Chapter 16
Mental Health of Chinese Immigrants in Australia

Harry Minas

Abstract The Chinese are among the earliest immigrants to Australia, with substantial numbers coming from the middle of the nineteenth century, fully half a century before Federation of the states to form the Commonwealth of Australia. The White Australia Policy, established immediately after Federation in 1901 specifically to prevent migration from China, was not dismantled until 1972, when Australia was among the first Western nations to recognise the People's Republic of China. Since that time, large-scale migration from China has recommenced, and the Chinese are now the fastest growing immigrant community in Australia. Substantial differences between the culture that Chinese immigrants bring with them and the dominant Australian culture contribute to risks for development of mental disorder, as a result of the challenges associated with settlement in a new country and culture. While there have been no adequate epidemiological studies of mental disorders in Australia's Chinese communities, it is probably the case that the overall prevalence of mental disorders is not substantially different to that in the overall Australian population and in other immigrant communities. Despite this, Chinese immigrants with mental disorder substantially underutilise public mental health services, largely as a result of the lack of culturally appropriate, acceptable and effective mental health services. In recent years, the political and economic tensions between Western countries – primarily the United States – and China have become prominent also in Australia, with the possibility that these may be undermining Chinese immigrants' sense of security and wellbeing.

Keywords Chinese immigrants · Mental health · Mental health services · Acculturation · Culture and psychopathology · Politics, migration and mental health

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H. Minas (ed.), *Mental Health in China and the Chinese Diaspora: Historical and Cultural Perspectives*, International and Cultural Psychology,
https://doi.org/10.1007/978-3-030-65161-9_16

Chinese Migration to Australia

The Chinese diaspora – people of Chinese origin who are resident outside the People's Republic of China – constitutes a population of almost 50 million, with people of Chinese descent and Chinese migrants in almost every country in the world. Almost 30 million people of Chinese origin are in Asia, with the largest numbers in Indonesia (8.4 million), Thailand (7.0 million) and Malaysia (6.6 million) (Ch 11, Poston and Zhang).

While the Chinese have been settling in Southeast Asia since the Han Dynasty (second century AD) (Suryadinata 2004), migration to Australia commenced in the mid-nineteenth century, initially consisting of people fleeing civil unrest, floods and famine in southern China and subsequently in response to the discovery of gold. By 1861, the Chinese community made up nearly 7% of the Victorian population (Museum of Victoria). Although some who came to work on the goldfields left, many remained, settling into multiple occupations and establishing many Chinese religious and cultural organisations. The influx of Chinese in the mid-nineteenth century prompted the imposition of a poll tax (Yong and Vosslamber 2018), a precursor to the White Australia Policy, and multiple other forms of racial discrimination. Despite these measures, there has been a small but significant and continuing Chinese presence in Australia since the 1850s. The Immigration Restriction Act, passed in 1901, soon after federation, was aimed primarily at stopping Chinese migration and prevented further immigration from Asia.

Prior to the 1970s, there was a small, widely dispersed Chinese population in Australia. Immigration of Chinese re-commenced in the early 1970s after adoption of non-discriminatory immigration policy by the Whitlam government. This was mostly from Southeast Asian countries such as Malaysia (which became one of the top ten sources of migration in the 1970s) and subsequently from Taiwan, Hong Kong, Vietnam and China. By 1986, there were a dozen countries from which 100 or more Chinese immigrants came. While some Chinese came as refugees, e.g. from Vietnam in the late 1970s and into the 1980s, and as family reunion migrants, increasingly Chinese immigrants have come as professionals and business migrants and as overseas students who have settled in Australia following completion of their studies.

The China-born population rapidly increased as a result of the granting of asylum and permanent residency to thousands of Chinese students and their dependents who were in Australia at the time of the 1989 Tiananmen Square (or June 4th) Incident (Banham 2003). In the past two decades, the rate of growth of immigration from China to Australia is faster than for any other immigrant group (Fig. 16.1). At the time of the 2016 Census, the overseas-born constituted 28% of the Australian population. China-born immigrants were the third largest immigrant group, the number having more than doubled – growing at 8% per year – in the previous 10 years. Figure 16.1 shows that 37.4% of all China-born residents in Australia in 2016 arrived in the previous 5 years (2011–2016), while the corresponding figure for all overseas-born was 21.5%. The large proportion of recently arrived immigrants among the Chinese presents particular challenges for mental health services.

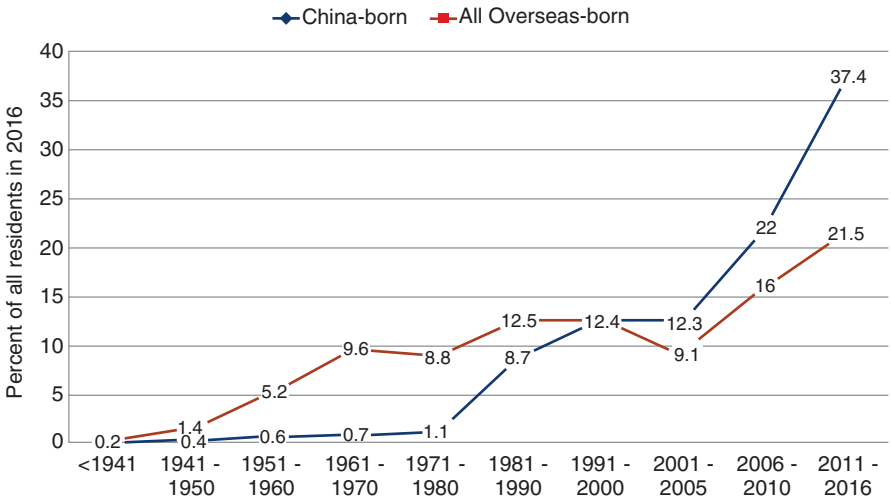

Fig. 16.1 Overseas-born residents in Australia in 2016 by year of immigration to Australia. (Source: Australian Bureau of Statistics Census 2016. Figures are percent of total China-born and all overseas-born populations in Australia in 2016 by year of arrival)

While the median age of the longer-established immigrant communities has continued to increase, the median age of Chinese immigrants has dropped from 38.7 years in 2006 to 34.7 years in 2016 (Australian Bureau of Statistics 2017a). The proportion of Chinese immigrants aged 65 years and over (9.2%) is less than half that in all overseas-born immigrants (19.9%) and substantially lower than that in the Australia-born population (13.5%). However, among Australia-born persons of Chinese ancestry, the proportion of elderly persons is substantially higher than among China-born immigrants, so mental health problems of old age are a significant issue among Chinese Australians.

In 2016, the top five languages spoken by persons at home were English (72.7%), Mandarin (2.5%), Arabic (1.4%), Cantonese (1.2%) and Vietnamese (1.2%) (Australian Bureau of Statistics 2017b). The proportion of China-born immigrants who speak English "not well" or "not at all" is substantially higher (31.0%) than that in all overseas-born immigrants (10.5%). This is a result of the relative recency of arrival of China-born immigrants and of the fact that Chinese immigrants place high value on maintenance of cultural traditions and language, as indicated by the fact that only 26% of China-born immigrants speak "English only", whereas 41.9% of all overseas-born speak "English only".

China-born and all overseas-born have greater proportions of persons with a bachelor degree or other tertiary-level qualification than the Australia-born and higher proportions of high school completion. Despite these higher levels of educational attainment, China-born immigrants have significantly lower levels of personal, family and household income than both the all overseas-born and Australia-born groups.

Chinese and Australian Culture

Over several decades, Hofstede and his colleagues (Hofstede Insights 2018) have developed a global database of national cultural values that is widely used in business and in research studies of culture. Figure 16.2 shows the different patterns of scores on the cultural values dimensions from surveys conducted in China and Australia.

While both China and Australia encompass considerable cultural diversity, and there are very substantial individual differences in cultural values, there are some broad cultural differences between China and Australia at national levels. Of course it should not be assumed that these "national" values are relevant to any particular individual of Chinese origin. However, these group differences constitute important cultural background information and, for mental health professionals, a starting point for an exploration of cultural factors that may be relevant in understanding mental health problems and in framing a helping strategy for a particular individual of Chinese origin with mental health problems.

Also, the pattern of scores from mainland China and from Chinese respondents in other regions and countries from which Australia's Chinese immigrants

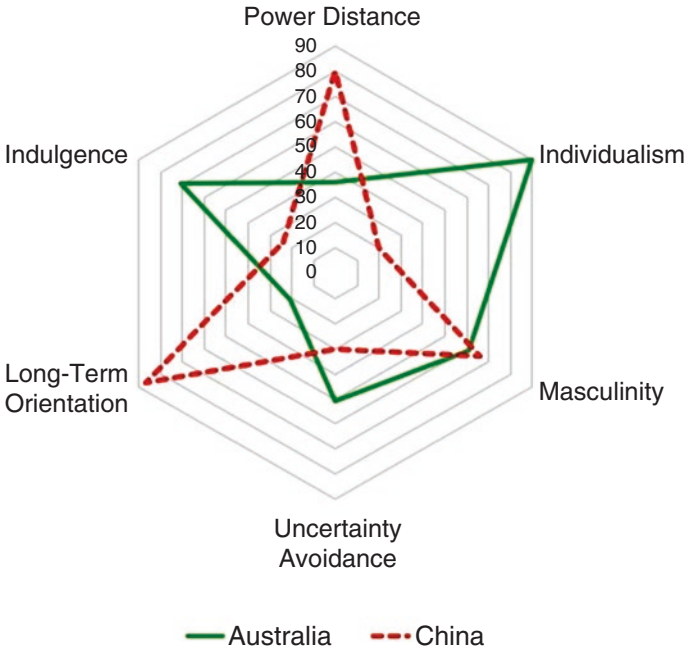

Fig. 16.2 Comparison of China and Australia on Hofstede's national cultural values dimensions. (Data source: Hofstede Insights 2018)

come – e.g. Hong Kong, Taiwan, Singapore, Malaysia, Vietnam and others – is likely to be significantly different, as would be the scores of Chinese immigrants in Australia.

The most well-known of the differences in values are in individualism, high in Australians and low in Chinese, and power distance, high in Chinese and low in Australians. Less well-known but just as important are the large differences between the two cultures in long-term orientation and indulgence. The smaller but significant difference between the two cultures in uncertainty avoidance also carries some explanatory power. An understanding of these values is important in designing and delivering appropriate mental health services, and their possible relevance in a specific clinical situation of a particular individual with mental illness and her/his family should be considered by the clinician.

As well as values differences between Chinese and Western societies, such as Australia, there are both close similarities and also considerable differences in core values among Chinese societies in different countries. Figure 16.3 shows the cultural values profiles of China, Hong Kong, Singapore and Taiwan.

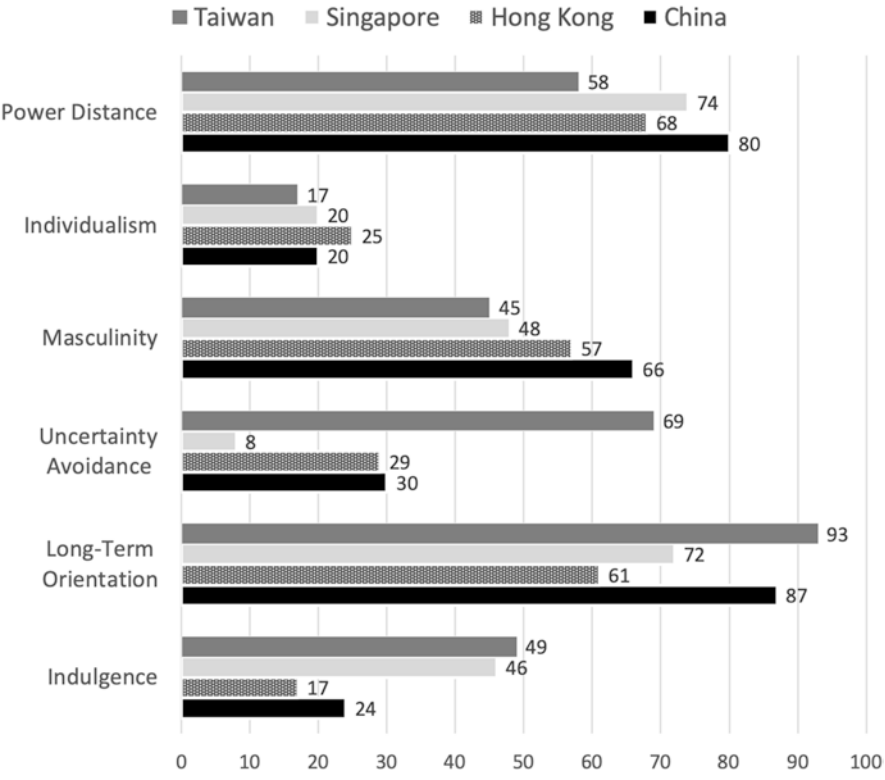

Fig. 16.3 Comparison of Chinese societies on Hofstede's national cultural values dimensions. (Data source: Hofstede Insights 2018)

Acculturation

As immigrants arrive in a new society and culture, they are faced with challenges concerning the extent to which they maintain their own cultural attitudes, beliefs and practices and the extent to which they incorporate aspects of the host culture into their lives. The process of cultural transformation is referred to as acculturation. Dominant acculturation strategies include assimilation, where the individual renounces the culture of origin and adopts the host culture; integration, where the individual maintains her/his own cultural identity while also being an active and capable participant in the host culture; separation, where the individual strongly maintains the culture of origin and rejects the host culture; and marginalisation, where the individual neither values nor fully accepts or participates in the culture of origin or the host culture (Berry et al. 1989; Berry 2001) The extent and pace of acculturation are influenced by many factors, including age on arrival in the new country, the cultural distance between the culture of origin and the host society, the size and level of geographic concentration or dispersal of immigrant communities of origin and the existence and influence in the host country of immigrant community institutions such as schools (such as the Chinese schools system in Malaysia (Chap. 12, Ting et al.), religious organisations, language of origin media and business and professional and employment opportunities. In large immigrant communities, it is possible for those who wish to do so to be completely immersed in culture of origin employment and leisure using the primary language. Just as important as cultural characteristics and issues within the immigrant population are the attitudes of the host population to the immigrant community, the nature and extent of denigration of and discrimination against particular immigrant groups, government policies concerning cultural maintenance and very many other factors.

The Australian policy of inclusive multiculturalism explicitly supports the *integration* form of acculturation by promoting the learning of English and understanding of and respect for Australian laws and culture while at the same time supporting the maintenance of the culture of origin, including language and cultural practices. The dominant mode of acculturation of Chinese immigrants in Australia is integration – maintenance of language of origin and important aspects of Chinese culture while adoption of important Australian cultural values and being fluent in English.

Level and type of acculturation have been shown to be associated with health status and with level of access to health services. For example, adoption of Australian diet and lifestyle is associated with increased cardiovascular disease risk factors, such as hypertension and diabetes, among Chinese immigrants in Australia (Jin et al. 2017). Low levels of acculturation are frequently associated with persistence of traditional conceptions of mental health and illness, high levels of mental illness-related stigma and limited knowledge of, and access to, mental health services, all frequently observed in Chinese immigrant communities.

Culture and Psychopathology

A recent overview of culture and psychopathology (Kirmayer and Ryder 2016) summarises progress that has been made in improving our understanding of the ways in which social and cultural contexts shape illness onset, experience, course and outcome by influencing developmental processes, exposure and response to social adversity and risk of specific forms of psychopathology. Cross-national epidemiological, clinical and anthropological studies over many decades have made clear the wide variations across cultures in prevalence and expression of specific mental disorders, and in cultural understandings, explanations and social responses to mental illness. The most common mental disorders, depression and anxiety, also display great variability across cultures in the ways in which disorders are experienced and expressed, and in social (including health system) responses that are intended to support the individual's recovery, and enhance interpersonal and social functioning (Minas et al. 2007a).

There are substantial differences across cultures in the experience and expression of mental disorders. For example, Parker et al. have suggested that the existing evidence supports the commonly held view that the Chinese are more likely than Australians to deny depression or to express it through somatic symptoms (Parker et al. 2001a, b). However, cultural changes in China in recent decades (Chap. 5, Huang) and among Chinese immigrants in Australia appear to have resulted in significant changes in both the experience and expression of depression. In a study of the impact of acculturation on depressive experiences of Chinese patients in Sydney, Parker et al. (2005) found that both the low rates of reported depression and the phenomenon of somatisation in Chinese people are likely to be influenced principally by cultural factors. These differences in experience and expression of illness can be a source of difficulty for mental health professionals. New Zealand Lifeline counsellors providing services to Chinese immigrants (Dong 2016) were less comfortable and confident when callers focused on physical problems, a particularly common issue in Chinese immigrants who are more likely to express mental disorders through somatic symptoms.

Anxiety, depression and somatoform disorders (a group of psychological disorders resulting in experience of physical symptoms that are not produced by physical pathology) account for a large proportion of all problems seen in general practice in Australia. Under-diagnosis of mental disorder is thought to be a particularly significant problem in persons who do not speak English and in immigrants from Asia (Tang et al. 2009), including immigrants from China, particularly among patients who present with somatic symptoms of mental disorders. A study of Chinese patients attending a general practice in New South Wales found that, while only 12% of subjects reported ever having depression or anxiety, between one-third and one-half of the subjects scored in the probable depression range. The authors suggested the need for specific exploration for symptoms of depression and anxiety, with the possible use of screening instruments. Chan and Parker (2004) also suggest that more direct and sensitive questioning regarding psychological symptoms in Chinese patients may be needed to "unveil the true nature of the distress" and to arrive at a correct diagnosis.

Prevalence of Mental Disorders

Despite the progress in understanding of culture and mental health referred to above, there is still considerable uncertainty about whether variations that have been observed in prevalence of specific disorders represent real differences in prevalence or are due to problems with conceptualisation and measurement across countries and cultures. Unfortunately, these issues have not been studied in a sufficient number of different national contexts and across enough immigrant and minority ethnic groups to enable a full understanding of the origins of such differences (Minas et al. 2013). There are, for example, no studies of prevalence of mental disorders in Chinese Australians.

Reliable estimates of population prevalence of different types of mental disorder in populations of interest are required before anything useful can be said about the scale of mental health problems in specific populations, whether attempts to improve population mental health are effective and are a good investment, or whether differences in observed patterns of mental health service utilisation between different population subgroups are due to differences in rates of mental disorder in those subgroups or to other factors, such as obstacles to service access. A lack of prevalence information results in poorly informed mental health policy and service design and delivery. This is currently the situation in Australia in relation to most immigrant communities, including the Chinese community (Minas et al. 2013).

Mental Health Determinants

A key goal of population health research is to understand the determinants of health and illness – both risk and protective factors – and to develop effective health promotion, illness prevention and early intervention and effective treatment and psychosocial support service programs (Cohen and Minas 2010).

Several factors have been identified as potentially important risk or protective factors for mental illness among immigrant groups in Australia and are likely to be relevant to Chinese immigrants. Factors found to be associated with increased risk of mental disorder among immigrants include limited English proficiency (Alizadeh-Khoei et al. 2011); "marginalised" cultural identity (Sawrikar and Hunt 2005); loss of close family ties (Thompson et al. 2002); lack of opportunity to make effective use of occupational skills (Reid 2012); and the many stresses associated with migration and adjustment to a new country (Krupinski 1984). Protective factors include religious belief and observance, younger age at migration, better proficiency in the language of the host country, a higher sense of personal control, stronger social support and higher self-efficacy (Leung 2002; Connor 2012). A survey of 1139 immigrant and refugee people in two rural and two metropolitan areas in Victoria focused on their experiences of racism and its association with psychological distress (VicHealth 2007). Approximately two-thirds of participants had experienced racism

in the previous 12 months and reported that this had adversely affected their mental health. The extent of experiences of racism was positively correlated with level of psychological distress.

The distribution of these factors across immigrant populations and their importance and impact in different immigrant populations are not well understood. Existing findings are mostly from a very small number of studies with only a very few immigrant groups. Such findings as we have must be regarded as provisional.

Suicide and Self-Harm

Risk of suicidal behaviour among immigrants is influenced by experiences in the country of origin (Kliewer 1991), living circumstances (Kliewer 1991; Morrell et al. 1999), low socio-economic status (Taylor et al. 1998) in the host country, and many other factors. Strong family ties, religious adherence and maintenance of traditional values may lead to lower suicide rates in immigrants (Burvill et al. 1983).

Suicide rates for China and Australia are close to the regional average of the countries of the Western Pacific region, which is 10.8 per 100,000 population, while there is a fourfold difference in suicide rates from the country in the Western Pacific Region with the lowest rate (Philippines) to that with the highest (South Korea). Aside from this wide difference in national rates, there are wide variations in suicide rates among population subgroups within countries (e.g. by age, gender, ethnocultural and socio-economic groups, rural and urban regions, etc.) (Kliewer 1991; Taylor et al. 1998; Morrell et al. 1999; Ide et al. 2012). Among persons aged 65 years and over, immigrants from non-English-speaking background countries have substantially higher rates of suicide. This difference appears to be particularly prominent in immigrants from Northeast Asia. It is not known whether this specifically applies in the Chinese Australian population.

Whereas suicide is substantially more common among males than among females in most countries, China has consistently had a high female suicide rate, particularly in rural regions, and particularly for suicide by pesticide ingestion, although this has been substantially reduced in recent years by improved regulation of pesticide storage and use in rural areas. Rates of suicide of immigrants in Australia are more similar to rates in countries of origin than with the overall Australian suicide rates, but there is convergence in the rates to those in the host country with increased length of stay. Among Chinese in Australia, female suicide rates are half those of male rates, a pattern more like the Australian pattern than that in China (Table 16.1). It is worth noting from Table 16.1 that there is also variation among Chinese immigrants in Australia who come from Mainland China, Hong Kong and Singapore, highlighting the fact of diversity among Chinese immigrants from different countries.

Although the World Health Organization has defined deliberate self-harm as a behaviour that is intended to cause self-harm but without suicide intent and having a nonfatal outcome, deliberate self-harm, or parasuicide, or attempted suicide, is the

Table 16.1 Suicide rates per 100,000 by country of birth and sex in Australia during 2001–2006 compared with suicide rates of COB

Males			Females		
Country of birth	ASR in Australia 15+?[a]	ASR in COB[b]	Country of birth	ASR in Australia 15+	ASR in COB
Australia	22.8	–	Australia	5.8	–
China	10.7	13.0	China	5.5	14.8
Singapore	9.6	13.7	Singapore	np	6.7
Hong Kong	5.7	22.0	Hong Kong	3.4	13.1

Source: Ide et al. (2012)

[a]Age-standardised suicide rates of persons aged 15+ years by country of birth and sex in Australia was sourced from the Australian Institute of Health and Welfare, National Mortality Database

[b]Age standardised to the World Standard Population

clearest predictor of future self-harm and of suicide, with around a quarter of those completing suicide having previously engaged in deliberate self-harm (Wong et al. 2010; Heerde et al. 2015). Deliberate self-harm, which occurs substantially more frequently among females than among males (Heerde et al. 2015), often occurs in the context of wide-ranging problems in adolescents' lives, common features of which are high levels of depression symptoms (Wan et al. 2011), antisocial and other forms of personality disorder and alcohol use. The high rates of suicidal thoughts among Chinese in Malaysia are thought to be related to the political and socioeconomic context of Chinese communities in that country (Chap. 11, Ting et al).

McDonald and Steel (1997) found wide variation in rates of hospital attendance due to self-harm across country-of-birth groups. The rates for males born in China or Hong Kong were among the lowest for all country-of-birth groups. The rates for females born in China or Hong Kong were significantly lower than for those born in Australia. It is not known whether the lower rates of hospital attendance are due to lower population rates of self-harm or due to lower likelihood of presentation to a health service.

Help-Seeking

A number of studies have explored explanatory models of mental health and illness in individual immigrant and refugee groups in Australia and their influence on help-seeking (Cheng, 1985; Hsiao et al. 2006a; Hsiao et al. 2006b; Klimidis et al. 2007; Lenzi et al. 2012; Minas et al. 2007b). Although the findings of these studies are of considerable theoretical value, there have been few systematic attempts to explore the practical significance of the findings – to inform clinical practice, community engagement and use of health services, mental health service design or mental health policy.

A majority of persons with mental disorder in Australia, and throughout the world, do not seek and do not receive any help from mental health professionals and mental health services. In Australia, at the beginning of this century, only 35% of the Australian general population with a mental disorder in a 12-month period sought help from health services (Andrews et al. 2001). In immigrant communities, particularly the Chinese community, the proportion of persons with mental disorder who receive mental health services is much lower than is the case for the Australia-born.

Anxiety disorders and major depressive disorders are the most commonly occurring mental disorders in all adult populations, including in Australia (Andrews et al. 2001). This is true in China as it is in all other countries (Baxter et al. 2016) and in immigrant populations (Stuart et al. 1998; Minas et al. 2008). They are associated with substantial disabilities. Rates of access to public mental health services by immigrants of non-English-speaking background in Australia have been consistently low for several decades (Stuart et al. 1998; Klimidis et al. 1999a, b; Minas et al. 2008, 2013; Stolk et al. 2008).

Within Chinese immigrant populations, cultural factors that have been identified as barriers to seeking help from mental health services (Blignault et al. 2008) are generally based in Chinese traditions of Confucianism, Taoism and Buddhism. Acculturation, ethnic identity and English proficiency are known to influence attitudes towards seeking professional mental health services.

Pathways to Care

A New South Wales study of pathways to first contact with specialist mental health care by Australian-born and Vietnamese-, Chinese- and Arabic-speaking patients making their first lifetime contact with mental health services (Steel et al. 2006) found that an average of three professional consultations was made prior to first contact with public mental health services. Family physicians occupied the key role in the help-seeking pathway with 53% of patients consulting a general practitioner. Many of the findings of this study, particularly the centrality of general practitioners in pathways to mental health care, have been confirmed by subsequent studies of pathways to care shown by Chinese immigrants.

It should be pointed out, however, that these results are applicable only to persons with mental disorder that did eventually make contact with a specialist mental health services. They tell us nothing about persons from immigrant communities with a mental disorder who either choose not to make contact with mental health services or, for whatever reason and regardless of the severity of their mental disorder, do not come into contact with mental health services.

An Australian study of Chinese- and English-speaking persons who undertook an Internet-delivered cognitive behavioural therapy (iCBT) for depression (Choi et al. 2015) showed that the Chinese-speaking participants had significantly milder depressive symptoms and were less likely to have previously sought professional

help compared to the English-speaking participants. The Chinese-speaking participants were more likely to seek iCBT due to lack of knowledge about face-to-face treatment, while the English-speaking participants were more likely to report not benefiting from standard mental health services.

Mental Health Service Utilisation

The likelihood of receiving treatment for mental disorder has been shown to be influenced by immigrants' country of birth (Burvill et al. 1982; Stuart et al. 1998), and in general, immigrants are under-represented in the populations who utilise mental health service in Australia (Hassett and George 2002; Boufous et al. 2005; Wagner et al. 2006). The key barriers identified are stigma and shame associated with mental illnesses (Wynaden et al. 2005; Youssef and Deane 2006; Drummond et al. 2011), limited knowledge of services, communication difficulties, confidentiality concerns, lack of trust in service providers, service constraints and discrimination (Youssef and Deane 2006; Blignault et al. 2008). A pattern of under-utilisation of mental health services by particular groups may point to systematic inadequacies in service systems, important questions concerning the need for service reform, community attitudes towards and beliefs about mental illness and psychiatric treatment, barriers to service access, difficulties in diagnosis and racism.

In studies of public mental health service utilisation by immigrant communities in Victoria in 1995/1996 and 2004/2005 (Klimidis et al. 1999a, b; Stolk et al. 2008), China-born persons had among the lowest rates of utilisation of both hospital services and specialist community mental health services. China-born persons were also more likely to be admitted as involuntary patients, to have a diagnosis of psychotic disorder and to spend more days in hospital than the Australia-born and most other non-English-speaking country-born persons. In 1997 McDonald and Steel reported very similar findings from New South Wales (McDonald and Steel 1997). China-born patients in New South Wales had among the lowest rates of admission to hospital for psychiatric disorder and use of community-based mental health services.

A recent, unpublished, analysis of data from the National Hospital Morbidity Database on all mental health-related hospital admissions in 2013/2014 included data from a total of 260,158 admissions to Australian hospitals. Table 16.2 is a summary of main findings for China-born, all non-English-speaking country-born and the Australia-born. It can be seen that over a period of more than 20 years, China-born persons continue to have extremely low rates of mental health service utilisation and continue to have longer hospital admissions and be more likely to be admitted involuntarily than the Australia-born and most other non-English-speaking country-born persons.

Chinese Australians, particularly those who are more recently arrived, have low English proficiency and are older, experience multiple barriers to access to effective mental health services (Stolk et al. 2008; Colucci et al. 2013; Minas 2017). These

Table 16.2 Admissions to Australian hospitals in the 2013/2014 financial year

Country of birth	Mean admission rate per 10,000 population	Proportion involuntary admissions (%)	Proportion of admissions with psychotic disorder (%)	Mean duration of admission (days)
Australia	133.0	15.6	14.6	6.7
All non-English-speaking country-born	71.4	23.5	21.6	8.6
China-born	21.6	35.0	27.7	9.9

Source: Minas and Hall (unpublished)

barriers include the stigma of mental illness, concerns about confidentiality, lack of knowledge about mental health services and how to gain access to them, perceived and actual discrimination within the general community and among service providers, and problems with communication. Also important is the unavailability of professionals who speak the necessary community languages and who are familiar with the cultures of immigrant communities (Blignault et al. 2008) and a widespread lack of knowledge among health professionals and health service managers of the particular needs and preferences of particular immigrant communities (Colucci et al. 2013; Minas et al. 2013). Such barriers can only be eradicated through adequate information on the particular issues facing immigrant communities and by involving these communities in the design, delivery and evaluation of mental health services (Minas et al. 2013).

Although Australia's National Mental Health Strategy and successive national and state and territory mental health plans have emphasised a focus on quality, effectiveness and cultural appropriateness of services, and a major national effort has been made on continuously measuring the quality of outcomes for service users (Burgess et al. 2012), the evaluation of outcomes has not included analysis of relative outcomes for immigrant groups. As a result of the systematic failure to collect relevant demographic data as part of the national mental health outcomes data collection there is no useful information concerning outcomes for immigrant and refugee clients of mental health services (Minas et al. 2013).

As mentioned above, the Chinese community has been in Australia for a long time. The high value placed on education within the Chinese immigrant community means that Chinese in Australia are significantly better educated than the Australia-born population. In addition, the Australian immigration program is such that a substantial proportion of immigration places within the annual quota is reserved for skilled immigrants, so among the large number of recent Chinese immigrants, there are many who have professional qualifications, skills and experience. All of these factors result in substantial resources within the Australian Chinese communities, including physicians and other health professionals, Chinese social assistance organisations of many kinds throughout the country and a vibrant Chinese language media. The existence of these community resources may at least partly explain the very low rates of utilisation of public mental health services by Chinese in Australia.

Politics, Migration and Mental Health

Politics have always been important in Chinese migration to Australia, and Chinese migration has had, and continues to have, substantial impacts on Australian politics. For example, the transparently racist White Australia Policy was a direct response to Chinese migration in the nineteenth century and was virtually the first act of the national parliament following the creation of the Australian nation through Federation in 1901. This immigration policy was not finally dismantled until the early 1970s, following which, Australia was one of the first Western countries to recognise, and to establish diplomatic relations with, the People's Republic of China. Over subsequent decades, relations between the two countries have become increasingly close, despite major political and cultural differences. China is now Australia's largest trading partner, and Australian prosperity has become increasingly dependent on this trade with China. Australia is the second most favoured destination, after the USA, of Chinese international students (Minas 2020).

However, with China's rapidly developing economic and military might, and its increasingly confident and assertive posture in the region and globally, the relationship between Australia and China has become increasingly frosty. There are frequent expressions of concern in the West, including Australia, and among China's Asian neighbours, about China's approach and intentions in the South China Sea, the implementation of the Belt and Road Initiative and, for Australia, China's increasing influence among the small island nations of the Pacific. In this context Australia is engaged in a delicate positioning between its close alliance with and security dependence on the USA and its economic dependence on its trade with China. A constant stream of negative stories in the Australian media about possible Chinese influence on various aspects of Australian life, and about possible security threats from China, is having at least an unsettling impact on Chinese immigrants and international students in Australia and may be undermining these groups' sense of security and mental health and wellbeing.

Conclusion

Cultural considerations are relevant to all aspects of mental health and mental illness and mental health service design and delivery. Mental health professionals should have a high level of competence in incorporating cultural assessments into their understanding of the problems that their clients present and in crafting approaches to the solution of those problems. Because cultural maintenance in Chinese communities is strong, mental health professionals should have a good deal of knowledge about the more traditional Chinese understandings of mental health and illness, family structures and dynamics, and preferences concerning solutions to mental health problems. Unfortunately, this is not the current reality. There are few appropriate training programs, and neither mental health policy nor arrangements

that regulate mental health practice require the acquisition of such knowledge and skills.

The level of knowledge and the attitudes that different members of the Chinese Australian community have about mental health and illness, and their preferences concerning helping responses, are largely influenced by their age and previous experience when they migrated to Australia and were confronted with a different set of values and attitudes to those in their home country, their level of education and where that education was gained and many other factors.

In general, the level of knowledge and attitudes of the broad Australian community about the common mental disorders, depression and anxiety has changed greatly in the past few decades, as a product of active community education and information campaigns that have had a significant impact. There is less ignorance and less stigma, although there is still more than enough of both. There have also been significant changes in China as the massive economic and cultural transition has gathered pace over the past two or three decades, particularly in the large urban centres. People who migrated from China not long after the cultural revolution, when there was no mental illness but only wrong political thought in (China Chap. 4, Gao) will clearly have different understanding and attitudes to those who migrated in the past 10 years (Chap. 10, Yang).

In seeking to understand the thinking, practices and preferences of Chinese Australians concerning mental health and illness, and to inform helping approaches, mental health professionals would benefit from at least some knowledge of mental health in China and the massive changes that have occurred in China in recent decades and how these changes have influenced knowledge, attitudes and beliefs about mental illness, while traditional Chinese thinking, practices and values persist to varying extents.

Before ending this discussion of the mental health of Chinese immigrants in Australia, it is important to comment briefly on the range, quality and contemporary relevance of the Australian research on mental health of Chinese communities that is presented in this chapter.

A key point to highlight is that Australian research on mental health and illness in Chinese communities mostly consists of small-scale studies on small samples that are not representative of the entire Chinese-Australian population. An additional issue is that the Chinese-Australian population is diverse in terms of country of birth, primary language and period of arrival in Australia. When Chinese migration to Australia re-commenced in the 1970s, most people came from Hong Kong and Southeast Asian countries with large Chinese populations, including Malaysia, Singapore and Vietnam. As Chinese migration gathered pace in the past few decades, the main source of Chinese immigrants has been mainland China. The histories, experiences and cultural influences in the source countries for Chinese migration have been very different, although there is in all a strong core of Chinese traditional values. As a result, studies carried out in the 1980s and 1990s and studies carried out more recently have actually been focused on significantly different populations. Virtually no studies have been replicated at different historical periods, in different components of the Chinese-Australian community or in different states and territories.

Therefore, what we know about mental health in Australia's Chinese communities is partial and fragmented, and frequently informed by inconsistent research findings. This mirrors the situation of all migration mental health research in Australia (Minas et al. 2007a, 2013) and in other countries of settlement and imposes limits on the usefulness of the research for the purpose of understanding the determinants, onset, course and outcome of mental disorders in specific immigrant communities, and for the purpose of informing service design and delivery and professional practice.

Along with the British, the Chinese are among the earliest immigrants to Australia, with substantial numbers coming from the middle of the nineteenth century. After a long interregnum, from the beginning of the White Australia policy after Federation in 1901 until the early 1970s when this loathsome policy was fully discarded, the pace of Chinese immigration has again accelerated. They are the fastest growing immigrant group in Australia. In many ways, Australia's communities of Chinese origin are similar to other large immigrant communities; in other ways, they are quite different. Like other immigrant communities, there are important differences with the Australia-born, and there is considerable internal diversity within Australia's population of Chinese origin. The lesson of this for mental health policymakers, service planners and clinicians is that along with a general commitment to respond to Australia's cultural diversity, there is also a need for specific knowledge about particular communities.

Acknowledgement This chapter is a much abbreviated, updated and revised version of an unpublished report – *Mental health of Chinese in Australia: What should telephone counsellors know?* – that was commissioned by Lifeline Australia in preparation for the development of a Chinese-language telephone counselling service.

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