was a no-go to me because at the time I was in leadership … The expectation is you put your best foot forward… Whatever issues you have you have to stay on top of those things, financial and emotional things." (Zimbabwean man)*

4. CALD SUICIDE JOURNEYS

It is very difficult to develop any particular model around the journeys of people from CALD backgrounds as they are so very different. They differ by:

- Age of migration.
- Family structure both overseas and in Australia.
- Type of migration (international education leading to permanent residency, skills and economic migration, refugee, and humanitarian migration).
- Mental health service capacity and responsiveness with regards to linguistic and cultural diversity (this consideration is further explored when discussing access to and satisfaction with available mental health services later in this report).
- Gender, with specific cultural expectation overlays for women and girls from CALD backgrounds in terms of their expected behaviour and cultural conformity.

It is important to consider that the migrant journey within the suicide consideration frame is not necessarily linear as it delivers people into an Australian context at very different ages, life situations, familial and cultural community responsibilities.

The practical effect is to have people parachuting to existing journey models at points which do not necessarily reflect the journeys experienced by people born and who have grown up in Australia. For many of these people the ability to understand their past experiences and the impacts of trauma that they may have suffered, further complicates the issues settling into a new country that impact on mental health and suicidal ideation.

While this is the case the research (especially identified from Stage 2 interviews) presented multiple stories about the migration of children who had experienced childhood trauma or had existing mental illnesses on arrival in Australia. The lived experience of these children was that their mental illness was not addressed at an early age and continued into their adult lives. This does suggest that developing a deeper understanding of the mental health of children pre-migration, through the migration process and into the settlement process needs to be given particular attention.

The other clear consideration is that the migration process itself is a stressor which may have significant causative impacts on suicidal behaviour. The following migration impacts can be identified through the interviews:

- Issues around the reasons for migration or refugee movement which may in themselves represent trauma, dislocation, or economic necessity. Those were the refugee experiences identified the refugee journey and time in refugee camps as particularly difficult and traumatic experiences.

- Vulnerability due to not having family supports through the migration process (this is particularly relevant to the growing number of international students coming to Australia with the intention of achieving permanent residency).

- Issues around both initial settlement and ongoing attainment of education and employment outcomes where there is a perception of an unsupportive mainstream population or the experience of both overt and covert racism and discrimination. In fact, the issue of racism or perceived racism and discrimination permeated the interviews.

> *"Coming to Australia from a refugee background there are huge expectations that life will be better and easier here. This is a myth. We carry with us the idea of a developed world, but the reality is you always have to prove yourself as everyone has assumptions about you because of the way you look for colour." (Congolese man)*

- Increased difficulty in achieving life objectives such as employment, housing, and education due to the difficulties of migration and in some cases the poverty associated with the initial settlement period.

- Intergenerational conflict associated with migrating into a country or community which may differ culturally, linguistically, and religiously from the individual's country of origin.

- Impacts associated with family agency and capacity as protective measures within a successful migration journey. Where this does not exist, it can be argued that there are increased pressures around both personal and family relationships and experiences which are more likely to be culturally bound.

As such, modelling of adverse experiences in childhood, psychological, relational, and social challenges in adolescence and co-occurring stresses in adulthood needs to:

- Broaden the model to be able to accommodate people coming to Australia with different experiences of trauma at different ages, and under vastly different circumstances.

- The ability to understand previous experiences and traumas prior to arrival in Australia will have significant impact on understanding the factors contributing to suicidal crisis for immigrants and refugees.

- Consider migration as a journey which has the potential for significant negative impacts that may increase stress and trauma leading to suicidal crises.

5. EXPERIENCES WITH SERVICES AND SUPPORTS

5.1 A Consideration of Culture Specific Services

When considering the service architecture of ethnic communities, and in particular the range of welfare services and other social support services that are delivered from within communities, there is a resulting void of structures or services that focus on mental illness and mental health maintenance.

This stands in contrast to the plethora of other service types such as general settlement, employment, age care, housing, and homelessness. In each of these areas there are significant ethnic community structures delivering services in language and in culture.

The experience of interviewees was twofold in this regard.

Firstly, there was very little identification of and usage of help and support services from within the language, cultural or religious community. In fact, as has been considered previously in this report, many of these community structures are believed by interviewees to reinforce negative prevailing attitudes towards mental illness and suicide crises.

This perception included examples of non-supportive bilingual and bicultural medical professionals

As such the participant behaviour neither demonstrated knowledge of any available services nor an expectation that such services would exist within their community.

> *When I came to Australia, I did not know English I didn't know anyone. I didn't know any services even existed. I had no contact with any services organisations." (Congolese man)*

Secondly, given the lack of support services from within the community of which they were part of the predominant response was to not seek help at all, including outside the community. This lack of service seeking was consistent in many of the interviews.

Where individuals did access services, the circumstances were predominantly opportunistic, such as referrals to university counsellors as part of the university experience. As well as being in response to a crisis, in which individuals entered the mental health system which then proceeded to provide appropriate referrals to bilingual mental health professionals.

It is important to note that across the interviews the services that were identified in this regard were predominantly community-based and multicultural in nature. That is, they were not operated as ethnic specific structures but rather broader structures with the capacity to deal with client linguistic and cultural diversity.

These multicultural service types included:

- Community Health Centres in areas of high CALD population
- Community mental health services
- Migrant Resources Centres with bilingual staff
- Neighbourhood Centres in areas of high CALD population
- Larger charitable organisations with refugee and migrant programs
- Government departments, such as Services Australia which have developed multicultural programs and services infrastructure

5.2 Service Cultural Competency and Responsiveness

All participants had negative experiences with mental health professionals and services (primary health providers). The issues ranged from a failure of the service and practitioners to understand cultural contexts, to not having the experience to operate in a cross-cultural service approach.

The two main types of support sought and commented on were GP's and mental health professionals (including psychologists and psychiatrists). Only one person had accessed online counselling services during their many years of experiencing mental health issues.

The following issues featured in the interviews:

- GPs are critical to both accessing initial support, as well as providing a pathway for ongoing mental health specific services. In one interview, the GP relationship was seen as extremely important and beneficial for the participant.

> *"In 2003 I went and saw a GP who had the same cultural background as mine. He was both understanding and sympathetic to my issues and my family situation. Other than my GP I have found most mental health services problematic. They are disjointed and they do not provide continuity of care. I am so tired of having to retell my story which is long and traumatic." (South African Indian woman)*

- Two other participants were quite critical of their GPs, one suggesting that they did not fully understand mental health considerations and just offered prescribed medicines, and in another that the advice was just of, "*you need to wake up in the morning, take a shower and go for a walk*". The participant's take on this was that the GP had not asked her about her routine and behaviour.

> *"I exercise and take a shower at night; she didn't want to listen to me and then stated that she had a client who followed her advice and got better.'' (Chinese woman)*

- Generalist mental health services were not seen as being sympathetic or supportive towards people from CALD backgrounds. There were numerous negative comments about the services participant's had tried after been referred to. These were grouped around language barriers, a concern that the cultural pressures they experienced would not be understood or considered, and a fear of being exposed to a system they did not understand and a mental health language they were not literate in.

> *"At 14 my psychologist's response was, 'well in two years you can move out and live on your own'. This was his response to my ongoing issues with my mother and my deep depressions. He failed to understand that this is not the done thing in my community. He made me feel incompetent." (South African Indian woman)*
>
> *"When you seek help and people don't care just because you do not speak English and you are black." (Congolese man)*
>
> *"I haven't had any interactions because you feel like you're selling family secrets… If I have not been able to be emotional around people who are close to me how can I be open to a stranger… I wouldn't know where to start." (Zimbabwean man)*

- Other considerations about accessing services and supports coming from the interviews included:

  - A belief that cultural community organisations and services would neither be relevant or effective in meeting the needs of people suffering suicidal crisis or indeed having mental health issues. All participant's indicated that their cultural and linguistic community were at best unhelpful or at worst compounding and reinforcing negative cultural perceptions around mental health and suicide.

  - The binary nature of GPs from similar cultural and linguistic backgrounds. In one case this was seen to be extremely beneficial and effective, while two other cases suggested that medical practitioners from the same cultural and linguistic background could in fact reinforce existing cultural stigma and taboos around both mental health and suicidal crisis.

    While this was the case, when service options were discussed having bilingual and bicultural service providers and counsellors available was seen as a positive attribute.

> *"I was uncomfortable in the service I was offered, firstly because she was a lady and would been better if a man and secondly I would prefer someone from my own culture who I can relate to*

and who can understand me. Our words and our expression have different meanings, they know." (Congolese man)

"I received six counselling sessions with a psychologist and the experience was hard. At the time I couldn't talk about my experience of violence or about my upbringing and was hard to open up… The counselling space did not make me feel really safe enough to open up. There was no shared lived experience to make the connection." (Niue/Fijian man)

- A lack of knowledge or understanding of other available community supports with only two participants mentioning the unsatisfactory use of Lifeline services. One of these sought out other available community support group in Tasmania and achieved this by searching online themselves. The participant found the group helpful for a significant period of time. Another stopped using or seeking mainstream services.

"I tried Lifeline, but I don't feel comfortable talking over the phone I would prefer to talk to people face-to-face." (Chinese woman)

- A consistent belief that cultural religious infrastructure was not helpful in dealing with mental health and suicide crisis. In fact, religious organisations or structures were seen as irrelevant around these issues and none of the participant's sought assistance from religious leaders or organisations.
- A belief that English language skills enable people with mental health issues to seek assistance beyond their cultural and linguistic community, thereby mitigating potential negative impacts of cultural stigma or shame.

5.3 Helpful Services

5.3.1 Positive Experiences

While the overall experience of service access was positioned as a negative in the majority of interviews, where there were positive comments these were consistent in their description of service types that they felt met participant's needs. These characteristics were:

- they were available in the local community and we set up for the community
- they employed people who are bilingual and who understood prevailing community perceptions and attitudes to mental health in the cultural group
- they were flexible in their approach and

- they demonstrate empathy and understanding of mental illness and suicide crises.

Once participants found a service that they felt understood them, was accessible, and was felt to be safe, there was a capacity to disclose and to be more open to support and treatments.

> *"After a long time, I was finally offered support locally in Logan through the World Wellness group who I believe are culturally appropriate and who used bicultural workers." (Congolese man)*
>
> *"After a crisis incident around November 2019, Bankstown Hospital referred me to a Vietnamese social worker at the local community health centre. I didn't follow up, but Vietnamese worker connected me, and I have been seeing them ever since." (Vietnamese man)*
>
> *I had a very good experience with Tony from a service called Mobile Wingman. I connected with him as he had lived experience of hard times and loss and shared lived experience of trauma with me. This was a big factor." (Niue/Fijian man)*

While there were a few exceptions overall, the picture emerging is a series of lived experiences in which individuals feel isolated and unsupported and to whom available services are either seen as irrelevant or through experience deemed to be ineffective.

Two participants identified and emphasised the importance of the services available to them at university to provide significant and effective support. Both indicated initial reluctance to use the services but found them generally relevant.

> *"I was a Master's student and was able to access a wide range of university services which supported me through my studies and her recent graduation with a Master's degree. I believe university saved me it gave me a sense of belonging and achievement."*

The second participant indicated initial reluctance to access university counselling services as he believed they were not established specifically for people from CALD or refugee backgrounds. After accessing the service and finding it initially more associated with academic considerations than relevant personal and/or health considerations, the participant felt that over time the counselling was effective as the counsellor made him feel comfortable.

> *"It helped me. It made me feel that I'm not alone. If I need any help I can just go there and get help I don't just have to be tough, even tough people can be easily broke."*

The only other support identified as beneficial was the role of a partner in two interviews.

> *"The most helpful person was my partner providing the practical support. He cooks for me and he takes me up for a walk".*

6. APPENDICIES

Participant Information Statement

CALD Lived Experience Research

This sheet is for you to keep

Principal Researcher: Pino Migliorino at the Cultural and Indigenous Research Centre Australia (CIRCA)

Who is doing the study?

The research is being done by the Cultural & Indigenous Research Centre Australia (CIRCA) for the Australian Government's Suicide Prevention Taskforce. The research is taking place between July and September 2020.

What is the study about and why am I being asked to participate?

We have been asked by the Suicide Prevention Taskforce to do research that will help to build a better understanding about the lived experience of suicide in Australia to inform recommendations to government. The focus of the research is on people who have tried to commit suicide or have gone through a suicidal crisis. We are doing interviews with people from different cultural backgrounds to ensure that these experiences are part of the Taskforce's considerations.

What am I being asked to do?

- If you agree to take part, we would like to talk to you about your personal experiences in either attempting suicide or experiencing suicidal crisis.
- A CIRCA researcher will talk to you individually, either face-to-face, via videoconference, or over the phone about your experiences. The researcher will have skills in trauma-informed practice and mental health first aid.
- The interview will take about 45 minutes to one hour.
- We will ask your permission to audio record any interviews so the researchers have a proper record of everyone's feedback, but you can say no if you don't want this, and we will then take notes.
- The information you provide in this interview will be written up as a story, but your name will not be used, and we will remove any details of your story that might identify you. We will also prepare a small report looking at the overall themes from all of the interviews we conduct for this project.
- Both the short report and the stories will be provided to the Suicide Prevention Taskforce, but your name will not be shared with the Taskforce and we will remove any details of your story that might identify you.

Do I have to participate?

- You don't have to take part if you don't want to. You can say no.
- If you take part, you can pull out of the interview at any time without giving us a reason.

- If you decide not to take part or if you pull out, it will not affect your relationship with the Suicide Prevention Taskforce or the Australian Government.

Are there risks to me in taking part in this study?

You may experience some distress in talking about your personal experiences in either attempting suicide or experiencing suicidal crisis. If that happens, you can ask to take a break from the interview or stop the interview entirely.

Will anyone else know what I say?

- Everything you say in the interview will be confidential and private. Only the researchers will have access to the information you tell them.
- All files will be kept securely stored to protect your privacy.
- The results of the research will be reported in a written report. The results may be presented in a publication or at a conference, but individuals will not be identified.

How will the information be stored?

The recordings and any notes taken will be kept for 5 years on password protected computers or in locked filing cabinets in the CIRCA offices at 16 Eveleigh Street Redfern, NSW 2016 – this is a secure building with video at entry, pin-code entry and a back-to-base alarm system.

Will the study benefit me?

You may not receive any direct benefit from being part of the project, but the information will help the Suicide Prevention Task Force in its preparation of advice to the Prime Minister on how to deal with suicide prevention in Australia.

Will I be compensated for my time?

To thank and compensate you for your time, you will be provided with an incentive payment of $100.

What if I need more information?

If you would like more information about the study, or if you are worried about the study, please contact Pino Migliorino Managing Director, Research and Evaluation at CIRCA on 02 8585 1303 or pino@circaresearch.com.au.

What if I have any complaints or concerns?

If you have any concerns or complaints about the research, you can contact:

- Lena Etuk, Manager of Research and Evaluation at CIRCA on 02 8585 1353 or lena@circaresearch.com.au
- If you think there has been a breach of your privacy, you can write to the Office of the Australian Information Commissioner, GPO Box 5218 Sydney NSW 2001, or call 1300 363 992.

This information sheet is for you to keep

Tenancy 1, 16 Eveleigh Street

REDFERN NSW 2016

Tel: +61 2 8585 1353