Transcultural Mental Health Centre

Interpreters or bilingual mental health professionals should also be used during procedures such as:

- taking medical histories, assessments and treatment plans
- discharge procedures and referrals
- explanation of medication
- counselling

Free Telephone Interpreting Service (TIS) available 24 hours: 1300 131 450

Free onsite interpreting for GPs: 1300 655 081

(For advice on determining adequacy in English see TMHC Clinical Consultation and Assessment Service handout)

Transcultural Mental Health Centre (TMHC)
Clinical Consultation and Assessment Service

(02) 9840 3767 or (02) 9840 3899 Toll free: 1800 648 911

For free online multilingual information visit our website: www.tmhc.nsw.gov.au

(For further information see TMHC Clinical Consultation and Assessment Service handout)

Carer Issues

There are a number of ways in which a GP/mental health professional can work with NESB carers in a crisis situation.

- Acknowledge the traumatic nature of dealing with the situation for all those involved.
- Do not assume that the carers have any knowledge about the mental health system. If the patient/consumer has to go to hospital reassure the carers that admissions to hospital are generally very short and that there are legal processes to be followed to ensure the patient's rights.
- Explain that, if necessary, interpreters are available in hospital for speaking with the treating health professionals and for a Magistrate and Tribunal Hearings.
- It may be necessary to explain some of the characteristics underpinning the Australian health system, for example, responsibility to the individual consumer (privacy) rather than a systemic approach involving the family. Also, the fact that food and nursing care is provided in the hospital (rather than by the family) and that often there are specific visiting hours.
- Make them aware that there are services available to support carers.
- There is translated information available from the TMHC on various mental illnesses.
- The TMHC Clinical Services through its sessional workers can provide psycho-education for carers.

Working Cross Culturally

Why is cultural competence important in assessment?
The ability to work across cultures competently involves a capacity to interact with, and be accepted by, individuals from culturally diverse groups. This provides a setting for the correct assessment and diagnosis of problems.

An inappropriate understanding of the influence of culture on behaviour can result in the following errors:

- diagnosing variations in normal behaviour as evidence of mental illness
- diagnosing signs and symptoms of mental illness or distress as cultural differences
- ineffective treatment as often the severity of an illness is over or under estimated
- failure to engage client or maintain contact with client
- failure to use family as an appropriate resource
- reinforcing barriers to access to mental health services

In an **emergency situation**, where for example a person is acutely suicidal or homicidal, it may be very difficult to do an appropriate assessment. It may be that issues of safety and duty of care are of primary concern and that the immediate priority is to arrange the transfer of the patient to a safer situation where a proper assessment can be done.

However, even in an emergency, it is important to be aware of some of the barriers to appropriate assessment of people from non-English speaking background (NESB):

- communication difficulties in both language and the words used to describe distress
- stigma attached to mental illness may lead to delays in seeking help and non- disclosure of symptoms
- somatic symptoms may be the main form of presentations in some ethnic groups
- inaccurate assessment of severity of an illness if patient and family 'collude' to cover symptoms
- physical manifestations of stress and illness are modulated by culture- not showing emotion may be a sign of strength in some cultures and lack of response in others
- vocabulary for emotional states varies greatly across cultures

Language

- it is difficult to judge abnormality in a second language when the individual is not fluent in that language
- fluency is often lost in the presence of depression, psychosis or stressful situations
- fluency can be difficult to assess

ACUTE MENTAL HEALTH PRESENTATIONS

Thought content

- Some religious or cultural beliefs may be interpreted as delusional when they are not
- Magical beliefs concerning the cause of ill-health may be mistaken as delusions

Assessment of suicide

The suicide rate of immigrants reflects the country of origin. In Australia immigrants from Northern and Eastern European countries have a higher suicide rate than those from Mediterranean countries. Completed suicide is generally higher among men than women, with the exception of China where women, mainly in rural areas, have a higher suicide rate. There is evidence that younger women may also be at higher risk in Islamic countries although data from these countries is scarce.

Suicide risk is strongly influenced by a person's beliefs and religious faith. Religions such as Judaism, Christianity and Islam have a strong prohibition on suicide. Such taboos may be protective.

Factors commonly associated with immigration and refugee experiences may increase an individual's risk and these include:

- traumatic experiences or prolonged stress, prior to or during immigration
- prejudice and discrimination by the host population
- non-recognition of overseas qualifications and low English literacy
- decrease in socio-economic status
- separation from family and friends
- barriers to mental health services
- social isolation
- low levels of English language proficiency
- breakdown of traditional and family support structures (especially family and relatives, religious and social and cultural networks)

Methods of suicide amongst NESB communities often differ from popular methods among the Australian-born. When assessing availability of a means of suicide it may be necessary to consider popular methods within the particular community. For example, ingestion of pesticides or self-immolation.

With young NESB people attention needs to be paid to the intergenerational issues such as conflict between the culture of parents and peers.

Assessment tools

Barriers to proper assessment include the GP/ mental health worker not taking complaints seriously or using psychiatric tests standardised on English-speaking background (ESB) populations without considering cultural bias.

For example, the standardised mini-mental state examination has been shown to be unreliable in elderly with poor English and poor education.

Gathering information/patient history/cultural history

Should include, when possible, the patient, family, friends, bicultural health workers, ethnic community leaders.

Some knowledge of specific cultures and some understanding of patterns of difference can be useful, *provided they are not applied as stereotypes to the individual patient/consumer.*

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Insight needs to be assessed in terms of the individual's understanding of the illness, that is, their 'explanatory model'. The understanding should include their explanation for the cause, why it has led to the illness and why now, and possible ways of dealing with it.

(See the Cultural Awareness Tool)

Medication

There are substantial variations in drug responses between ethnic groups. For example, the rate of metabolisation of psychopharmacological medications can vary between ethnic groups depending on the presence of particular enzymes responsible for the metabolism of these medications. Side effects of psychotropics can be dosage related. It may be necessary to start the patient on a lower (or higher) dosage than is generally recommended. Neuroleptic levels in Asians should be 50% of those used in Caucasians as neuroleptic blood levels are higher for a given neuroleptic dose. Ethno-pharmacology is a complex field, for further information please refer to *Lambert and Minas. (1998) Ethnopharmacology. Australasian Psychiatry.*

The Mental Health Act

The *Mental Health Act* specifies that the 'religious, cultural and language needs' of patients be taken into account throughout the different stages of their care, control and treatment, and that they must be informed of their legal rights and entitlements in 'the language or terms that they are most likely to understand'. These provisions are particularly important in relation to those patients from a non-English speaking background.

- people from Non-English Speaking backgrounds are more likely to be in hospital involuntarily– that is, a higher proportion of NESB patients are involuntary
- voluntary entry into the service system is at a reduced rate for people of NESB
- people from NESB are over-represented in the forensic population.

Policy On Interpreter Use

If health care providers have difficulty understanding the patient/consumer interpreters must used:

- to explain the person's rights under the Act
- to obtain informed consent to ECT
- at the Magistrate's Inquiries and Mental Health Review Tribunal Hearings

The writing of a Schedule does not legally require an interpreter, any subsequent psychiatric examination does.

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