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ORIGINAL PAPER

Barriers Accessing Mental Health Services Among Culturally and Linguistically Diverse (CALD) Immigrant Women in Australia: Policy Implications

Yvonne Wohler[1] · **Jaya AR Dantas**[1]

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Abstract Immigrant and refugee women from diverse ethnic backgrounds encounter multiple barriers in accessing mental healthcare in various settings. A systematic review on the prevalence of mental health disorders among culturally and linguistically diverse (CALD) women in Australia documented the following barriers: logistical, language and communication, dissonance between participants and care providers and preference for alternative interventions. This article proposes recommendations for policies to better address the mental health needs of immigrant and refugee women. Key policy recommendations include: support for gender specific research, implementation and evaluation of transcultural policies, cultural responsiveness in service delivery, review of immigration and refugee claims policies and social integration of immigrants.

Keywords Access · Barriers · Mental health services · Immigrant women · Australia

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✉ Yvonne Wohler
marieyvonne@westnet.com.au;
marie.wohler@postgrad.curtin.edu.au

Jaya AR Dantas
jaya.dantas@curtin.edu.au

[1] International Health Programme, School of Nursing, Midwifery and Paramedicine, Faculty of Health Sciences, Curtin University, GPO Box U1987, Perth, WA 6845, Australia

Introduction

Australia's current immigration policies favour greater inflows of highly skilled women as primary applicants while maintaining a focus on family reunification [1]. The third Longitudinal Survey of Immigrants to Australia (LSIA), revealed that 55 % of women who entered Australia were primary applicants, 78 % of whom originated from a non-English speaking country [2]. The population diversity is complemented by humanitarian entrants who have been offered protection visas in Australia. Over the past 5 years of refugee programmes, the gender balance has remained relatively stable with women accounting for 47.6 % of all visa recipients [3].

While the increasing presence of women in migration flows worldwide has been documented [4], the impact of migration on culturally and linguistically diverse (CALD) women's mental health is still underexplored [5]. As a result, prevalence of specific mental health disorders among ethnic women in Australia remains poorly understood and under researched, despite evidence of a range of mental health disorders among this cohort such as depression, schizophrenia and stress [6, 7]. Despite an enabling healthcare policy [8], CALD immigrants underutilise mental health services compared to other Australians [9, 10]. The key barriers identified in the aforementioned studies were stigma, shame, limited access to services, limited knowledge of services, communication difficulties, a lack of trust, confidentiality issues, discrimination, and quality of care and service constraints.

Universal access to healthcare is one of the core service deliveries of any government towards its citizens. It is therefore imperative to explore the experiences of CALD women in accessing mental healthcare. The data collected would provide insight into service use and possibly

influence policy formulation for a better mental health service model for CALD women. This article emerges from the findings of a systematic review assessing the mental health of CALD women in Australia. The aim of this paper is to provide an overview of the reported barriers accessing mental healthcare by CALD women. Drawing on the participants' experiences in the reviewed papers, the implications for mental health policies are presented and complemented by some recommendations.

Methods

This paper draws on findings from a mixed methods systematic review on the prevalence and risks of mental health disorders among CALD women in Australia. The population of interest consisted of immigrant and refugee women aged over 18 years who had experienced mental illness post migration. Selected studies met the following criteria: quantitative, qualitative or mixed methods articles investigating self-reported mental health outcomes, diagnosed mental health disorders, vicarious mental health and trauma. The search strategy retrieved peer reviewed articles from ten electronic databases as well as grey literature dated between 1994 and 2014. Standard search procedures were followed using selected search terms. The identified published and unpublished material went through a two phased screening process. The first round of exclusions was based on the relevancy of the titles and abstracts to the phenomenon of interest. After the first elimination, the rest of the articles were subjected to full review upon compliance with the pre-set criteria.

The studies' methodological quality was appraised using the Mixed Methods Appraisal Tool [11]. Due to the limited number of eligible studies, the heterogeneity of samples and methods, no study was excluded in order to capture the breadth of the available literature. Finally the data from the findings were synthesised and analysed using a narrative approach. Three elements from Popay et al.'s [12] narrative synthesis framework were employed to address the aims of the study: (a) developing a preliminary synthesis of findings, (b) exploring relationships within and between studies and (c) assessing the robustness of the synthesis.

Findings

Language and Communication Barriers

Across many studies, participants voiced their difficulties in communicating with service providers due to lack of proficiency in English [13–24]. Fear of being judged, of not being understood, of losing their job, of being hospitalised and of community and family's reactions were major concerns [25]. Many women were uncomfortable discussing personal issues in a foreign language. In some cases, culture specific syndromes or daily emotional stressors related to acculturation could not be clearly articulated in English. Hence daily living stress can potentially lead to misinterpretation and misdiagnosis [15, 18]. Even though interpreters could be requested for assistance, many women were concerned about confidentiality, especially if they came from a small ethnic group. Some doctors were reported to be reluctant in using interpreters [15]. It was suggested that perhaps health practitioners viewed the refugee women as "a source of money rather than people" [15]. The use of interpreters impact on the duration of the consultation, thus reducing the number of appointments available to the general public.

Logistical Barriers

The most commonly cited barriers included lack of information and knowledge on available healthcare [14, 19–21, 26, 27], financial barriers and lack of private health insurance [14, 17, 21, 28]; difficulty with transport [17–20], lack of free or low cost childcare [13, 18, 29] lengthy waiting lists and delays in accessing specialists [14, 26]. Additional reported concerns included fear of consequences for the family and repercussions from the ethnic enclave, concern about deportation, fear of losing children, ignorance of legal rights and entitlement under Australian laws [17, 24, 27, 29–31].

Barriers of Cultural Dissonance Between Participants and Service Providers

Participants viewed doctors as being "inflexible and insensitive to their needs" [14]. This barrier emerged from their "need to be looked upon as a human being" [14] especially in a moment of vulnerability and uncertainty when isolated from close family and community. Some women reported that the medical practitioners "did not really hear what was being said" and rushed through the consultation, [15] thus preventing the development of trust and rapport between doctor and patient.

Doctors were perceived as "unfriendly and too young" who tended to cause discomfort with the "directness in which they delivered prognosis for serious illness" [23]. Participants' explanatory models of mental illness did not necessarily conform to western concepts. For example, South American women's experiences of culture bound syndromes to express distress and "loss of soul" had no English equivalent terms [15]. Some African women had no words to express anxiety and depression in their languages [18]. Filipinas viewed emotional problems as issues caused by daily stressors which could be mediated by

prayers, release of pent up emotions through a good cry or taking up physical chores [28].

Some women complained of culturally insensitive practices especially from maternity hospitals and consequently could not provide appropriate cultural self-care after the birth of their child. For example the Chinese perceived the postnatal period as being the most dangerous time in a woman's life due to the extreme imbalance in the body toward the yin resulting from loss of blood and energy during childbirth [19]. A strong call for gender appropriate services staffed by bilingual workers from CALD background was noted across studies most specifically for women who had experienced sexual assault and intimate partner violence [15, 19, 20, 24, 26]. Finally mental illness was highly stigmatised in many cultures and could lead to ostracism from community groups, being labelled "crazy" and bringing shame to the family [25, 26, 28, 29, 31].

Preference for Alternative Interventions

Some Brazilian participants felt that medical practitioners in Australia lacked respect for alternative healthcare methods and popular health beliefs [14]. Although some mental health symptoms may be common across cultures, doctors need to be aware that explanatory models tend to be culture specific and embedded within the cultural assumptions and beliefs of the patient. Hence the western medical approach would be irrelevant and alternative therapies preferred. Filipina women preferred to resolve their problems through self-reliance and friends' support [28]. Tears, prayers and friends' support are considered the "natural way" to address emotional issues in contrast to "the unnatural" method of seeking professional psychiatric assistance. Many Middle Eastern women had never heard of Post-Partum Depression (PPD) until they arrived in Australia [27].

Cultural practices and close family support cushioned them from isolation and stress during these crucial times. One mother expressed her distress when she was informed that she suffered from PPD. She was afraid of telling her husband and family as she would be considered a "crazy woman" which is a stigma in her culture. Religious teachings, traditional practices and a network of informal social support were also cited as a way of maintaining well-being and providing relief from distress [18, 31]. Therefore mental health problems as understood in the western context were not experienced nor treated [18].

Discussion and Implications for Policies

The findings of this systematic review are consistent with global literature on immigrant women's impediments to utilising mental healthcare facilities [10, 32]. The lived experiences of CALD women and accounts of their contact with mental health services provide a gendered perspective which could inform policy and practice. The following recommendations, resulting from our findings, are directed towards health policy makers. Immigrant women's access to mental healthcare and information is influenced and challenged by their migration experience and gender related complexities. It is therefore imperative that research in women's health integrates the interacting variables of sex, gender, ethnicity and migration in order to capture a holistic understanding of the complex determinants of mental health.

Every intervention aiming to benefit immigrant women's access to health should be framed within a justice, social equity and human rights approach to counter ongoing disparities and existing practice and discourse. Policies that support longitudinal and comparative research on immigrant and refugee women mental wellness are needed. Governmental and non-governmental agencies should join forces and collaborate on research exploring mental illness among immigrant women from various ethnic groups. Researchers should follow the participants throughout their illness and compare data on the interactions of gender, acculturation stage and mental health. Data comparison would assist in capturing trends and pinpointing patterns.

The fourth National Australian Mental Health Plan 2009–2014 [8] provides guidance and direction for particular areas of mental health reform with a focus on "service access, coordination and continuity of care" [8]. Despite the enabling environment and the specialised transcultural mental health policies of some states [33, 34], the implementation of policy has been slow and problematic [35, 36]. This is due to the lack of consideration of the population and cultural diversity in the framing of policies, lack of research and limited data on the effectiveness of implemented policies. Lack of accountability on policy implementation is of concern. Evidence based research on ethnic women's mental health is inadequate to inform policy [37]. In order to redress the barriers accessing mental healthcare, mental health policies relevant to CALD women must be translated into realistic implementation objectives, evaluated and disseminated. Comprehensive policies relevant to CALD women's mental health should be clearly articulated on national policy statements. These policy documents should detail specific implementation objectives such as prevalence of disorders, chronicity of illnesses, risks and protective factors, pathways to healthcare and mental health literacy. Funds should be made available for the implementation, monitoring and evaluation of specific programmes or interventions. Reporting and sharing progress among various agencies would inform future policies.

Reported cultural dissonance between the participants and service providers suggests that the healthcare system is

failing to provide a culturally safe and competent service despite a wide range of policies on cultural competence [38]. Gill and Babacan [39] found that the difficulty in implementing standards was due to the lack of application of cultural competence theories into practice. In addition, lack of data on diversity and the complexity and variability of cultural competence definitions were among factors contributing to the situation. We propose that policies referring to cultural competence are extended further to a cultural responsiveness framework as advocated by Werkmeister-Rozas and Klein [40].Cultural responsiveness ideally would complement cultural competence. It is about interacting with individuals "taking into consideration all aspects of their identities, experience, acculturation, socioeconomic status, gender, power, privilege, regionality, social status and personality" [40]. Cultural responsiveness is an ongoing co-created relationship between the client and the service provider in which there is a meaningful and respectful response to immigrants within the context of their own cultural background. This approach would encourage an individualised and holistic mental health care plan taking into consideration all the multifactorial influences (race, gender, ethnic heritage) impacting on the client's reality.

This review documented protective factors that mitigated mental health issues enhancing the participants' mental health, resilience factors and self-reliance. These protective factors are religion, social support and physical chores. Policy makers should take these three factors into account and invest in programmes offering avenues for women to connect to each other through religion, social network and physical activity to assist in reducing depression, anxiety and other mental health issues. Rather than pathologising immigrant women's migration experiences based on the biomedical model, we recommend policies and interventions that address the structural determinants of mental health. Low cost or free childcare, specialised English classes, discounted transportation, employment training or volunteering as well as cooking workshops or women's groups would assist in enhancing immigrant women's settlement experiences and promote social networks. Bilingual workshops on mental health information and self-care would empower and most importantly information session groups for men on Australian laws and policies as well as women's rights to a safe and healthy life. There is a need for holistic and supportive policies to help CALD women cope with acculturation challenges.

The development of those policies should articulate their needs, aspirations and voices. Policies regarding immigration and refugee claims should be redesigned to reflect gender specific issues that impact on immigrant women. For example if a family applies to immigrate to Australia, women tend to be assigned a dependent visa [41], even when both the husband and wife have comparable education skills and qualifications. This policy can be perceived as discriminatory because it fails to accord women the same rights as men and acknowledges immigrant women's potential and capacity for economic contribution. Loss of social standing, material wealth and professional achievement post migration have been linked to isolation, distress and mental health issues [16]. We advocate for policies which would eradicate barriers to the economic and community integration of immigrant women through recognition of previous training, work experience and educational qualifications. New policies would open avenues to employment and social integration which would reduce vulnerabilities to mental health.

Conclusion

This paper has identified significant barriers, reported in the literature, encountered by immigrant and refugee women in accessing mental healthcare services in Australia. Recommendations for innovative policies have been proposed to address these barriers. Key policy recommendations include: support for gender specific research, implementation and evaluation of transcultural policies, cultural responsiveness in service delivery, immigration and refugee claims policies and social integration of immigrants. Such an approach would require a partnership between various government sectors such as health, housing, employment, education, human services and justice and community organisations that work at the grassroots level.

Compliance with Ethical Standards

This article is a 'systematic review' and as no primary data was collected for the purpose of this review, ethical approval was not required. The review made use of secondary data in the form of published articles. However, the authors adhered to the Australian Code for the Responsible Conduct of Research. The authors worked with honesty and integrity and aimed to accurately represent findings from previous research, promote the truth, and avoid error in the hope that the review findings may lead to changes in policy and practice in relation to mental health among migrant women in Australia. No reviewed articles were fabricated, falsified or misrepresented.

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