Homelessness

amongst culturally and linguistically
diverse people with a mental illness

An Australian study of industry perceptions

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Contents

Foreword

It is very pleasing to witness the publication of *Homelessness amongst culturally and linguistically diverse people with a mental illness: An Australian study of industry perceptions.* This report shines a light on a largely forgotten segment of our population, of whom little is known and for whom not enough is done. It represents a first step in developing our understanding of pathways to homelessness for consumers from diverse backgrounds, and a way forward to improve service delivery.

This report is the product of a partnership between Multicultural Mental Health Australia (MMHA) and the Victorian Transcultural Psychiatry Unit (VTPU). It involved a review of the existing literature, development and distribution of a national survey to homelessness, mental health and ethno-specific organisations, and analysis of the data gathered. The support and involvement of the National Homelessness Research Project Reference Group has been crucial to the project, from inception to completion.

To this end, I would like to thank personally each member of the Reference Group: Margaret Augerinos, a delegate of Homelessness Australia; Sarah Kahn from the Council to Homeless Persons; Sean Lappin of Mission Australia; George Mudford of Yfoundations; Daryl Oehm of the VTPU; Wendy Smith of Psychiatric Disability Services of Victoria; and MMHA staff members Georgia Zogalis and Meher Grigorian.

One of the most important findings of this report is the need to improve data collection on culturally and linguistically diverse (CALD) Australians. Inadequate data collection on this section of the population has, in all likelihood led to its exclusion or under-representation in overall homelessness statistics. This, in turn, increases the risk of a misallocation of resources and deployment of culturally unsustainable models of care.

We shall not know how to help our fellow Australians until we understand who they are and what they need. This report reminds us of that simple fact.

I would like to thank the key people who developed this report: Brendon Moss, Dr Madeleine Valibhoy and Anna Walker of the VTPU. Congratulations on your achievement and thank you for your hard work.

I also thank the Australian Government Department of Health and Ageing, whose support and funding made this project possible.

I commend the *Homelessness amongst culturally and linguistically diverse people with a mental illness* report to you, and hope that it will contribute to the establishment of better health outcomes for all Australians, particularly those with a mental illness who are homeless.

Professor Abd Malak, AM
Chair, Multicultural Mental Health Australia

Acknowledgements

Executive Summary

The overall aim of the current project was to gain a baseline understanding of homelessness amongst Australian people from CALD backgrounds experiencing a mental illness. The current study examines homelessness in CALD communities with regard to:

- The quality and reliability of CALD data collection in homeless services.

- Homeless prevalence rates for people from CALD backgrounds who are identified as suffering from a mental illness.

- The precipitating and perpetuating factors of homelessness for people from CALD backgrounds, including mental illness and other psycho-social factors.

- The means of identifying CALD communities and population groups most vulnerable to homelessness.

- Current access and equity strategies employed by homelessness services to address access issues for clients from CALD backgrounds and communities.

- Referral pathways for clients from CALD backgrounds to and from homelessness services.

- Development of a data collection template and a cultural responsiveness tool for organisations that provide services to homeless clients (Appendix V and VI respectively).

A survey questionnaire was designed to collect both quantitative and qualitative data to address these research questions. Following an initial pilot phase that included nine organisations, the questionnaire was refined and placed online using SurveyMonkey™.

Target organisations for the research project included those that provided services to homeless consumers as well as mental health services and ethno-specific/multicultural organisations. There were 121 respondents to the survey, comprising 34 homelessness organisations, 49 mental health services, and 38 ethno-specific/multicultural organisations.

Discrepancies between reported incidences of homelessness amongst CALD populations and other results from quantitative data were further clarified by focus group and follow-up telephone discussions.

Analysis of the research data identified the following key issues for CALD clients experiencing homelessness:

- Poor data collection regarding CALD service users in general.

- Incomplete recording of pertinent information regarding clients' cultural backgrounds, diagnoses of mental illness and current residency status. This inhibited development of informed and targeted strategies to address homelessness in CALD populations.

- Increased risk of homelessness for people from CALD backgrounds with a mental illness.

- A lack of formalised partnerships and referral pathways between organisations serving homeless populations.

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- Poor support structures for users of homeless services from CALD backgrounds.

- Increased risk of long-term homelessness amongst immigrant populations from CALD backgrounds due to lack of resources.

The recommendations arising from this study are to:

- Implement standardised national data collection for homelessness services in recording prevalence and cultural information on people with mental illness from CALD backgrounds, with a view to more accurately targeting interventions to prevent homelessness and associated mental health issues.

- Collect more accurate data on the prevalence of mental illness and disability.

- Ensure greater accuracy in documenting the source(s) of diagnoses and any presenting mental illnesses.

- Enhance formalised partnerships between homelessness, mental health and CALD service sectors, including social and welfare services, community groups and government.

- Implement a national cultural responsiveness framework for the homelessness sector.

- Target interventions with specific high risk groups based on accurate data sets.

- Allocate further resources to research the needs of CALD groups at risk of homelessness.

Advances in strategies to prevent and reduce the incidence of homelessness in this demographic are reliant on better social integration policies for at-risk youth and refugees; improved prevention, early intervention and treatment services for clients from CALD backgrounds with a mental illness; and improved partnerships between services to facilitate access and referral to appropriate intervention and treatment services. These findings are consistent with gaps in service delivery to clients from CALD backgrounds across a number of sectors and reflect a need for better representation, and an enhanced focus on the specific needs of immigrant populations to prevent their marginalisation.

Introduction

Those who are homeless or indeed vulnerable to homelessness face a multitude of difficulties that largely exclude them from participating in the wider community. Being homeless makes it difficult to maintain employment or education, can have a considerable impact on a person's health and wellbeing, and can perpetuate intergenerational and other disadvantages.

Mental illness increases a person's vulnerability; it can fundamentally affect how a person feels, thinks, behaves and deals with managing the demands of their day-to-day life. It is reasonable to say that people who are homeless are often dealing with high prevalence mental disorders, such as depression or anxiety. It is also reasonable to say that those people, who are homeless as a result of a low prevalence mental illness, such as schizophrenia, psychosis or bi-polar disorder, constitute one of the most disadvantaged and at-risk groups in our society.

A person from a culturally and linguistically diverse (CALD) background with a mental illness who is homeless is particularly vulnerable. An already difficult situation is accentuated by language difficulties, unfamiliarity with service systems, social dislocation due to immigration, alienation from culture and community, grief related to experiences of torture, trauma and separation, and limited culturally appropriate service options.

Despite the recent refocus on access and responsive service provision aimed at improving social inclusion for all Australians (of which addressing homelessness is an integral part), it seems that issues affecting people from CALD backgrounds continue to be peripheral and that implementation strategies tend to overlook the particular needs of this group.

Accordingly, in 2010 Multicultural Mental Health Australia (MMHA) entered into a partnership with the Victorian Transcultural Psychiatry Unit (VTPU) to conduct research on the extent of homelessness of people from a CALD background with mental illness, in an attempt to gain a baseline understanding of this issue in Australia. This project was initiated by MMHA and funded by the Australian Government Department of Health and Ageing whilst being supported by a reference group that included senior staff from Homelessness Australia, Council to Homeless Persons, Mission Australia, Yfoundations, Psychiatric Disability Services of Victoria (VICSERV), MMHA and the VTPU.

This project endeavoured to answer the following questions:

1. Do homelessness services (both peak state-based and national) collect CALD and mental illness data on their client base?

2. From the data and anecdotal evidence available, what are the (reported) homelessness prevalence rates of people from CALD backgrounds with mental illness in Australia? What can be inferred about the *actual* rates (as opposed to reported rates)?

3. What are the reported precipitating and perpetuating factors of homelessness for people from CALD backgrounds with mental illness in Australia? Are these factors similar or different from those affecting the mainstream population?

4. Within CALD communities, what are the reported population groups most at risk of becoming homeless?

5. To what extent are access and equity strategies implemented by all state-based and national peak services for the homeless in their responses to homeless people from CALD backgrounds with a mental illness?

6. What are the referral pathways to the service, and pathways to health and mental health care from the service? Are services readily accessible to clients from CALD backgrounds? Are the rates of service access for people from CALD backgrounds with mental illness comparable with those rates that are applicable to people from the mainstream community?

A national survey was developed and distributed to capture responses on the topic of homelessness amongst CALD communities. The survey was distributed to hundreds of organisations providing services to homeless consumers, mental health organisations, and ethno-specific/multicultural organisations in all states and territories of Australia.

The current research identified issues regarding the collection of data associated with clients from CALD backgrounds with a mental illness, in particular the use of multiple and varying identifiers to define both CALD and mental illness. Inadequate data collection on this population leads to their exclusion or under-representation in overall homelessness statistics. Adequate data collection on this group is imperative if we are to understand the extent to which CALD populations are affected, their specific needs and the appropriate means of addressing these issues.

Additionally, this research showed that although it would seem that CALD communities are impacted by similar precursors to homelessness as the mainstream population, many of the underlying drivers may be related to various acculturation issues that may be better addressed through targeted interventions. An example of this would be helping newly arrived immigrants acclimatise to local environments, particularly in negotiating local service systems. The lack of formal partnerships across and between services, coupled with consumers' difficulties in accessing culturally appropriate services - be they mental health or homelessness - strengthens the case for more targeted initiatives that directly address these two issues.

Part One

Literature review

Homelessness

In Australia every night around 105,000 people are homeless (Australian Government 2008b). People who are homeless include men, women and children from all age groups and cultural backgrounds. Homelessness can potentially affect anyone, at any time and has a multiplicity of causes (Australian Government 2008b; Australian Institute of Health and Welfare, 2009).

Interactions between homelessness and other forms of exclusion are very complex. Homelessness can lead people to be excluded socially and economically and may intensify health related conditions including mental illness (Mental Health Council of Australia 2009; St Vincents Mental Health Service & Craze Lateral Solutions, 2005).

Mental illness can also play a role in social and economic exclusion and it appears that people who are chronically homeless are far more likely to have complex needs in relation to physical health, mental health, substance abuse and disability (Australian Government 2008b). And when this is combined with poor English proficiency, the potential to exacerbate all the above issues and disrupt access to services may be increased (Stolk, Minas, & Klimidis, 2008; Wositzky, 2001).

It is clear that homelessness is more than just a lack of appropriate housing. The current housing crisis is a critical issue. Private rental vacancies are at an all-time low (less than a 1% vacancy rate across a number of states in Australia in 2010), rental prices are at an all-time high and there is a critical shortage of social housing (public and community). Research also suggests that there are close to 30,000 less public and community properties in Australia than there were a decade ago. This, in turn, has resulted in a tightening of eligibility criteria, effectively locking many of those experiencing housing stress out of social housing (Refugee Council of Australia, 2009).

One of the main sources of information regarding homelessness in Australia, *Counting the Homeless,* is based on data from the 2006 ABS Census of Population and Housing, and is supplemented with data from the Supported Accommodation Assistance Program (SAAP) (Australian Government 2008b). The ABS uses the "cultural" definition of homelessness (Box 1.0).

The cultural definition of homelessness facilitates a systematic collection of data, and reflects the minimum acceptable standards of housing in Australia. This is seen as a room to sleep in, with a bathroom and kitchen and some sort of secure tenure (Mental Health Council of Australia 2009; St Vincents Mental Health Service & Craze Lateral Solutions, 2005). It is not dependent on a person's subjective view of their housing situation. Other definitions incorporate considerations such as perceptions that a person's home is likely to damage their health or place them at risk of eviction. (Shelter SA 2004; St Vincents Mental Health Service & Craze Lateral Solutions, 2005).

Box 1.0: Cultural definition of homelessness

Primary homelessness includes all people without conventional accommodation, such as people living on the streets, sleeping in parks, squatting in derelict buildings, or using cars or railway carriages for temporary shelter.

Secondary homelessness includes people who move frequently from one form of temporary shelter to another. On census night, it includes all people staying in emergency or transitional accommodation provided under the Supported Accommodation Assistance Program (SAAP). Secondary homelessness also includes people residing temporarily with other households because they have no accommodation of their own and people staying in boarding houses on a short-term basis, operationally defined as 12 weeks or less.

Tertiary homelessness refers to people who live in boarding houses on a medium- to long-term basis, operationally defined as 13 weeks or longer. They are homeless because their accommodation situation is below the minimum community standard of a small self-contained flat.

Source: Counting the Homeless (Chamberlain & MacKenzie, 2008)

Defining cultural and linguistic diversity

There is considerable debate over the definition of culture, a cultural group and identifying groups through ethnicity. Mays, Siantz and Viehweg (Ethnic Communities Council Victoria 2006) defined culture as the interplay of many elements which include behaviours, customs, beliefs, values and institutions.

Community has historically been defined in a similar way to culture, as a group of people who share a common identity. Culture and community are inextricably linked and it stands to reason then that both culture and community can influence a person's perceptions and interactions in everyday life. These concepts, and in particular the concept of culture, are dynamic. Over time, culture will change and members of a particular culture or ethnicity will not always think, act or behave in ways which are typical of their background (Ethnic Communities Council Victoria, 2006).

Cultural and linguistic diversity can therefore be said to refer to "the range of different cultures and language groups represented in the population who identify as having particular cultural or linguistic affiliations by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home" (Department of Health, 2009, p4).

Defining mental illness

Defining mental illness is not a straightforward process. Definitions depend on the context of use and range from a broad understanding of mental health issues to narrower clinical approaches (St Vincents Mental Health Service & Craze Lateral Solutions, 2005).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) provides perhaps the most oft-cited conceptualisation of mental disorders, ranging widely from psychotic disorders to non-psychotic disorders, mood disorders, anxiety disorders, personality disorders and substance use disorders (American Psychiatric Association 2000).

According to the Australian Government Department of Health and Ageing (2007), a mental illness is a health problem that significantly affects how a person feels, thinks, behaves, and interacts with other people, diagnosed

according to standardised criteria. Findings from the Australian National Survey of Mental Health and Wellbeing (2007) show that almost half of the population (45.5%) met the criteria for a mental disorder at some stage in their entire lifetime. These figures included high prevalence disorders such as depression and anxiety as well as substance use disorders. Mental disorders are experienced with different levels of severity and low prevalence disorders, often referred to as serious mental illness, can be particularly disabling (Slade, Johnston, Oakley Brown, Andrews, & Whiteford, 2009).

The symptoms of mental illness may reduce a person's quality of life and make managing the demands of day-to-day life, including work, study and relationships, more difficult. Of particular significance to this report is how mental illness impacts on maintaining stable accommodation, the ability to access services and gain appropriate responses from services (Mental Health Council of Australia, 2009).

The policy and service context

In May 2008 the Federal Government released the Green Paper *Which Way Home? A New Approach to Homelessness* (Australian Government 2008a). Subsequently, consultations were held around Australia and there were more than 600 written submissions. The general consensus was that Australia's response to homelessness needed to improve.

Submissions urged the government to focus on prevention and early intervention, affordable housing, flexibility of housing and support models, development of workforce strategies and the need for a better understanding of the complexities of homelessness. Some submissions highlighted the need to address homelessness among people from CALD backgrounds, including the needs of refugees and asylum seekers (Hanover Welfare Services 2008).

Following the Green Paper, the White Paper *The Road Home: A National Approach to Reducing Homelessness* was produced, which outlined the Federal Government's vision. The stated aims, with the agreement of state and territory governments, are to:

• Halve overall homelessness by 2020.

• Offer supported accommodation to all rough sleepers who need it, by 2020 (Australian Government 2008b).

The White Paper states that homelessness can be prevented by addressing the structural drivers of homelessness, such as unemployment and the absence of affordable housing,

to name a few. It also emphasises the challenges that can be faced by persons who need to approach services, such as health, employment, family violence and specialist homelessness services, separately or in combination. *The Road Home* identifies the need for service delivery to be more co-ordinated and for greater co-operation between these services (Australian Government 2008b).

The Supported Accommodation Assistance Act (1994) is a significant piece of legislation targeting homelessness. It brought together a range of homelessness programs under one nationally co-ordinated program. This act has now been subsumed under the National Affordable Housing Agreement (Urbis 2009). The legislation is framed in a rights-based approach, and within the preamble reference is made to the protection of universal human rights and fundamental freedoms (Urbis 2009). Interestingly, international conventions such as the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights (which include the right to adequate housing) are referred to in the preamble but not included in the body of the legislation. Consequently, these conventions are not enforceable in Australian Law (Urbis 2009).

The new National Affordable Housing Agreement (NAHA), which commenced in January 2009, and the National Partnership Agreement (NPA) provide the overarching policy framework for government responses to homelessness (Urbis 2009). Implementation plans have been agreed to between each state and territory, as well

as the Federal Government. The NPA contains three broad strategies, which are:

1. Prevention and early intervention to stop people becoming homeless.

2. Breaking the cycle of homelessness.

3. Improving and expanding the service response to homelessness (Council of Australian Governments (COAG) 2009).

In addition to the overarching federal approach, each state has developed its own regulatory and service delivery framework for homelessness services. However, these policies and strategies make little reference to people from a CALD background. The Victorian standards mention that services must be culturally appropriate. The ACT homeless strategy refers to the enhancement of skills amongst service providers for the provision of culturally appropriate support, while Western Australia's strategy states that all services must be accessible to CALD clients. A summary of these quality frameworks and the legislative instruments on which they are based can be seen in Box 1.1.

Box 1.1: Quality frameworks for homelessness and related services across Australia

Jurisdiction	Legislation / International Instrument	Policy / Quality Mechanism	Relevant Section
Victoria	*Charter of Human Rights and Responsibilities Act* 2006 *Residential Tenancies Act* 1997	Homelessness Assistance Service Standards (HASS) Homelessness Advocacy Service (HAS)	Section 2.6
Queensland	*Residential Tenancies and Rooming Accommodation Act* 2008 *The Residential Services (Accreditation) Act* 2002	Standards for Community Services (2007)	Section 2.7
New South Wales	*Residential Tenancies Act* 1987 (NSW)	Performance Monitoring Framework for SAAP services NSW SAAP Standards 1998	Section 2.8
Australian Capital Territory	*Human Rights Act* 2004 *Residential Tenancy Act 1997* (ACT)	Homelessness Charter (the Supported Accommodation Assistance Program Guarantee) ACT Service Guarantee Good Practice Standards 2002	Section 2.9
South Australia	*Residential Tenancies Act* (1995) *Local Government Act* (1934) *Public Health and Environment Heath Act* (1989) *Development Act* (1993)	SAAP Performance Management Framework 2005	Section 2.10
Tasmania	*Residential Tenancy Act 1997*	Tasmanian SAAP Service Standards 2006 Community Services Core Module Standards	Section 2.11

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Jurisdiction	Legislation / International Instrument	Policy / Quality Mechanism	Relevant Section
Western Australia	*Residential Tenancies Act 1987* (WA) *Health Act Local Laws* (pursuant to the *Health Act 1911*)	WA SAAP Service Standards 2002	Section 2.12
Northern Territory		NT SAAP Service Standards 1998	Section 2.13

Source: (Urbis 2009)

Pathways to homelessness

While mental illness may be identified as one of the pathways into homelessness, there are many others. Both individual and systemic factors can pave the way to homelessness (Australian Government 2008b; Hanover Welfare Services 2008).

One of the major factors contributing to homelessness is the lack of appropriate and affordable housing. The supply of housing over the past fifteen years for those on low incomes has not met the needs of the population (Pressnell & Chamberlain, 2006). According to Mission Australia, those who are marginally housed may experience difficulties in gaining alternative accommodation and for those who are already homeless it increases the difficulty in securing accommodation (Hanover Welfare Services 2008).

An underlying feature of the homeless population is the predominance of low incomes and poverty. Many in this group also experience unemployment. The income profile of people seeking assistance through SAAP shows that most people are reliant on government income support, and most are either unemployed (23.5%) or not in the labour force (67.9%) (Hanover Welfare Services 2008).

Additional factors contributing to homelessness can include family breakdown, intergenerational disadvantage, limited education, domestic violence, drug and alcohol use, problem gambling, involvement in the juvenile justice or prison system, or exiting the care of the state. It should be noted that information regarding pathways to homelessness for CALD populations in Australia is limited, mainly focusing on the subgroups mentioned in the following section. Much of the international literature that was reviewed focuses on homelessness as it affects specific ethnicities. (Gervais & Rehman, 2005; Ransley & Drummond, 2001; Shelter SA 2004)

Homelessness among culturally and linguistically diverse communities

Services under the Supported Accommodation Assistance Program (SAAP) are the predominant response to homelessness and from the data that is collected it is evident that people coming from non-English speaking countries are under-represented in their use of these services. In addition, they are less likely to return for support (Urbis 2009). Limitations of the SAAP data, in terms of the information collected about CALD populations, have been noted by researchers in the field (Francis & Cornfoot, 2007).

The SAAP National Data Collection Annual Report 2007-08 shows that immigrants were generally under-represented in their use of SAAP services, which may indicate issues with access to services. However, those from North Africa, the Middle East and sub-Saharan Africa were over-represented (Urbis 2009). Reasons for the over-representation of these groups are not well understood and this is recognised in the government's discussion paper (Urbis 2009). It may be the case that immigrants from North Africa, the Middle East and sub-Saharan Africa were more likely to

be humanitarian entrants (with refugee backgrounds), compared to immigrants from Europe, Asia and the Americas, who are more likely to be skilled immigrants (Department of Immigration and Citizenship 2009).

Regarding the general under-representation of CALD populations, the government discussion paper suggests that cultural barriers to accessing SAAP services could exist or that there may be a lack of knowledge about such services in these communities (Australian Government 2008a). There is also the suggestion that this group may have access to different support groups in their communities or have extensive family networks (and hence not present as frequently to the formal service system). Currently, however, there is insufficient evidence to support this supposition (Urbis 2009).

According to Homelessness Australia, more than one in ten people who used services for people who are homeless are from a non-English speaking background (Homelessness Australia 2007). In comparison, out of Australia's total population, 22.2% is born overseas and 15.8% speaks a language other than English at home (Australian Bureau of Statistics, 2006).

Much like the limited information on pathways to homelessness for CALD populations, little is also known about the extent of homelessness in CALD communities. Census data on homelessness does not include country of birth or languages spoken, while migration data collection on cultural and ethnic identity, languages spoken and visa streams is minimal (Ransley & Drummond, 2001).

The bulk of the research literature currently available on homelessness in Australia's CALD communities relates to two main sub-groups of CALD service users. These are: a) women and children escaping from domestic violence, and b) youth, in particular, those from a refugee background (Aly & Gaba, 2007; Ransley & Drummond, 2001).

Women escaping domestic violence who come from CALD backgrounds face many challenges and barriers to accessing appropriate services, while the challenges of finding crisis accommodation for some groups of these women is heightened (Alimant & Ann, 2008). In the report *No Place to Go,* some of the issues highlighted are: inappropriate environment, the perception that information

may not be kept confidential, cultural differences with service providers and other residents, language difference, religious difference and a sense of guilt and shame (Aly & Gaba, 2007).

It should also be noted that women from CALD communities can be particularly vulnerable to violence as they may be less likely to have social supports and economic resources to assist them to leave a violent relationship (Aly & Gaba, 2007; NISWA, 2009), and even the act of leaving may be seen as inappropriate by many. Critically, people from CALD backgrounds who are homeless, including those escaping domestic violence, often face additional barriers in accessing the resources and support they need. Principal amongst these barriers are language difficulties and a lack of understanding of the local service system (Aly & Gaba, 2007; Gervais & Rehman, 2005; NISWA, 2009).

Systemic barriers can also compound issues, and often due to insufficient funding and other related issues, agencies can find it difficult to develop and employ cultural competence in individual staff members or across a service. This can result in a variety of problems, including staff members not having a sound understanding and knowledge of cultural issues, not engaging with or using interpreters appropriately, and even racism and discrimination (Aly & Gaba, 2007). While these barriers have been noted in relation to women, it is likely that these also apply to other sub-groups from CALD backgrounds that are homeless.

Youth homelessness is sometimes less evident, particularly in newly arrived refugees, as it often takes the form of gross overcrowding or 'couch surfing', which people often do not consider to be a form of homelessness. In a survey of 70 young people, 55 identified homelessness in its primary form of 'rough sleeping' and did not identify temporary accommodation with friends as being homeless (Association for Services to Torture and Trauma Survivors 2008).

According to a report written by the Centre for Multicultural Youth Issues (Ransley & Drummond, 2001), young people from refugee backgrounds are six to ten times more likely to become homeless than other young people. They face a number of disadvantages compared to other young people: they are less likely to fully establish

economic viability and social networks, they may have problematic family relationships, and their experience of trauma in the past may affect their settlement in a new country. Many face additional disadvantage due to language barriers, a lack of a rental history, lack of knowledge of the service system and experiences of discrimination. Some may also find accommodation offered by services to be culturally inappropriate, with particular reference to gender and segregation, while prayer space (or

lack thereof) and food preparation can present additional problems for this group (Francis & Cornfoot, 2007).

From our reading of the available literature, little research has been undertaken exploring and documenting the experiences of people from CALD backgrounds in the homeless service system. This may be related to the scarcity of data on this group (Ransley & Drummond, 2001).

Homelessness and mental illness

There appears to be a greater prevalence of mental illness and substance use amongst the homeless compared to the mainstream population, leading some to deduce that these are factors that cause homelessness. Much of the available literature states that mental illness increases a person's vulnerability to becoming homeless as this may fundamentally affect a person's organisational skills, relationships, employment opportunities and their ability to maintain tenancy (Australian Government 2008b; Johnson, 2006; Mental Health Council of Australia 2009; St Vincents Mental Health Service & Craze Lateral Solutions, 2005).

Some mental health related problems precede a state of homelessness, while some are a consequence of homelessness. However, determining the number of homeless consumers who experience a mental illness is very difficult, as estimates vary considerably. Such estimates may depend on whether the illness is self-reported, reported by staff not trained in mental health, or reported by a specialist mental health service. There is uncertainty around the accuracy of some diagnoses reported by homeless services (Harvey, Evert, Herrman, Pinzone, & Gureje, 2002; Johnson & Chamberlain, 2009; Mental Health Council of Australia 2009; St Vincents Mental Health Service & Craze Lateral Solutions, 2005). What is clear is that, regardless of having a mental illness prior to or as a consequence of homelessness, "most people with mental health issues experienced long-term homelessness" (Johnson & Chamberlain, 2009, p1).

While there is debate about the actual extent of mental illness within the homeless population, there is general agreement that there is an increased prevalence of mental illness in this group (Fazel, Vivek, Doll, & Geddes, 2008;

Johnson & Chamberlain, 2009). In western countries in particular it seems that homeless people are much more likely to have alcohol and substance use issues (Fazel, et al., 2008). There also seems to be a much greater incidence of mental illness in relation to low prevalence disorders, otherwise referred to as serious mental illness, or psychotic disorders that include schizophrenia, bipolar affective disorder, and related psychotic disorders (Harvey, Evert, Herrman, Pinzone, & Gureje, 2002).

The literature suggests that differences in statistics relating to overall levels of mental illness and homelessness may be due to methodological issues. Some research has lacked clear definitions of homelessness and had poorly defined mental health diagnostic categories. Psychiatric evaluations have not always been based on the diagnoses of skilled clinicians (Herrman, 2008; Johnson & Chamberlain, 2009).

The importance of collecting sound data is highlighted in the report *Home Truths,* by the Mental Health Council of Australia (2009). They argue that without definitive statistics, it is not possible to know whether people from CALD backgrounds were being reached by existing programs, what proportion required treatment or whether the treatment received was effective (Mental Health Council of Australia, 2009).

Stigma is also considered to be a major issue for those suffering mental illness and homelessness. In a survey conducted by SANE, 90% of those interviewed believed they had been discriminated against because of their mental illness, particularly in seeking private and rental accommodation. This often resulted in people from this group accepting unsafe or substandard housing options

(SANE Australia 2008). As stigma is a significant issue in many CALD communities, it can contribute to a reluctance to accept and present for the treatment of mental health problems, thereby preventing a formal diagnosis (Multicultural Mental Health Australia, 2010c).

The need for services to respond effectively to people with mental illness who are homeless or at risk of homelessness is essential. "They require mental health services in addition to social support, housing, and economic security to alter their life circumstances" (Harvey, et al., 2002, p44).

Culturally and linguistically diverse communities and mental illness

It is widely acknowledged in the mental health sector that people from CALD backgrounds do not access mental health services at a comparable rate to those from the mainstream community (Australian Government, 2004; McDonald & Steel, 1997; Stolk, et al., 2008). The reasons for this are, in all likelihood, related to a range of "service barriers and psychosocial factors in ethnic communities, contributing to presentation to mental health services… late in the course of a disorder" (Stolk, Minas, & Klimidis, 2008), rather than lower rates of mental illness in CALD communities.

Some of the major identified barriers include: language, lack of information regarding services, communication, stigma, inappropriate use or lack of appropriate interpreters, and cultural differences between clients and clinicians (Australian Government, 2004; McDonald & Steel, 1997; St Vincents Mental Health Service & Craze Lateral Solutions, 2005). These issues were highlighted in MMHA's series of state and territory consultations on the mental health needs of CALD communities, held between 2007 and 2010 (Multicultural Mental Health Australia, 2010c).

Additionally, it has been noted that people from CALD backgrounds are often unaware of the range of services and supports available and very frequently misunderstood how these services operated (National Ethnic Disability

Alliance (NEDA), MMHA, & Australian Mental Health Consumer Network (AMHCN) 2004).

The difficulty in acquiring data about CALD communities and mental illness is highlighted in the report by the Victorian Government inquiry into supported accommodation for Victorians with a disability and/ or mental illness. The report points out that under the Mental Health Act 1986, respect for privacy and dignity is highlighted. Consequently, people do not have to provide information about their background or country of birth in order to receive a service (Family and Community Development Committee 2009).

It is widely acknowledged that there is a need for services to become more adept at working with people from a CALD background by adopting culturally competent practices (Alimant & Ann, 2008; Homelessness Australia 2007; Multicultural Mental Health Australia, 2010a; Wositzky, 2001). This may include working appropriately with interpreting services, consulting with consumers and carers, engaging in greater community development and training, employing bi-cultural staff to work with CALD consumers, and/or utilising the MMHA National Cultural Competency Tool for Mental Health Services (Multicultural Mental Health Australia, 2010a).

Case Study

Sarah*   By Jill Parris

When I first met Sarah* she was angry. She was angry because the police had found her washing her clothes in a creek alongside a country road and had brought her to a homeless shelter.

At first Sarah would not talk to me at all. She would just look at the door and cry. When she finally began to trust me, she revealed that she had left Shepparton in Victoria because the police had refused to allow her to visit her children without supervision. She said she was accused of making them sad because she had pulled her little boy out of bed. She told me she had done this to save him from being burnt alive. No-one else could see the red hot flames licking the sides of her son's bed. Her husband called the police and told them she was mad and was always talking and shouting at empty spaces.

Sarah was taken to hospital. She was confused as to why she couldn't be let out, why she couldn't see her children, and why people laughed at her when she longed to be in the sun but couldn't abide the smallness of the garden. She didn't like hospital food and she didn't like the medication. It made her feel sleepy and want to sit in her room. Alone.

Upon her release from hospital Sarah went to stay with a friend. This arrangement didn't work out because she refused to take her medication and kept returning home and upsetting her family. Eventually, Sarah left her friend's place and walked south. She told me that is what she had done as a child when she fled southern Sudan. Back then she had walked south until she came to Kenya.

For eight years Sarah lived in a refugee camp, attending classes under the trees, at times going hungry, and struggling to learn. Her nights were filled with memories of the long journey through a land filled with wild animals and angry people with guns. In 1998 she was offered asylum in Australia.

Sarah said it was better in Australia. It was not so hot and people would give her a bit of money so she could eat. She said she was happy when she first arrived and was grateful to have a safe place to bring her children. But now she wanted to go back. And she didn't want to take her medication. All she wanted to do was to put distance between her and the police and go home. There, she believed, she could bring up her children in a safe place with her mother by her side.

This case study is not about an actual individual but is based on a number of real-life cases not related to the research presented in this report. Rather, the case study has been included to highlight issues service providers may encounter when working with consumers from CALD backgrounds.

Jill Parris is a psychologist who has worked for 24 years in counselling and welfare services. She currently supports refugees settling in Australia at the Brotherhood of St Lawrence's Ecumenical Migration Centre in Fitzroy, Victoria.

Part Two

Overview of
the current study

Methodological Overview

An exhaustive literature search was undertaken by St Vincent's Hospital Library (involving all relevant available databases, yielding more than 50 citations, sourced both nationally and internationally) with additional internet searches undertaken by the authors. The purpose was to identify the current research on CALD homelessness and mental illness; identify relevant literature (both academic and non-academic) and policy and strategy documents that are used to address issues of CALD homeless populations; and draw on staff expertise to highlight relevant mental illness and recovery issues. The aim of this literature review is to provide background information to the research and identify gaps within Australian literature on the relationship between CALD homelessness, mental illness and other precipitating factors.

Consultations

Consultations were undertaken with experts on multicultural mental health and homelessness research. The expert panel was consulted about the research questions, relevant research projects, data collection processes, and the national survey. The group included representatives from:

- Council to Homeless Persons
- Homelessness Australia
- Mission Australia
- Multicultural Mental Health Australia
- Psychiatric Disability Services of Victoria
- Victorian Transcultural Psychiatry Unit
- Yfoundations.

Additionally, a focus group of industry representatives met to discuss the research questions after data collection had been completed and a cursory review had taken place. For an overview of the questions discussed during this meeting refer to Appendix III. The organisations represented in the focus group were:

- Advocacy, Disability, Ethnicity and Community (ADEC)
- Alfred HOPS
- Asylum Seeker Resource Centre
- Doutta Galla Community Health Service
- Hawthorn Asylum Seeker Centre
- Red Cross ASAS
- Sanctuary
- Vincent Care Community Connexions.

The National Survey

Survey design

A national survey was designed to address the research questions, with three slightly varied versions: for organisations providing services to homeless consumers, mental health organisations, and ethno-specific/multicultural organisations. Questionnaire items were developed based on the literature review, contributions of the expert members of the reference group, and consultations with leaders in the sector.

A mixed methods approach was adopted, with both quantitative and qualitative questions. Quantitative questions were a mixture of forced choice questions, multiple response questions, and service-level data collection. For example, a forced choice question was "Do you collect data about homeless clients?", which required the respondent to choose either "yes" or "no". An example of a multiple response question was "What

would make mainstream homelessness organisations more responsive to people from a CALD background with mental illness? (tick all that apply)", with response options including "appropriate use of interpreters; bi-lingual staff; trained staff in cultural responsiveness/competence; accommodation that was sensitive to cultural and religious needs; food that met cultural and religious needs; visual displays conveying respect for cultural diversity; translated information; service has policies on cultural diversity; improved outreach capacity/assistance with transport to service; other: please specify".

Questionnaire items were re-drafted several times, incorporating the feedback of experts on multicultural mental health and homelessness research, followed by a piloting phase, as described in the following.

Piloting phase

Nine pilot surveys were sent out: three to homelessness organisations, three to mental health organisations, and three to ethno-specific/multicultural organisations (reflecting the three slightly varied versions of the survey).

Feedback from the piloting process

In summary, the feedback from the pilot organisations suggested that:

- A random approach to targeting organisations may lead to a low response rate. The pilot organisations all gave verbal commitments to filling in the survey, but still required follow-up phone calls. This suggested that a mailout approach to a randomly selected group of 250 national organisations was not likely to yield a satisfactory response rate.

- Hard copy mailouts requiring a pen-and-paper response were unlikely to be posted back. Most selected pilot

participants requested the survey to be emailed to them, or conducted via phone interview. This lent support to the plan for SurveyMonkey™ to be the primary procedure for conducting the surveys, with supplementary phone interviews.

- Ideally, the questionnaire required shortening.

- Some questions posed difficulties for respondents, particularly on prevalence rates, as this data was not available to the respondent, thus they needed to request input from others (e.g. more senior staff, or IT staff, to run queries on the service database).

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One difficulty was that whilst some questions required a managerial perspective, other questions required a frontline caseworker perspective.

- Based on feedback from the piloting phase several survey questions were modified to secure more specific responses that would be directly relevant to the research questions.

- The survey was shortened and placed on the web using SurveyMonkey™ to increase participation and reduce the time needed by organisations to complete the questionnaire.

Sampling of organisations to survey

The aim of the national survey was to capture responses on the topic of homelessness amongst CALD communities from organisations providing services to homeless consumers, mental health organisations, and ethno-specific/multicultural organisations from all states and territories of Australia. Given the population distribution of Australia, with most Australians residing in the eastern states, it was assumed that the majority of participating organisations would naturally be based in these states. However, due to the methods employed in distributing the surveys, it was not possible to oversample from particular areas to compensate for this.

The advantages and disadvantages of various sampling approaches were considered, with a targeted approach being favoured to increase the response rate and the appropriateness of the services approached. It was decided to use a targeted sampling strategy drawing upon well-established email lists in each sector to send out the survey request and links to SurveyMonkey™. These included mailing lists provided by Multicultural Mental Health Australia, Victorian Transcultural Psychiatry Unit, Homelessness Australia, the individual state Directors of Mental Health, Mission Australia, Yfoundations, Psychiatric Disability Services of Victoria and the Council to Homeless Persons. Links were also posted on the VTPU and Australian National Homelessness Clearing House websites and circulated in newsletters by MMHA, the Federation of Ethnic Communities Councils of Australia, and the VTPU.

Procedure

SurveyMonkey™ was used as the host site for the online survey, and to collate the data. Recipients were also welcome to indicate if their preference was for a hard copy to be posted. It was initially intended to use phone interviews as a complementary method to increase the response rate, to sample hard-to-reach and busy organisations, and to generate more qualitative data and anecdotal findings than electronic respondents could provide. However, it was found that this was difficult to facilitate and the researchers contacted only those organisations that initiated discussions about the survey questions or those who provided data that contained a mistake or typing error.

Data analysis

Quantitative data analysed by SurveyMonkey™ yielded frequencies and percentages, and qualitative responses were analysed to produce summaries and to identify common themes. Results of the mixed methods analysis are synthesised in the discussion.

Anticipated strengths and methodological limitations expected prior to sampling

Strengths:

- The study constituted a first step towards collecting comprehensive, systemic data on CALD homelessness.

- The approach combined verbal and written feedback, specialist input and targeted surveys to collate and cross-check as much data as possible in the time available.

- Researchers were able to draw on the expertise of service providers to the homeless as well as mental health clinicians with clinical and recovery knowledge.

Limitations:

- Low response rates were anticipated due to the generally accepted notion of low response rates for surveys, the high workload in homeless services, and the experience of the pilot survey phase.

- Lack of availability and validity of data collected by the sampled organisations.

- Responses may depend on who within the organisation completes the survey (e.g. managerial perspective vs. frontline caseworker perspective).

Overview of the result collected from survey responses

Overall, 121 organisations responded to the survey.
These comprised:

- 34 homelessness organisations.

- 49 mental health services.

- 38 ethno-specific/multicultural organisations.

Case Study

Ali*

<div align="right">By Jill Parris</div>

Before I met Ali* he had been living in a high-rise building with a lady who had come from the same village in Afghanistan. She had offered him shelter because she knew his family and they had arrived in Australia on the same boat eight years ago. He had been smaller then, and happy to do anything she asked. He was also scared because he didn't know if he would see his family again and so felt immediately comforted by the sound of the lady speaking to him in his mother-tongue.

The apartment Ali and the lady lived in was small and cramped. To escape the noise and confined space, Ali spent most of his time after school with a gang of teenagers who roamed the streets and harassed the locals. They talked loudly and occasionally shook the high fences surrounding Ali's school. The police were called on several occasions but the youths were swift and usually dispersed before the law arrived. However, on one particular occasion Ali did not run as fast as the others. He was apprehended and given a warning.

After this incident, everything changed for Ali. The gang of youths decided they didn't want him around and they began teasing him. He started thinking that everyone was taunting him and began to hear voices. The voices told him that his parents had not wanted him and that this was the reason he was forced to leave Afghanistan. He began to wake at night, shouting, terrified that the lady didn't want him anymore because she now had a husband and children.

Eventually he became so distressed that the lady's family asked for help. He was taken out of their home and placed with another family in the suburbs. Ali knew no-one in his new surroundings. He began to hide in his room. He refused to go to school. Eventually he was referred to a hospital for a psychological assessment and sent to an early psychosis unit.

Once admitted, he quickly responded to treatment and within six months he was ready to be discharged. However, during his confinement he had turned sixteen and was not able to return to the lady's small unit. She told him he could come for visits but there was simply not enough room for him. As an alternative, he was offered shared accommodation with two other young men, both of whom also had mental illnesses. Ali did not feel comfortable with his new living arrangement.

It was some months after this that I met Ali. He was sleeping on the streets and had no medication. He was desperate to get his life back on track.

This case study is not about an actual individual but is based on a number of real-life cases not related to the research presented in this report. Rather, the case study has been included to highlight issues service providers may encounter when working with consumers from CALD backgrounds.

Jill Parris is a psychologist who has worked for 24 years in counselling and welfare services. She currently supports refugees settling in Australia at the Brotherhood of St Lawrence's Ecumenical Migration Centre in Fitzroy, Victoria.

Part Three

Significant findings
from the surveys

Responses from homelessness organisations

Thirty-four (34) homelessness organisations responded to the survey, with 11 from New South Wales, 17 from Victoria, one from Tasmania, three from Queensland, one from South Australia and one whose location remained unidentified.

Of the homelessness services, 87.9% indicated that they collect data on clients from CALD backgrounds, while 63.6% indicated that they collect data specifically on clients from

CALD backgrounds with mental illness. When asked how clients from CALD backgrounds were identified, 90.6% did so using country of birth; however, many services used multiple identifiers (for example, 71.9% allowed clients to self-identify as CALD). The other main identifiers included language(s) spoken, interpreter need and level of English proficiency:

Figure A: CALD identifiers used by homelessness organisations
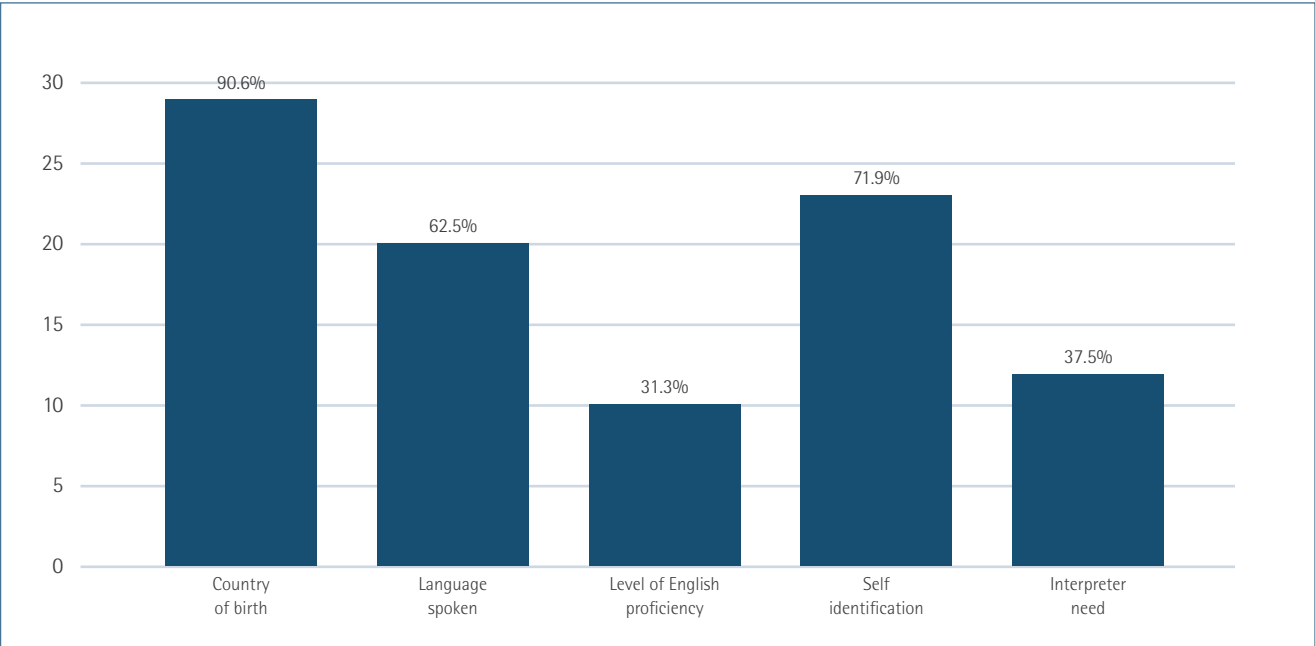
Clients were identified by homelessness services as having a mental illness via formal and informal diagnosis, referral from a mental health service or self-identification.

The majority of organisations (61.3%) agreed that clients from CALD backgrounds faced difficulty in accessing appropriate support after referral to health and mental health services. 78.3% of organisations agreed that unfamiliarity with the service system was the most significant challenge facing clients from CALD backgrounds on referral.

Organisations were further asked to comment on what they had found to be the causes of homelessness or at risk of becoming homeless (precipitating factors of homelessness), in regards to people from a CALD background with a mental illness. The five most common responses were: family breakdown/conflict (96.8%), lack of appropriate housing (87.1%), domestic violence (80.6%), economic reasons (74.2%) and isolation (74.2%).

Agencies also commented on what groups within CALD communities were most at risk of becoming homeless. The five most common answers were:

• People with mental illness (87.5%).

• People with low income (84.4%).

• People with a dual diagnosis (mental illness and substance abuse) (81.3%).

• People with a substance use problem (drug and/or alcohol) (78.1%).

• Women experiencing domestic violence (71.9%).

Figure B: Perceptions of most at vulnerable groups within CALD communities of becoming homeless
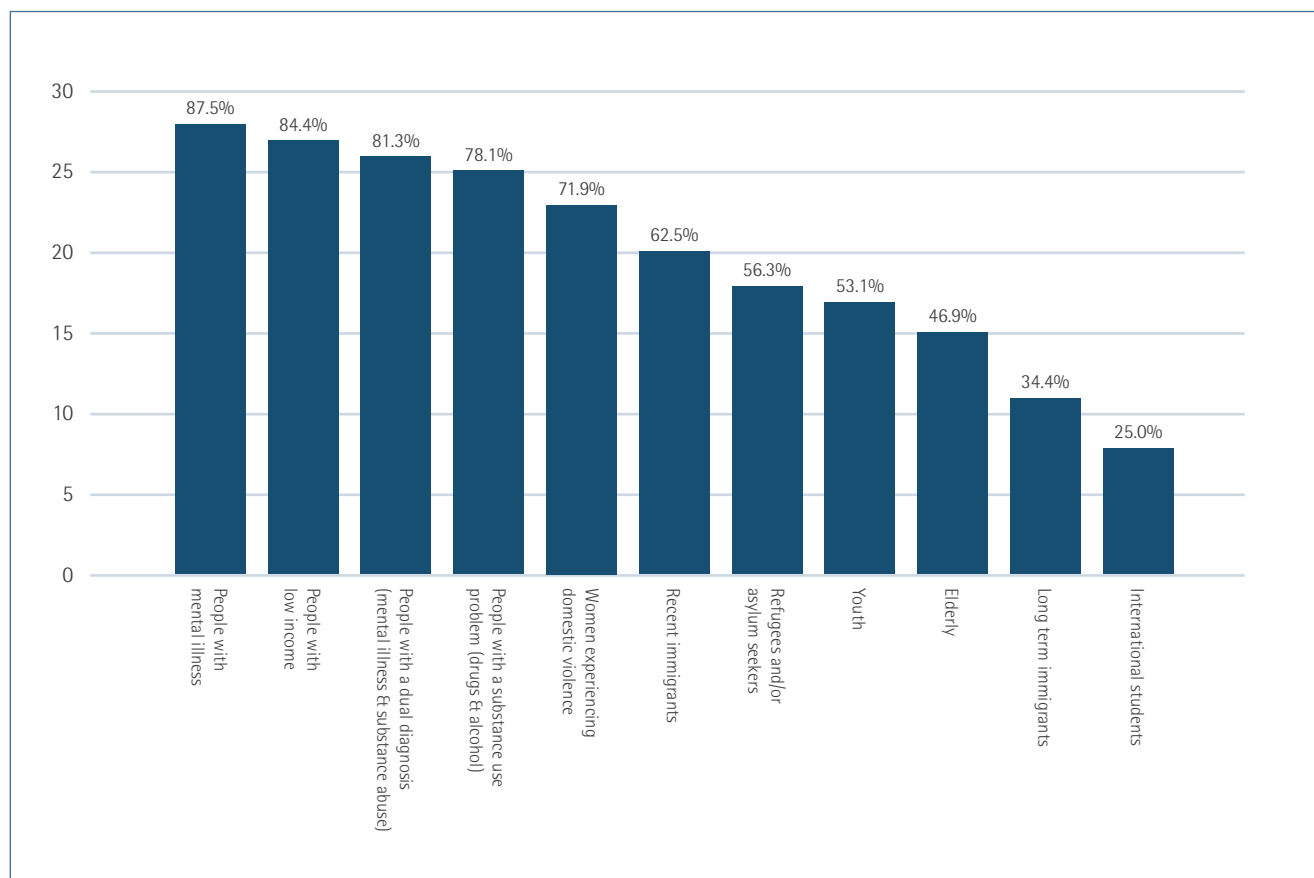
Responses from mental health organisations

A total of 49 mental health organisations responded to the survey, with 12 from New South Wales, 17 from Victoria, five from Queensland, two from South Australia, eight from Western Australia, and one each from the Northern Territory and Australian Capital Territory.

Of the mental health services, 83.7% indicated that they collect data on clients from CALD backgrounds, while 87.8% indicated that they collect data specifically on clients from CALD backgrounds with mental illness. When asked how clients from CALD backgrounds were identified, 83.0%

stated that they collected information on country of birth; however, many of the services used multiple identifiers, such as self-identification or language(s) spoken.

The majority of mental health organisations (77.1%) also said that they collected data about clients that were at risk of homelessness.

When referring clients from CALD backgrounds to homelessness agencies for support, 61.4% of respondents agreed that clients from CALD backgrounds faced additional difficulties in accessing the appropriate support:

## Figure C: Difficulties faced by clients from CALD backgrounds after referral
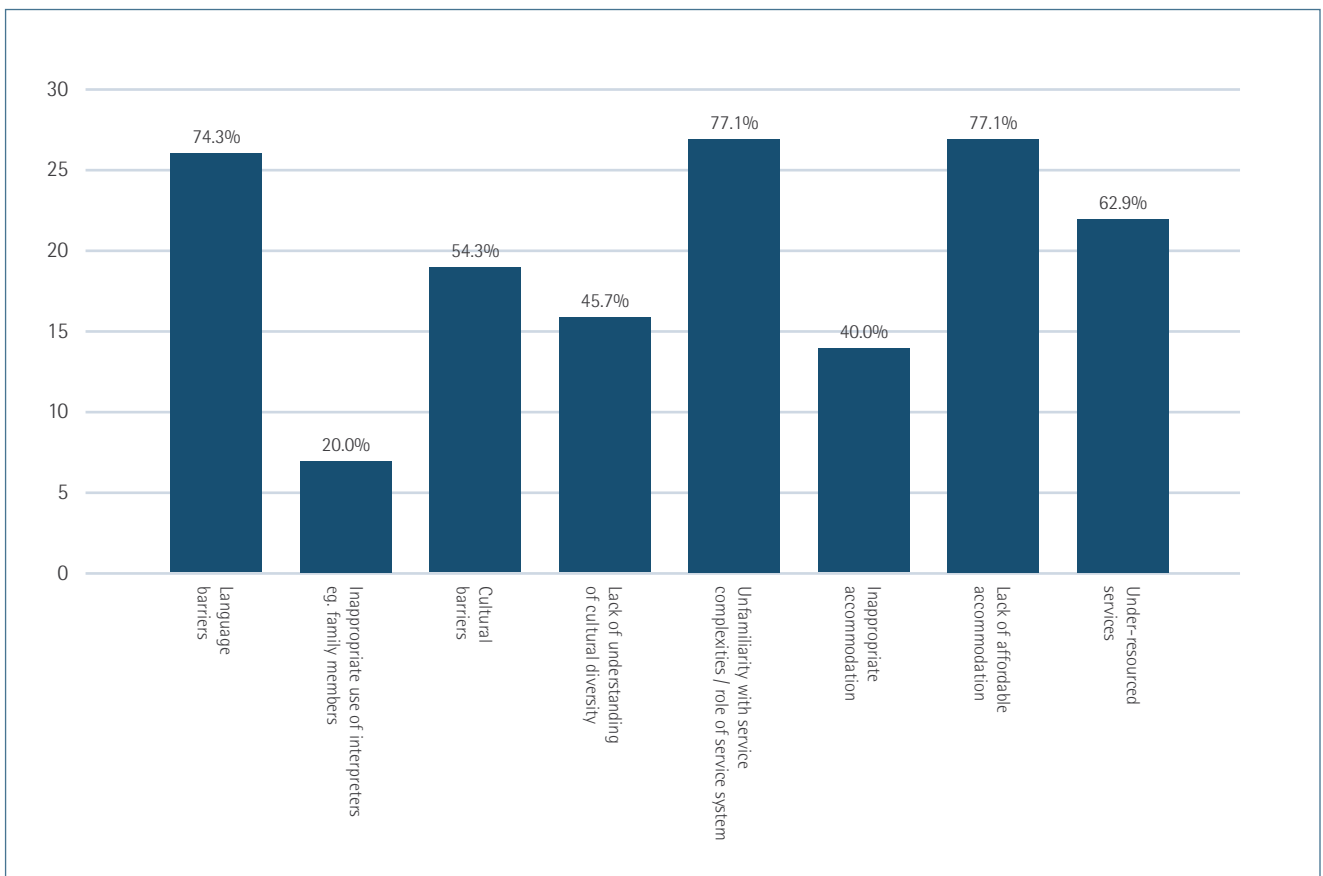
Organisations also commented on what they had found to be the causes of homelessness or at risk of becoming homeless (precipitating factors of homelessness) in regards to people from a CALD background with a mental illness.

The five most common responses were:

- Lack of appropriate housing (91.3%).

- Economic reasons (89.1%).

- Family breakdown/conflict (78.3%).

- Substance use (78.3%).

- Symptoms of mental illness (71.7%).

Figure D: Perceived precipitating factors for homelessness of CALD populations with mental illness
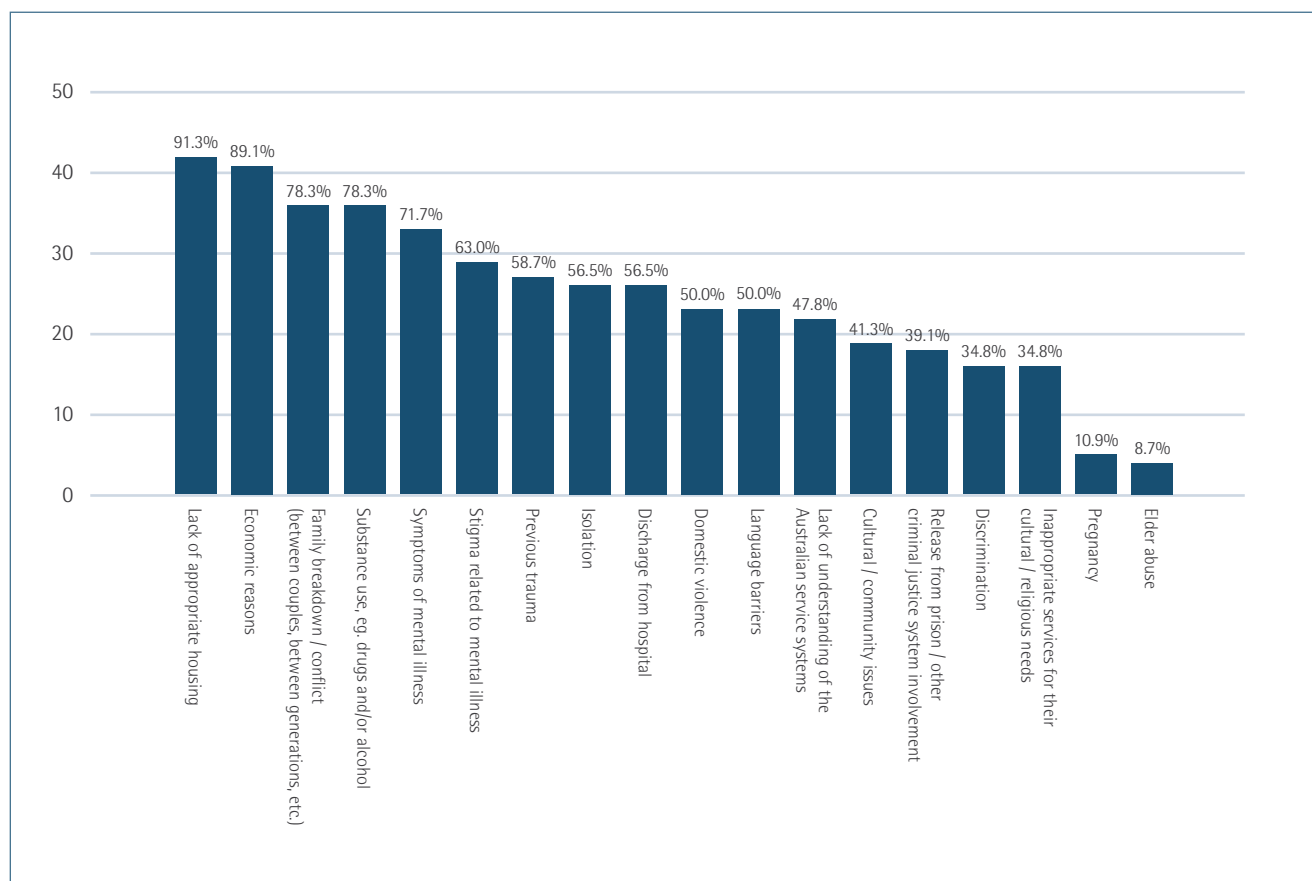
Agencies further commented on what groups within CALD communities were most at risk of becoming homeless and the most common five answers were:

- People with mental illness (97.8%).

- People with dual diagnosis (88.9%).

- People on low incomes (71.1%).

- Youth (64.4%).

- Victims of domestic violence (60%).

Responses from ethno-specific/multicultural organisations

A total of 38 ethno-specific/multicultural organisations responded to the survey, with 12 from New South Wales, 15 from Victoria, two from Tasmania, three from Queensland, three from South Australia, one from Western Australia and two from the Australian Capital Territory.

Of the ethno-specific/multicultural services, 92.1% indicated that they assisted clients who were homeless.

Of these organisations, 62.2% collected data regarding those at risk of homelessness using a variety of data collections methods. The majority (62.5%) collected information at the intake point. Services provided to clients that were homeless or at risk of homelessness included legal advice, settlement advice, advocacy, accommodation support and referral to homeless support organisations and mental health services:

Figure E: Services provided by ethnic/multicultural organisations to CALD clients at risk of homelessness
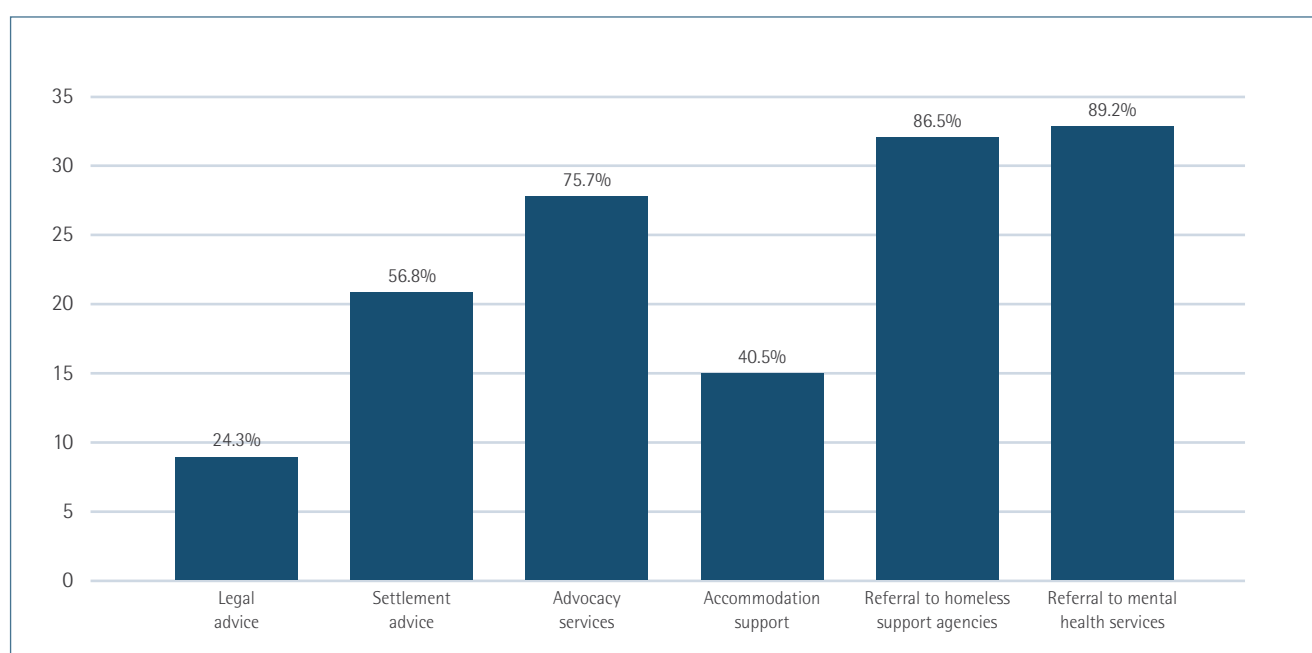
When asked how clients from CALD backgrounds were identified, services varied markedly in their data collection processes, with 77.1% collecting information on country of birth, with many using multiple identifiers. For example, 74.3% identified clients by their use of a language other than English.

The vast majority (89.2%) of ethno-specific/multicultural services indicated that they collect data on clients with a mental illness, with 62.2% indicating that they collected data regarding homelessness.

Many (89.2%) felt that their clients from CALD backgrounds faced difficulties in accessing the appropriate support from mental health services. Most of these organisations (91.2%) agreed that unfamiliarity with the service system was

the most significant challenge facing clients from CALD backgrounds on referral.

Ethno-specific/multicultural organisations were also asked to comment on what they had found to be the causes of homelessness or at risk of becoming homeless (precipitating factors of homelessness) in regards to people from a CALD background with a mental illness. The five most common responses were:

• Family breakdown/conflict (84.2%).

• Language barriers (81.6%).

• Economic reasons (78.9%).

• Isolation (73.7%).

• Lack of appropriate housing (71.1%).

These agencies also commented on what groups within CALD communities were most at risk of becoming homeless. The most common answers provided were:

- People with low incomes (76.3%).

- People with mental illness (73.7%).

- People on low incomes from refugee and asylum seeker backgrounds (65.8%).

- Victims of domestic violence (60.5%).

- Equally both youth and people with a dual diagnosis (57.9%).

Figure F: Perceptions of most at-risk groups within CALD communities of becoming homeless
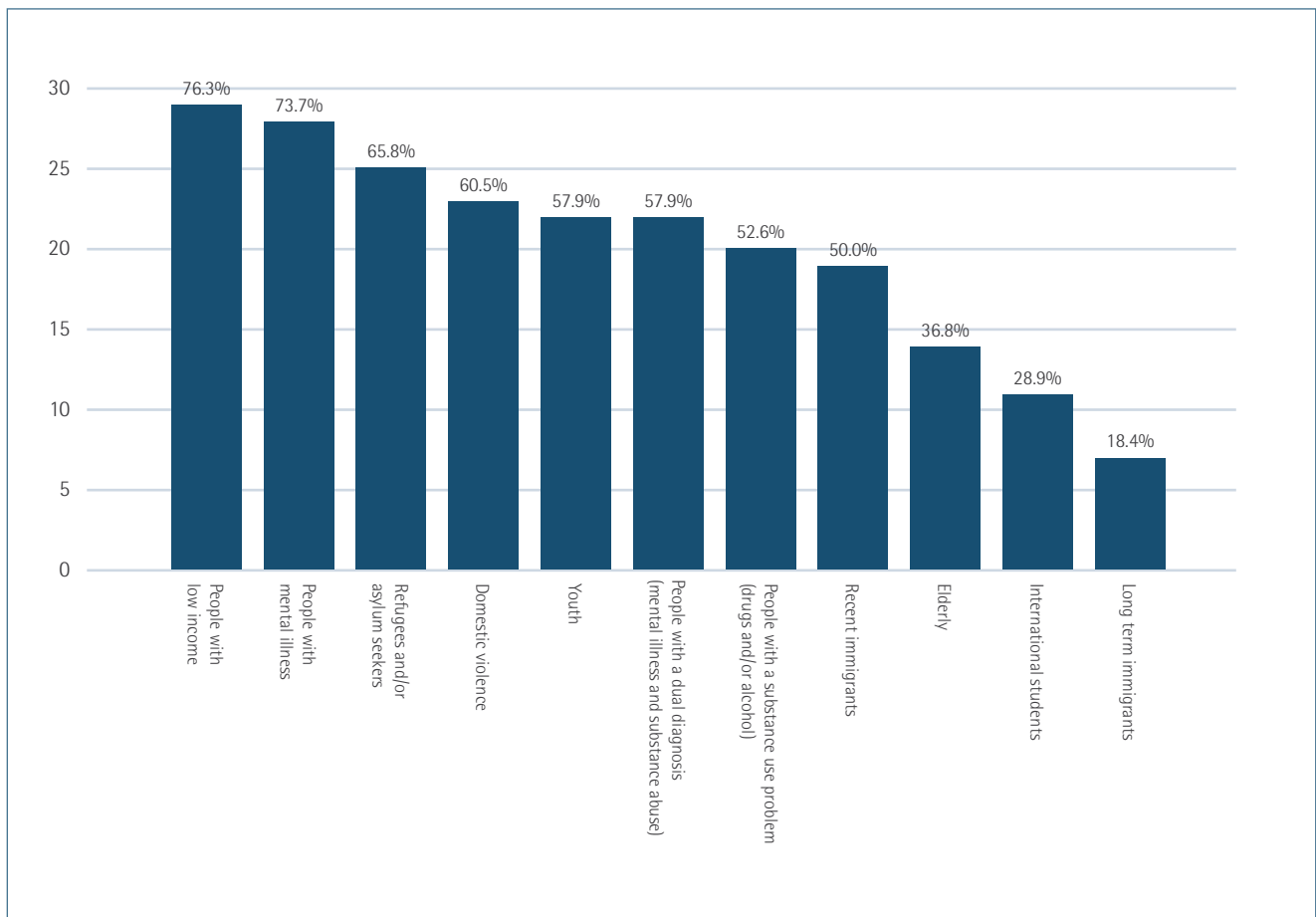
The majority of ethno-specific/multicultural organisations (70.3%) had not been asked to be involved in assisting homelessness organisations with access and equity strategies. Of those who did assist, many were involved in strategies aimed at increasing equity of access, with the majority (90.9%) advising on cultural responsiveness. Other strategies included being members of a reference group, assisting community development projects and providing cultural competency training.

Differences and similarities in responses from the sectors

As previously mentioned, there was a fairly even spread of responses from the three service sectors, with 34 coming from homelessness organisations, 49 from mental health, and 38 from the ethno-specific/multicultural sector.

One point of difference in responses by service type was on the causes of homelessness. On this point, there was some variability in the top reasons cited:

- Homelessness organisations noted family breakdown/ conflict and lack of appropriate housing as the most common causes.

- Mental health organisations noted lack of appropriate housing and economic reasons.

- Ethno-specific/multicultural organisations noted family breakdown/conflict and language barriers.

Organisation type	Main causes of homelessness
Homelessness	• Family breakdown/conflict • Lack of appropriate housing
Mental health	• Lack of appropriate housing • Economic reasons
Ethno-specific/multicultural	• Family breakdown/conflict • Language barriers

On the other hand, three clear similarities can be discerned in responses across all sectors:

1. Country of Birth is the mostly commonly used CALD identifier in data collection processes.

2. Unfamiliarity with service systems on the part of clients from CALD backgrounds is cited as the most important barrier to equitable service access and outcomes.

3. People with a mental illness, people on a low income, people with a dual diagnosis (mental illness and substance abuse), women experiencing domestic violence and youth consistently rated as the most at-risk groups of becoming homeless.

Based on the above, and in forming improved service responses to people from CALD backgrounds living with a mental illness, the following should be noted:

1. Particular attention needs to be given to identifying the needs of second generation immigrants as well as first generation immigrants who were ethnic, linguistic and/or religious minorities in their countries of origin. Examples of such groups include people of Indian ancestry who have emigrated from Fiji, people of Chinese ancestry who have emigrated from southeast Asia, and people of Coptic ancestry who have emigrated from Egypt. It is highly likely that these groups remain largely unidentified by frontline services because of the primary reliance on Country of Birth as an identifier.

2. As unfamiliarity with service systems is a key barrier for clients from CALD backgrounds, it is critical that services enhance their cultural competency in better communicating and serving these individuals, and their communities. The focus of these strategies must be to get clients 'in the door', and then to enable them to successfully navigate service pathways.

3. Further research and the development of targeted service responses in this area should concentrate on those CALD groups that have been identified as most at risk of homelessness. This is likely to yield the greatest improvement in overall outcomes for this group.

More detailed information on the survey responses can be found in Appendices I, II and III.

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Part Four

Discussion
and analysis

"The overall project aim was to gain a baseline understanding of the level of homelessness of people from CALD backgrounds with mental illness in Australia"

The following discussion and analysis of the extent of homelessness amongst people from CALD backgrounds is a synthesis of:

• Results from the national survey of services for homeless people (distributed by VTPU through SurveyMonkey™ in collaboration with the reference group), mental health services and ethno-specific/ multicultural organisations conducted from July to September 2010.

• Feedback from a focus group of industry representatives.

• Anecdotal feedback from service providers to further enrich the information presented in the study.

Research questions

The overall project aim was to gain a baseline understanding of the level of homelessness of people from CALD backgrounds with mental illness in Australia. This discussion will address the following research questions:

• The precipitating and perpetuating factors of homelessness for people from CALD backgrounds.

• Homelessness prevalence rates of people from CALD backgrounds with mental illness.

• Population groups within CALD communities at risk of becoming homeless.

• The implementation of access and equity strategies by state-based and national agencies in relation to CALD clients with a mental illness.

• Whether homelessness services collect CALD data on their client base.

• Whether referral pathways to homelessness services and pathways to mental health and health services are the same for CALD people with mental illness compared to those from the mainstream community.

Limitations of the data

Despite the limited nature of the current study, it is reasonable to deduce that the data collected from the surveys is likely to be representative of the current climate in the homelessness service sector in regard to clients from CALD backgrounds with a mental illness, given that the information was consistent across all the sources noted above. As research regarding CALD communities and homelessness is very limited, it was our intention to use the information gathered to establish a baseline for future research.

It is our recommendation that these results are best interpreted only as a guide to improve service development initiatives and data collection methods.

For example, the current study cannot objectively state the extent to which unfamiliarity with service systems, and language barriers, are challenges faced by people from CALD backgrounds. The data does suggest it would be sound to presume that these are key issues that impact people from CALD backgrounds when trying to access homeless services. It would also be reasonable to suggest that access is an important equity issue for services to consider when addressing the cultural responsiveness of their organisation.

In addition, this study did not make distinctions regarding the diagnoses of mental illness. It is recognised that needs associated with low prevalence disorders and high prevalence disorders are unique and distinct. Research suggests that many of those living with severe mental disorders are more reliant on government pensions or social benefits, more likely to be housed in tenuous forms of accommodation, and require greater support to maintain tenure (Psychiatric Disability Services of Victoria (VICSERV), 2008). However, it was not feasible to make these types of distinctions or conclusions from the information gathered from the surveys, since participant organisations did not differentiate diagnoses.

Data collection, the impact of definitions and what this means for prevalence

The importance of collecting sound data on the extent of homelessness and mental illness in Australia (Mental Health Council of Australia, 2009) and the relationship between the two has been highlighted by this research. The absence of clear definitions and differing methodologies has impacted on the reliability and validity of research (Harvey, et al., 2002) and may account for many of the differences in statistics. While the current research was subject to similar limitations, it does shed more light on why meaningful data related to homeless people from CALD backgrounds with a mental illness is so limited.

A key goal of this study was to develop a baseline understanding of the reported prevalence rates of people from CALD backgrounds with a mental illness who are homeless, and the extent of CALD homeless data collected by agencies. When homelessness services were surveyed, it was clear that the majority did collect information on this group. However, their data was not always reliable and, as will be discussed, the information on people from CALD backgrounds with mental illness was often used by organisations in a limited manner. Classification of CALD and mental illness were intentionally left undefined in the surveys as it was felt that these terms were generally well understood by those in the targeted sectors. It was also assumed that homelessness workers would be unable to distinguish between low and high prevalence disorders without a formal confirmation of the diagnosis and this, as discussed previously, was one of the limitations expected in this study.

As discussed in the literature review, cultural and linguistic diversity refers to a range of different cultures and language groups defined by a variety of affiliations linked to birthplace, ancestry, ethnic origin, religion or preferred language (VIC Department of Health 2009). This is obviously open to a variety of interpretations when deciding what data is collected or used to define these clients. For example, some services use country of origin or first language spoken, others birthplace or religion, and some

self-identification or ethnicity. The most common identifier of clients from CALD backgrounds across all sectors was country of birth, followed by client self identification. Most organisations that took part in the survey used multiple and varying identifiers to define who their clients from CALD backgrounds were. Generally the information was collected at the point of intake. Feedback from the surveys and discussions with focus group members as well as others in the industry pointed to a variety of reasons for these differing methods of identification.

Often organisations were gathering data about clients from CALD backgrounds as a response to funding arrangements rather than for quality improvement and internal evaluation purposes. Feedback also suggested that many of the data collection tools designed for reporting did not allow agencies to access specific data and generate useful reports. Additionally, some agencies were unable to review their data in a meaningful way due to issues associated with the technology, diminishing its usefulness in reviewing and reforming their organisation's practices. This inability to retrieve data is also evident in the basic prevalence tables, where many organisations left fields blank.

Comments:
"Data collection covers the questions, but is electronically collated and processed. We have very limited access due to the coding of data"

"We only record women who access our service, there are women from CALD backgrounds who are referred to us but not accommodated and therefore not captured in the data"

Comments made by some unfunded agencies suggested that data collection was generally ad-hoc, since it was designed to provide a snapshot of prevalence at a particular time (for example, to record who was housed at a particular point, and where they were placed), but not identify ethnicity. Agencies also reported that much of their data was used to allocate human resources, or track individual workloads across the organisation, rather than inform strategies to address the cultural responsiveness of particular services:

"Our current database is inappropriate as it was designed for another service; however, due to a lack of funding we have to live with it"

"Our workers are over-run with administrative tasks – we don't have the human resources to review our current data"

Using multiple definitions to define a person's cultural and linguistic background and mental illness impacts significantly on attempts to acquire reliable prevalence rates, or draw significant conclusions about prevalence. Collecting only one variable to define clients from CALD backgrounds is inadequate. For example, collecting only country of birth neglects second or subsequent generations and consequently under-represents acculturation issues pertinent to many youth from CALD backgrounds. Additionally, relying on self-identification can exclude people with a mental illness who, for differing reasons, may not want to identify as being from a CALD background. Such people may include women fleeing domestic violence, those suffering the effects of stigma or racism, or those who identify as Australian.

Data from services demonstrates that measures of mental illness and homelessness amongst clients from CALD backgrounds were subject to inconsistent definitions and multiple identifiers. Mental illness is an inadequate measure of either the cause or consequence of homelessness without additional information on diagnoses and/or the level of disability associated with the disorder. Interestingly, the services for homeless people tended to use only one method of identification, and these varied from service to service. It cannot be assumed that this is the case across the whole sector.

A client could have a mental illness and not be formally diagnosed, or their formal diagnosis may not be known to the service. Similarly, informal diagnosis, referral from a mental health service and self-identification are inadequate as sole indicators of having a mental illness. For example, a consumer may present at a mental health service as a result of being homeless, not because of mental illness. Research demonstrates that clients from CALD backgrounds are under-represented in mental health services and may therefore have an undiagnosed mental illness. Alternatively, their mental illness may remain unidentified in an attempt to avoid stigma in their community.

Taking into account issues in relation to the collection of data and the use of multiple variables to define

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CALD and mental illness, it is clear that prevalence data presented in this study is unreliable due to the individual service interpretations used to define clients from CALD backgrounds, as there is no standard method of defining CALD or mental illness across agencies. The accuracy of the reported data is therefore questionable. Follow-up phone interviews with agencies confirmed these conclusions and added weight to the need to develop clear and precise definitions for use in any future research in this area. Unfortunately, this seems to be a common and recurrent theme in much of the research to date, particularly if it is considered that other studies have shown the prevalence of mental illness in homeless populations to be anywhere from 35% to 75% (Johnson & Chamberlain, 2009).

Although there has been a significant amount of research on homelessness amongst individuals with low prevalence disorders, many studies do not distinguish between high and low prevalence disorders. Also, broad definitions of mental illness make it difficult to interpret if the issues facing individuals are not simply related to the material conditions of being homeless. Johnson and Chamberlain aptly point out that "asking a person (sic. who is homeless)

if they have felt 'down', 'depressed' or 'anxious'... could not, in any meaningful way be taken as an indication of mental illness" (Johnson & Chamberlain, 2009, p3).

It can be concluded that the lack of data collection in many services, and their inability to access data, indicates that data on service users from CALD backgrounds experiencing homelessness will be clearly unrepresentative of the true need faced by this population, while prevalence data calculated from these figures will be an underestimate. In addition, it is clear that a lack of CALD data collection impacts on an organisation's ability to be culturally responsive. It is difficult to develop strategies to improve services for consumers from CALD backgrounds if prevalence and demographic data are unavailable.

Data identifying ethnicity and physical access for clients from CALD backgrounds doesn't capture other pertinent access and equity issues that relate to client satisfaction, the client's experience of the service (including their sense of cultural safety), or the relevance of the service provided. Some of these issues could be addressed through the development of closer partnerships with local ethno-specific/multicultural organisations.

Who are the most vulnerable culturally and linguistically diverse groups?

Responses from homelessness organisations and mental health organisations overwhelmingly suggested that the most vulnerable group in CALD populations were those who had a mental illness. Responses from ethno-specific/multicultural organisations suggested that the most at-risk group were people on a low income. It may be that these issues are, in fact, related.

People living with mental illness
Many respondents identified mental illness as the major contributing factor that placed people at risk of homelessness. However, much of the previous research suggests the presence of a mental illness does not necessarily place an individual at any greater risk of homelessness when compared to other common precipitating factors, such as economic disadvantage or family breakdown (Johnson Chamberlain). It would be reasonable to suggest that mental illness greatly

increases the odds of introducing economic, personal, social and cultural disadvantage, which makes it more difficult for individuals to maintain tenancy. Acculturative stressors amongst second generation immigrants might go some way to explaining youth homelessness in CALD communities. Alternatively, issues related to being homeless, such as exposure to drugs and alcohol, increased stress, lack of security, exposure to violence and lack of available support mechanisms, may contribute to mental illness. A major mental illness may in fact be a precursor to increasing socio-economic disadvantage, thus leading to homelessness.

Women victims of domestic violence
Domestic violence is a major driver of homelessness. Women from CALD backgrounds who are victims of domestic violence, although under-represented in service utilisation, were considered by respondents to be

multicultural MENTAL HEALTH AUSTRALIA

at a significant risk of homelessness. Service providers have previously reported that homelessness driven by domestic violence is often different from other forms of homelessness, where many women cycle in and out of being homeless (Australian Government 2008b).

For many women from a CALD background, the cultural belief that leaving your spouse is unacceptable makes escaping domestic violence more difficult. It should also be noted that discussions during the study with various respondents indicated that women from CALD backgrounds often lacked the economic, social, and cultural resources to leave a relationship and secure alternative tenancy. Additional issues of stigma, a poor understanding of the system, poor English proficiency and culturally inappropriate accommodation and services increases the risk that this group will not seek assistance from specialist services. Women experiencing domestic violence will often seek refuge with friends or relatives (Australian Government 2008b), however feedback suggests that women from CALD backgrounds may be less likely to involve other community members, placing them at even more risk.

Refugees and asylum seekers

Many people also commented that refugee and asylum seeker populations constitute a large group that are at risk of homelessness. Again, there are many factors that put this group at more risk of homelessness, including trauma, anxiety about the welfare of family members left behind in situations of danger and deprivation, and a sense of helplessness. All these stressors can act as triggers for anxiety and depression. Long-term post-traumatic stress reactions often accompany refugees and other immigrant groups with a history of exposure to violence,

torture, environmental disasters and the experience of migration (Refugee Council of Australia, 2009). Poor English proficiency and lack of knowledge of service systems can place this group at further risk, while asylum seekers often lack the basic 'safety net' of Medicare and Centrelink that most of us take for granted. Forced migration may be a causative factor in low socio-economic presentation to homelessness services. Voluntary immigrants are more likely to have sought-after skills and qualifications, and are less likely to come from impoverished backgrounds. Resettlement issues are often complex for personal, cultural, socio-economic and psychological reasons, including experiences of isolation and discrimination. The shortage of housing and high cost of rental accommodation also impacts significantly on this group.

Youth

Youth from CALD backgrounds, both in the survey responses and focus group discussions, were also highlighted as an increasingly at-risk group. In particular, young refugees are more likely to become homeless than other young people, and in comparison they face a number of disadvantages. They are less likely to establish economic viability and host culture social networks, more likely to have problematic family relationships due to acculturation issues faced by second generation immigrants (Ransley & Drummond, 2001), and be disadvantaged by language barriers, lack of a rental history, and a lack of knowledge of the service system. Youth are often the 'unseen' homeless as homelessness takes the form of 'couch surfing'. Often unrecognised by most youth as a form of homelessness, it would appear to be a result of their reluctance to seek services. This is possibly a result of broader access issues as discussed above.

What are the causal and perpetuating factors for culturally and linguistically diverse communities regarding homelessness?

The perpetuating factors for homelessness are complex and inter-related (Australian Institute of Health and Welfare, 2009), while the reasons people become homeless are as heterogeneous as the people who make up the homeless community in Australia (Urbis 2009). For some, homelessness is a once-in-a-lifetime event, others cycle in and out of homelessness, and for another group it becomes a chronic state of existence (Australian Institute of Health and Welfare, 2009). The interactions between exclusion and homelessness are also complex and it has been proposed in much research that homelessness may indeed exacerbate any existing problems people have, such as mental illness (Australian Institute of Health and Welfare, 2009; Johnson & Chamberlain, 2009).

The current research investigated the issue of precipitating and perpetuating factors in the context of what service providers perceived to be the most common causative and continuing factors contributing to homelessness.

Across all three services (homelessness, mental health and ethno-specific/ multicultural) there was variation in the most common reasons cited for homelessness. However, most organisations surveyed placed family breakdown, lack of appropriate housing and economic reasons as the key issues that placed consumers from CALD backgrounds at risk of homelessness. All of these issues could be associated with underlying problems related to acculturation, unemployment due to mental illness, alcohol and drug abuse, domestic violence or indeed combinations of these problems. Unfortunately, this was something that could not be verified in the current study, other than through anecdotal observations.

As mentioned previously, in the absence of other data, it is not possible to objectively state the most common individual precipitating factors for homelessness. It is reasonable to assume that there are key factors that contribute to homelessness, and indeed that the interactions between these variables are major precursors to homelessness. Adding weight to the view that there are key causal factors of homelessness is the fact that various organisations rank the causes of homelessness in industry-

specific categories – that is, in relation to the service they provide. For example, mental health services describe substance abuse and mental illness as key contributors, while ethnic/multicultural organisations describe language barriers and isolation as key contributors to homelessness.

Interestingly, only homelessness organisations ranked domestic violence as one of the five prominent causes of homelessness. Domestic violence is commonly considered to be the major cause of homelessness (Australian Government 2008b); however, issues of stigma associated with domestic violence, lack of access to financial resources, and lack of family support may dissuade women from CALD backgrounds to seek assistance. Unfortunately, the answers to this and similar questions are beyond the scope of this study.

Any of the events discussed above can trigger homelessness (Australian Government 2008b), and many people who become homeless have struggled over long periods of time with other personal problems which may include long-term unemployment, violence, mental illness, addiction and dependence, and disability. It would seem that CALD communities are impacted by the same precursors to homelessness as the mainstream population, but sections of these communities may be at a greater risk of homelessness due to long-term unemployment/under-employment, refugee status, and family breakdown. Family breakdown is often considered to be the second most significant cause of homelessness and is a major contributing factor to youth homelessness in the general community.

Feedback in both surveys and the industry focus group indicates that people from CALD backgrounds who have entered Australia under the Humanitarian Program may be at higher risk of exposure to some of the causal factors of homelessness. Research indicates that skilled immigrants may have lower rates of homelessness relative to other immigrant populations because they generally come with better financial means, and are expected to have employment arranged. On the other hand, people coming to Australia under the Humanitarian Program typically come from refugee backgrounds, and are likely to be

exposed to more risk factors for homelessness: poverty, trauma-related mental illness, being of non-English speaking background, lacking familiarity with the service system, providing care for younger siblings and other family members, disconnection from significant family members, and anxiety about family members left behind who often face dire economic and security circumstances.

Discussions with various industry representatives also highlighted that organisations struggled to place immigrants in appropriate housing, often resulting in immigrants and refugees being placed in temporary, overcrowded or transient housing situations. Immigrants were often encouraged to stay in transient housing situations due to a lack of long-term housing, thus perpetuating a tertiary homelessness situation. Clients are in fact housed, as inappropriate as the housing may be, but not really 'settled'. Living in marginal accommodation for long periods of time makes it harder to gain long-term employment, maintain educational interests, and retain contact with the community – all factors which can impact on physical and mental health. Inadequate housing often plays a part in the cycle of intergenerational disadvantage, especially where extended migration experiences that include refugee transit camps and detention centres have led to long-term social and family disruption. This group may have become more accepting of transient living conditions and have lowered expectations.

It is clear that homelessness removes stability in people's lives (Australian Government 2008b). There are factors which increase the likelihood of consumers from CALD backgrounds remaining homeless, such as poor English proficiency, lack of knowledge of the service system and poor health, including mental health. It is, however, difficult to say that these factors don't also affect homeless consumers in general. For example, many Australian-born people have difficulty navigating the service system and may have poor written English proficiency due to a poor educational background (impacting on employment, healthcare, etc).

What can be said is that a lack of cultural responsiveness, particularly the lack of access to interpreters and culturally appropriate accommodation options, impacts significantly on the access to mainstream homeless services for consumers from CALD backgrounds. This increases the probability of long-term homelessness among this population. It was a common theme among agencies that clients from CALD backgrounds who had difficulty accessing services often failed to re-present to those services again.

"Misunderstandings often lead to consumers from CALD backgrounds being referred back to us (refugee/asylum seeker organisation), eroding our relationship with the clients. It is traumatic for them and often they will not go again (to a mainstream service) after this experience"

Referral pathways, types of referrals and some of the difficulties faced by clients and the implications regarding access and equity

Data collected on referral types makes it possible to draw conclusions on some overall themes. Referrals to health and mental health services by homelessness organisations were key aspects of service delivery. In fact, referral to health services was the most common type of assistance given to clients, followed by referral to mental health services and accommodation support. When looking at these results, however, it is important that inappropriate conclusions are not drawn from the data. Although referral to health and mental health services is a common service provided to homeless clients, this does not allow us to

reach conclusions regarding mental illness among homeless consumers (Homelessness Australia 2007).

Overwhelmingly, services for homeless consumers as well as mental health services responded that there were no differences in referral pathways to or from their services for consumers from CALD backgrounds, in comparison to mainstream consumers (80.6% and 87.8% respectively). Unfortunately, there was no way to measure how appropriate these referrals were. Many agencies felt that referrals to mainstream agencies without CALD responsive services often led to misunderstandings and poor service

responses. Referrals to services for the homeless came from social workers, other homelessness agencies, and housing organisations. At first glance, homelessness organisations referring homeless consumers to other services may seem unusual, but often community and public housing is provided by specialist services, as is crisis and transitional accommodation (Homelessness Australia 2007). Additionally, homelessness organisations may need to refer clients on if there is no accommodation available at the time.

Of more interest is what organisations felt to be the challenges that clients from CALD backgrounds faced after referral. Overall, the three types of organisations surveyed felt that clients from CALD backgrounds had difficulty accessing appropriate support from homelessness services following referral, while homelessness organisations indicated they too felt clients had difficulty accessing services provided by mental health organisations and ethno-specific/multicultural organisations. It would appear that there is consensus on the notion that consumers from CALD backgrounds have great difficulty in accessing appropriate services, be they mental health or homelessness services.

All the services generally agreed that the greatest issues faced by clients from CALD backgrounds are unfamiliarity with service systems and language barriers. Access and equity strategies were moderately implemented by most agencies; many included CALD strategies in their policies and procedures, provided staff with some professional development on CALD issues, and had access to interpreter services. Very few organisations used data for future planning, had strategies regarding bilingual employment, pursued community development strategies for consumers from CALD backgrounds, or actively engaged in partnerships with ethnic/multicultural or mental health organisations.

Recommendations

Consumers from CALD backgrounds who are at risk of homelessness have a variety of unmet needs. Further, inadequate data collection on this population leads to their exclusion or under representation in overall homelessness statistics. Adequate data collection on this group is imperative if we are to understand the extent to which CALD populations are affected, their specific needs and the appropriate means of addressing this issue at both a policy, systemic and service level. Responsive service delivery is difficult if it is informed by poor quality or unrepresentative data. Quality data is particularly important when providing targeted services to clients who are faced with incredibly difficult life situations, such as being homeless. Reliable data is essential to service development and the appropriate targeting of resources and service responses.

As many clients presenting to organisations for homeless people do not actually become homeless, or receive a service from the agency, the agencies often do not collect data regarding these clients. It is reasonable to suggest that there should be better attempts made to document who these clients are and what led them to seek support at a particular point in time. With this data, we may be provided with a better understanding of the contributing factors and precursors to homelessness of people from CALD backgrounds, in turn implementing better targeted social supports and early intervention and prevention services.

Collection of more detailed data regarding diagnoses of mental illness and disability could lead to better planned and integrated service for these clients. Those presenting with low prevalence disorders, have distinct needs and often require a greater level of support to maintain long-term secure tenancy (Psychiatric Disability Services of Victoria (VICSERV), 2008). The strong association between housing and clinical recovery are well documented, and the economic, social, and personal cost of not providing appropriate support to these clients cannot be underestimated. Closer formal partnerships between mental health services, social services, homeless services and ethno-specific multicultural service providers may go some way to addressing the needs of this client group. A more holistic approach to providing appropriate long-term support mechanisms for consumers from CALD backgrounds with a mental illness is likely to decrease periods of homelessness.

In view of the significant number of refugee and asylum seekers represented in this research, it may be pertinent to direct attention to psycho-social issues associated with refugee and immigrant populations that lead to social isolation and failure to negotiate the local cultural environment.

It was not the intention of this report to criticise or undermine the incredible work that many services, and indeed individuals, deliver in what is often a confronting and challenging environment. In fact, it is contended that if there was a strengthened effort to gather quality data on clients from CALD backgrounds presenting to homeless services, mental health services and ethno-specific/ multicultural organisations, it may lead to more appropriate allocation of resources to immigrant support groups. It was the intention of this homelessness research brief to include a tool that would help organisations develop more culturally responsive strategies. However, it seems clear that the issue of data collection needs to be addressed, and therefore a data collection template is included (Appendix IV) which may be incorporated into general intake templates.

The more culturally competent services become, the less likely it is that many of the gaps identified in this research will continue to exist. Not only is this incredibly important for consumers from CALD backgrounds, but it may go some way to addressing the frustrations felt by many services. It is our hope that the attached cultural responsiveness tool (Appendix VI) will assist organisations to discuss, both internally and across services, issues faced by consumers from CALD backgrounds, and lead to practices that address these issues practically.

The tool is designed to assist organisations identify ways in which their service can improve their cultural responsiveness. Completing the tool will aid organisations in goal-setting and planning, and ultimately enable services to be more effective in meeting the needs of consumers from CALD backgrounds. The tool can be circulated for consideration, and then completed at a meeting of relevant staff (managers, educators, organisational leaders, direct services staff and any additional staff with responsibilities or an interest in clients from CALD backgrounds). It can be used on multiple occasions to review and reflect on an organisation's progress.

In summary, the recommendations of this study are to:

1. Implement national standardised data collection for homelessness services to allow better reporting on and analysis of service users from CALD backgrounds. This is imperative if we are to understand the extent of service utilisation, the specific needs of consumers from CALD backgrounds (and sub-groups thereof), and the appropriate means of addressing prevention, support, access and equity.

2. Undertake more detailed data collection on the diagnosis of mental illness and disability, to provide more integrated and planned services for these clients.

3. Include the following categories in standardised data collection (refer to template in Appendix V):
   • Country of birth (acculturation)
   • Parents' country of birth (ancestry)
   • Ethnic group
   • Residency status
   • Languages spoken and preferred language
   • Religious background
   • Any special cultural, religious or gender-based needs.

4. Establish or enhance formalised partnerships between homelessness, mental health, ethno-specific/ multicultural, and social services and Government.

5. Implement a national cultural responsiveness framework aimed at the homelessness sector, to be followed by ongoing monitoring and evaluation.

6. Conduct targeted interventions with CALD communities (specifically refugees and asylum seekers, the elderly, youth and women who are victims of domestic violence) to address the acculturation issues that underlie many of the precursors to homelessness for this population.

7. Allocate further resources to research in this area to clarify why clients from CALD backgrounds remain unrepresented in the data; what issues precede, underlie and contribute to homelessness in this population; what policies should be implemented to address these issues, and what services are needed to bridge the gap.

Appendices

Appendix 1

Survey responses from homelessness organisations

Homelessness service characteristics and data collection trends

A total of 34 homelessness organisations responded to the survey with 33 organisations identifying themselves and one choosing to remain anonymous. Of these responses, 12 surveys were completed on behalf of the whole organisation while 19 respondents replied specifically in regards to their branch. None of the respondents provided data that represented a state- or territory-wide organisation, while three organisations did not reply to this question. A state-by-state breakdown is as follows: 11 New South Wales, 17 Victoria, 1 Tasmania, 3 Queensland and 1 South Australia.

Most organisations worked exclusively with people who were homeless or at risk of homelessness 76.5% (n=26), and the remaining organisations 23.5% (n=8) were

prompted to answer the survey questions only in regard to their clients who were homeless or at risk of homelessness.

Homelessness services worked with a diverse range of clients, including youth, older people, refugees/asylum seekers, immigrants, international students, people with mental illness and people with mental illness and drug and alcohol problems. Additionally some respondents worked specifically with men (n=1), families (n=1), women and their children (n=2), young women (n=1) and low income households (n=1). Many organisations worked with a variety of cohorts from CALD backgrounds with only 25% (n=8) of the organisations surveyed specialising in one field. For a summary of the number of organisations working with a particular client type, please refer to Table 1.0:

Table 1.0: Summary of organisations in regard to specific client types

Youth	Refugee & Asylum	Elderly	Immigrants	International Students	Mental Illness	Drug & Alcohol	Total Organisations
15	15	9	14	6	21	18	**32**

*Service types overlap and do not sum to total.

Services provided to clients by various agencies included legal advice, settlement advice, advocacy, accommodation support and referral to health, mental health and ethnic services. Again, agencies provided multiple services and, perhaps most surprisingly, the most common assistance specified by homelessness services was referral to health services, rather than accommodation support, as perhaps one would expect.

Figure 1.1: Services provided by homelessness organisations to CALD clients
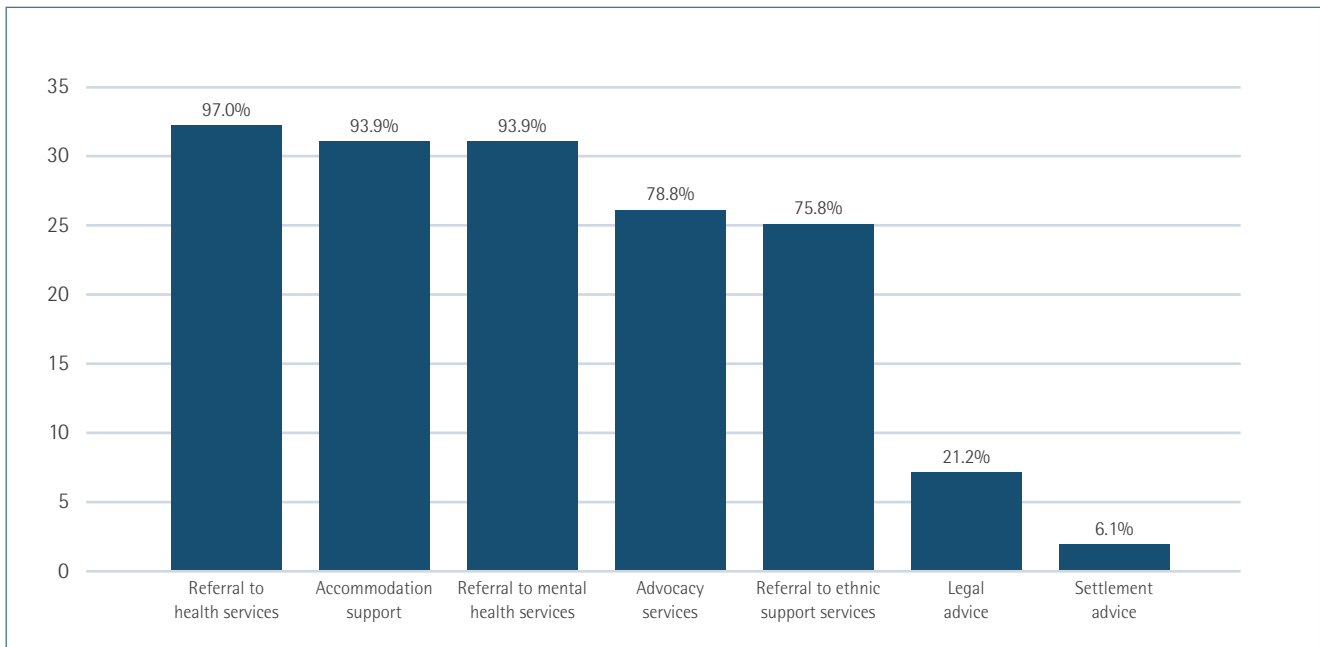
Service types overlap

Of the homelessness services, 87.9% (n=29) indicated that they collect data on clients from CALD backgrounds, while 63.6% (n=21) indicated that they collect data specifically on clients from CALD backgrounds with mental illness. When asked how clients from CALD backgrounds were identified, services varied markedly in terms of their data collection techniques. 90.6% (n=29) collected information on country of birth; however, many of the services who replied used multiple identifiers, for example 71.9% (n=23) also allowed clients to self-identify as CALD (Figure 1.2).

Homelessness amongst culturally and linguistically diverse people with a mental illness

Figure 1.2: CALD identifiers used by homelessness organisations

Bar chart showing:
- Country of birth: 90.6%
- Language spoken: 62.5%
- Level of English proficiency: 31.3%
- Self identification: 71.9%
- Interpreter need: 37.5%
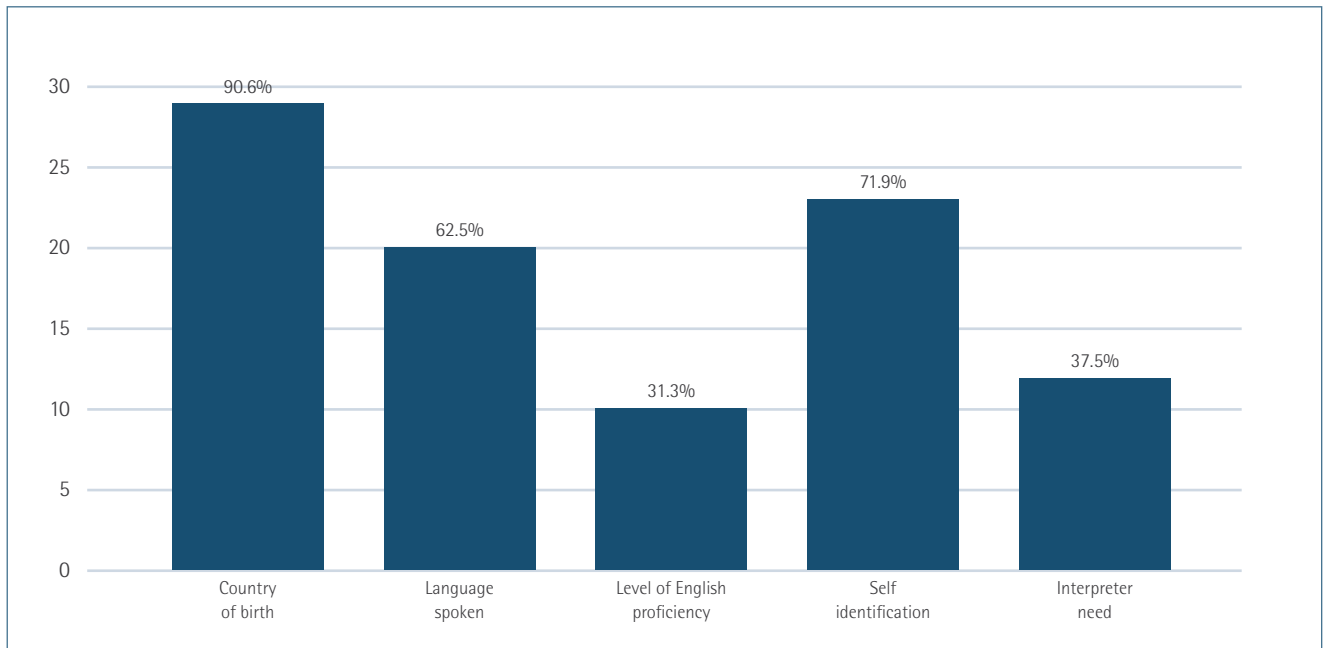
Multiple identifiers were used by agencies

Regarding data collection on mental illness, only 6.1% (n=2) of services did not identify clients with a mental illness. However, responses to this question indicated that many clients who have mental illness could be overlooked. Clients were identified by the homelessness services as having a mental illness via formal and informal diagnosis, referral from a mental health service or self-identification as shown in Figure 1.3. All services used only one of the methods mentioned.

Figure 1.3: Identification methods of mental illness employed by homelessness agencies

Bar chart showing:
- Formal diagnosis: 42.4%
- Informal diagnosis: 9.1%
- Referral from a mental health service: 18.2%
- Do not identify: 6.1%
- Self-identified: 24.2%
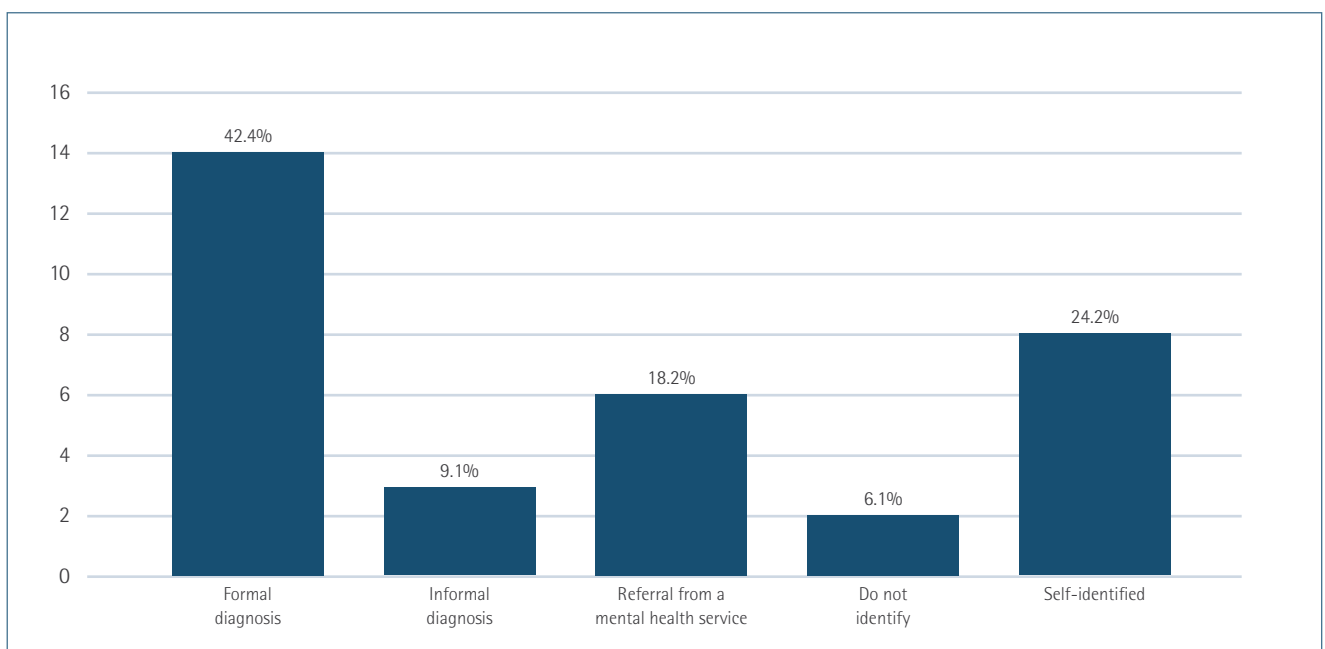
Each service used only 1 method to identify mental illness

The systems used for the collection of client data included registration forms 32.3% (n=10) and SAAP data collection forms 48.4% (n=15), while 54.8% (n=17) of the services used an internal electronic data collection system, and most services 64.5% (n=20) used their intake processes to collect client data. Additionally, four organisations indicated they collected and reported data using HACC-MDS (Home and Community Care – Minimum Data Set) systems. Again, much of the survey data regarding collection systems overlaps, as many agencies use more than one means of collecting data.

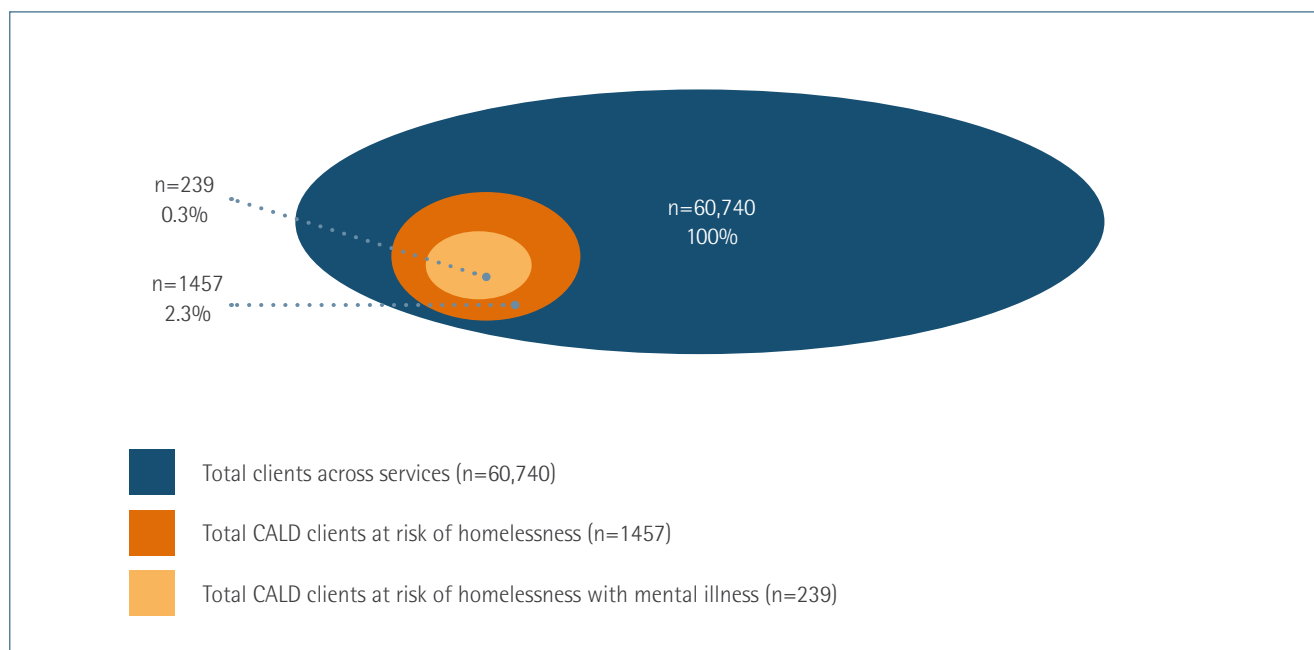As mentioned previously, of the homelessness services surveyed, 87.9% (n=29) indicated that they collect data on clients from CALD backgrounds. However, it should be noted that only 22 organisations were included in the following calculations. Prevalence calculations were made from responses to three questions:

- Over the past year how many clients who are homeless or at risk of homelessness have used your service? (Total homeless/risk of homelessness clients).

- Over the past year how many of these clients were from a CALD background? (CALD homeless/risk of homelessness).

- Over the past year how many clients from CALD backgrounds with mental illness have used your service? (clients from CALD backgrounds at risk of homelessness with a mental illness).

Organisations were excluded if they did not respond to the previous questions or did not explain their reasons for excluding this data (i.e. we do not collect this data). Prevalence data is presented in Appendix I and Figure 1.4. Additionally, the views of organisations on the accuracy of data they have collected is seen in Figure 1.5.

Figure 1.4: Prevalence figures for clients accessing homelessness organisations over previous year

n=239
0.3%

n=1457
2.3%

n=60,740
100%

Total clients across services (n=60,740)

Total CALD clients at risk of homelessness (n=1457)

Total CALD clients at risk of homelessness with mental illness (n=239)

Clients from CALD backgrounds and clients with mental illness from CALD backgrounds at risk of homelessness expressed as percentage of total clients

multicultural MENTAL HEALTH AUSTRALIA   Homelessness amongst culturally and linguistically diverse people with a mental illness

Figure 1.5: Organisational confidence of data accuracy
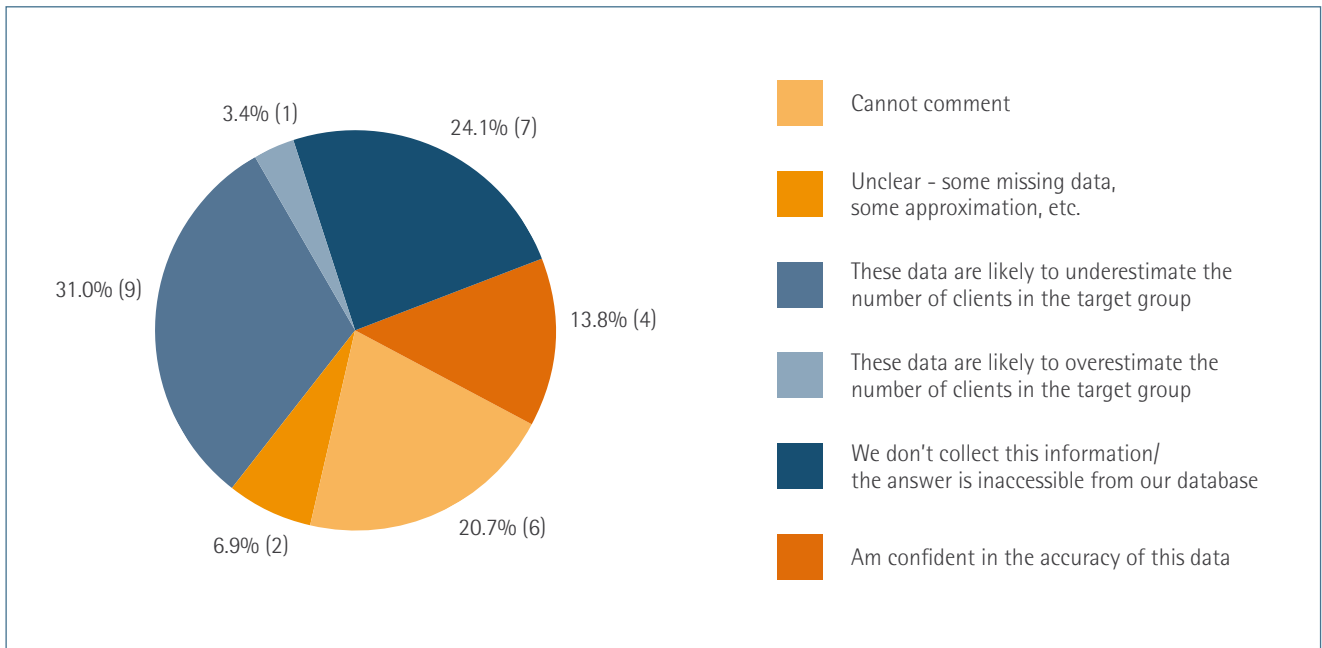
The referral pathways to homelessness services were many and varied. Interestingly, 80.6% (n=25) of services surveyed mentioned that there were no differences in referral pathways for clients from CALD backgrounds than those of mainstream clients to their services. Similarly, 74.2% (n=23) replied that there were no differences in referral pathways to health and mental health services from their services.

The majority of organisations 61.3% (n=19) agreed that clients from CALD backgrounds faced difficulty in accessing appropriate support after referral. The challenges faced can be seen in Figure 1.6, with most organisations 78.3% (n=18) in agreement that unfamiliarity with the service system was the most significant challenge facing clients from CALD backgrounds on referral.

Figure 1.6: Difficulties faced by clients from CALD backgrounds after referral
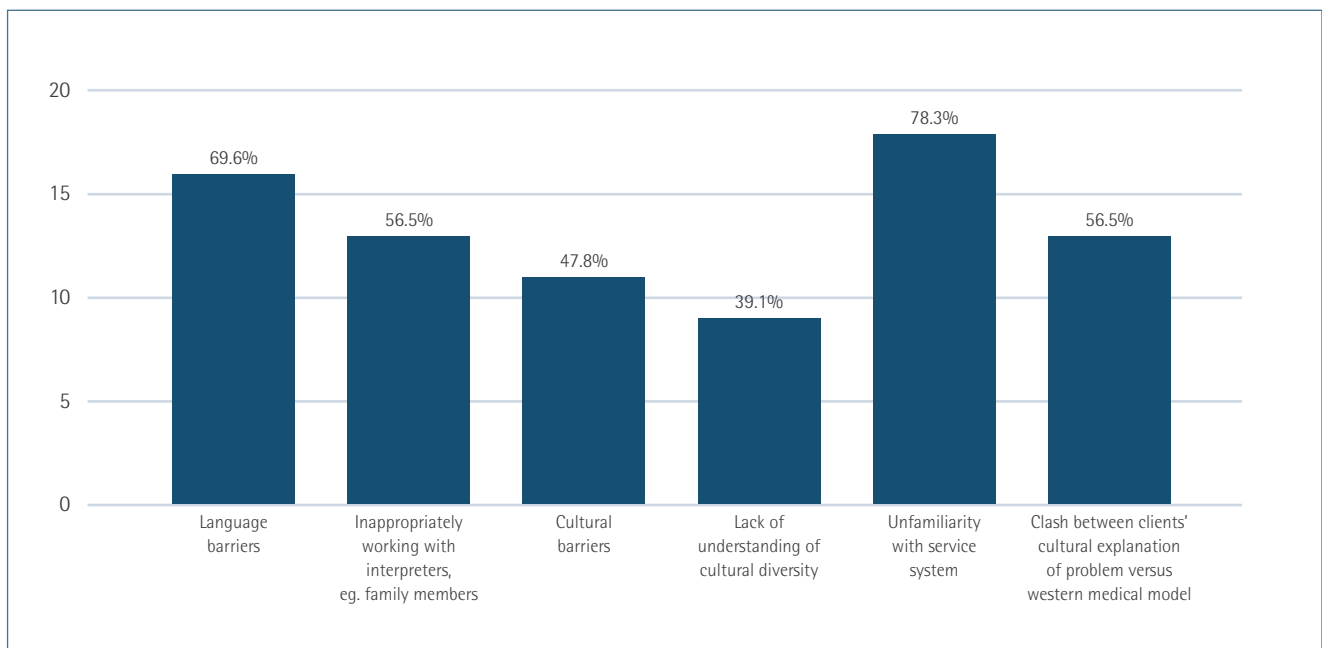
*Multiple replies were used to collect data presented in figure

Organisations also commented on what they found to be the causes of homelessness or at risk of becoming homeless (precipitating factors), in regards to people from a CALD background with a mental illness. Again, multiple answers were accepted for this category and the five most common responses were: family breakdown/conflict 96.8% (n=30), lack of appropriate housing 87.1% (n=27), domestic violence 80.6% (n=25), economic reasons 74.2% (n=23) and isolation 74.2% (n=23) (see Figure 1.7).

Further, the five most common answers on what groups in CALD communities were most at risk of becoming homeless were: people with mental illness 87.5% (n=28), people with low income 84.4% (n=27), people with a dual diagnosis (mental illness and substance abuse) 81.3% (n=26), people with a substance use problem 78.1% (n=25) and women experiencing domestic violence 71.9% (n=23) (see Figure 1.8).

Figure 1.7: Perceived precipitating factors for homelessness of CALD populations with mental illness
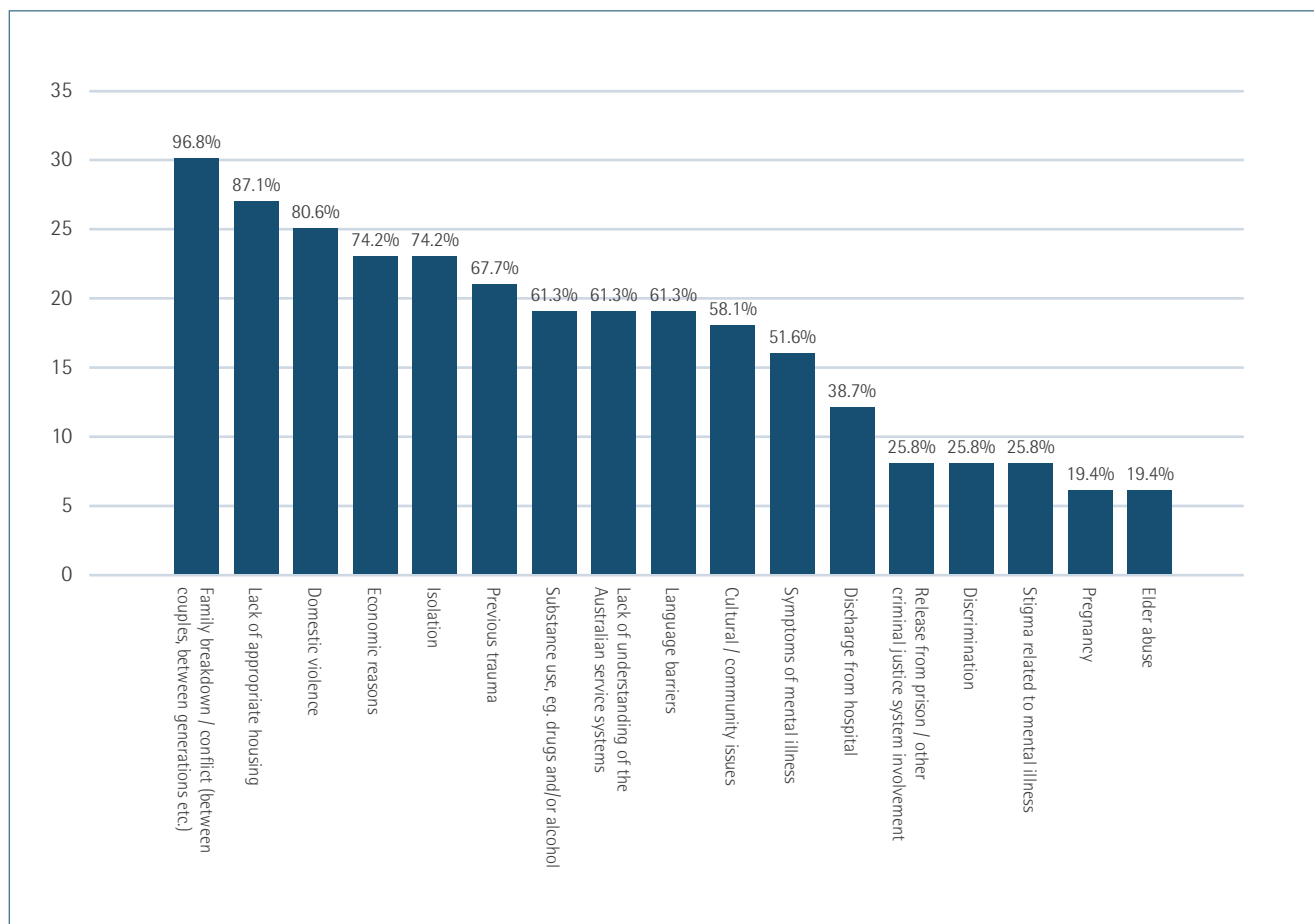
Figure 1.8: Perceptions of most at vulnerable groups within CALD communities of becoming homeless

Bar chart values:
- People with mental illness: 87.5%
- People with low income: 84.4%
- People with a dual diagnosis (mental illness and substance abuse): 81.3%
- People with a substance use problem (drugs and/or alcohol): 78.1%
- Women experiencing domestic violence: 71.9%
- Recent immigrants: 62.5%
- Refugees and/or asylum seekers: 56.3%
- Youth: 53.1%
- Elderly: 46.9%
- Long term immigrants: 34.4%
- International students: 25.0%
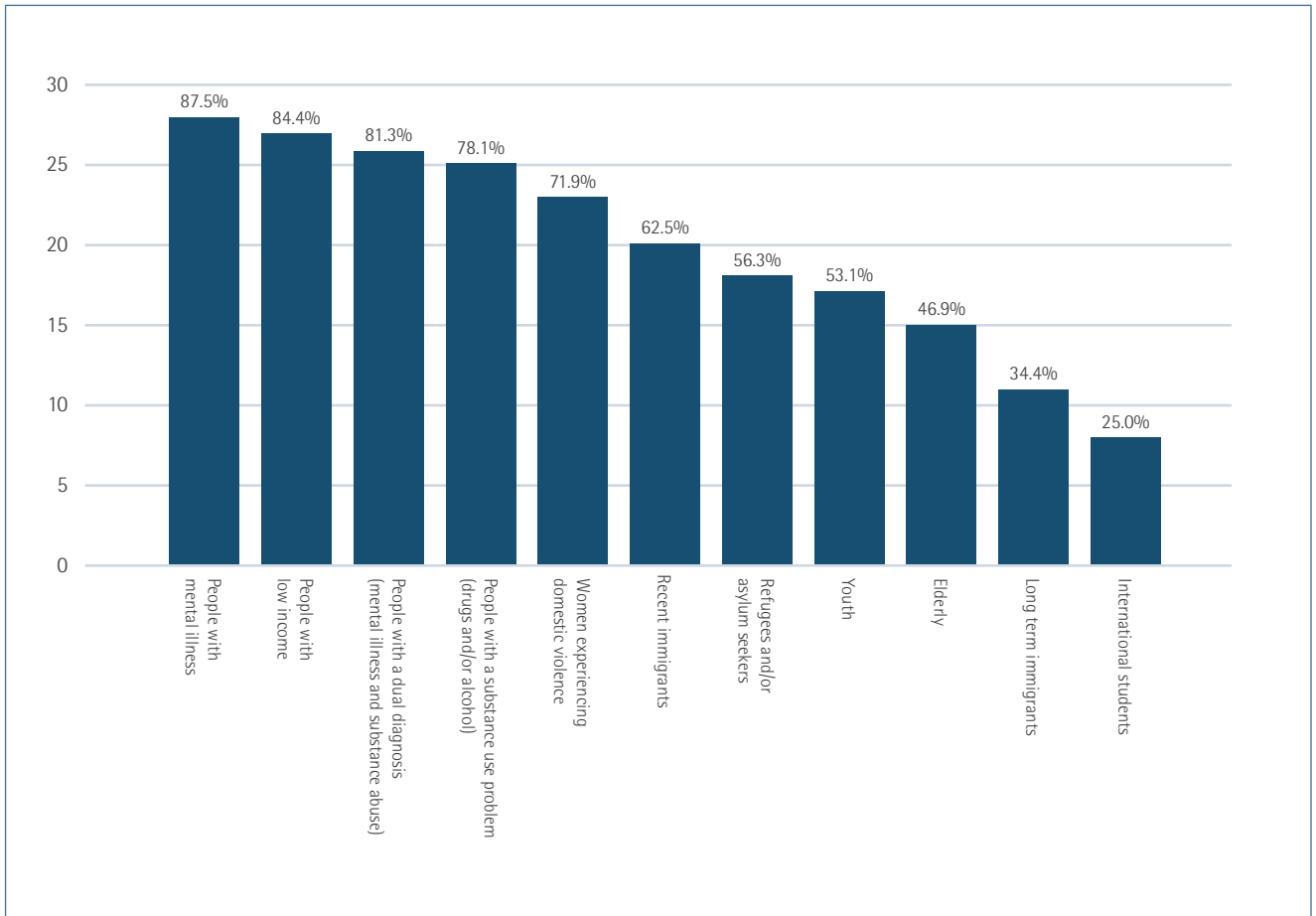
Organisations were also asked to what extent their organisations had implemented access and equity policies for clients from a CALD background with mental illness and what examples were in place to illustrate this. These results can be seen in Figures 1.9 and 2.0 respectively.

Figure 1.9: Extent of implementation of access and equity policies for CALD/mental illness

Pie chart values:
- 39.4% (13) Moderate degree
- 27.3% (9) Significant degree
- 9.1% (3) Not at all
- 24.2% (8) Minimal degree

Legend:
- Not at all
- Minimal degree
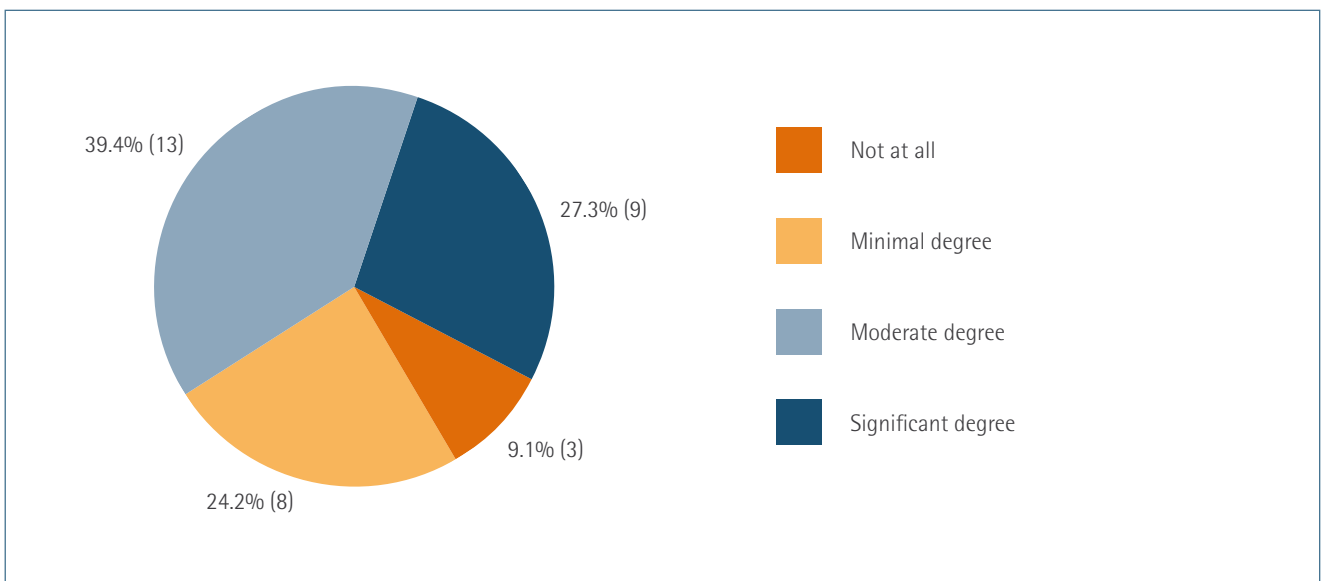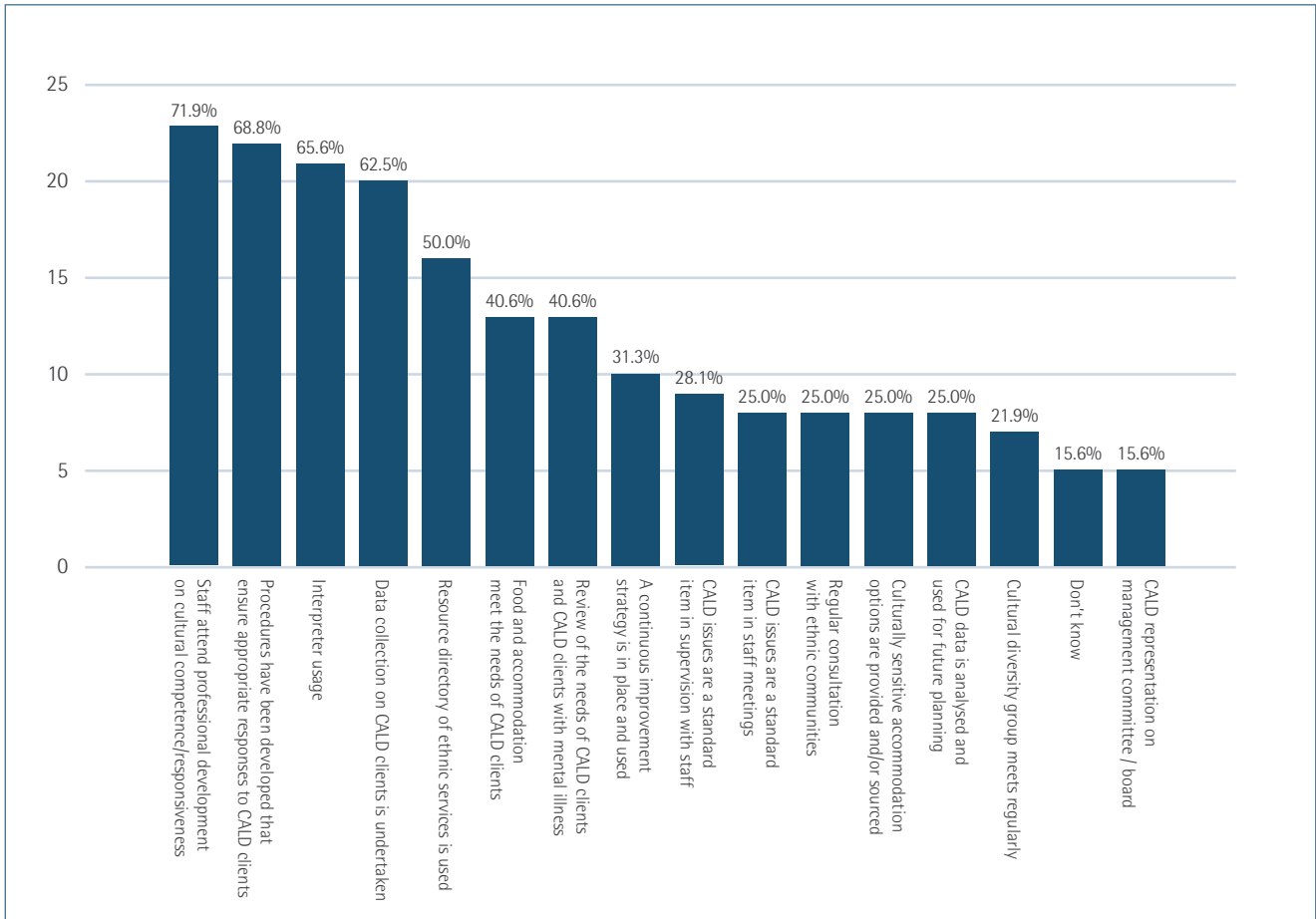- Moderate degree
- Significant degree

Figure 2.0: Examples which illustrate implementation of access and equity strategies

Appendix II

Survey responses from mental health organisations

A total of 49 mental health organisations responded to the survey, with 48 organisations identifying themselves and one choosing to remain anonymous. Of these surveys, 24 were completed on behalf of the whole organisation, 18 respondents replied specifically in regards to their branch and six respondents provided data that represented a state- or territory-wide organisation. Only one respondent did not reply to the relevant question. A state-by-state breakdown is as follows: 12 New South Wales, 17 Victoria, five Queensland, two South Australia, eight Western Australia, one Northern Territory, and one Australian Capital Territory.

Mental health services worked with a diverse range of clients, including youth, older people, refugees/asylum seekers, immigrants, international students, people with mental illness and people with mental illness and drug and alcohol problems. Additionally, two respondents worked with carers. All the organisations worked with a variety of cohorts from CALD backgrounds with only one of the organisations specialising in youth. For a summary of the number of organisations working with a particular client type see Table 2.1.

Of the 49 organisations, 26% (n=13) also worked with specific CALD communities, which included: Italian (n=1), Greek (n=2), Macedonian, Polish, Turkish (n=1), Serbian (n=1), Sudanese (n=2), Karen (n=1) and Vietnamese (n=4). One organisation specifically worked with the following communities: Iraqi, Chinese, African, Indian, Afghani and Filipino (n=1).

Table 2.1: Summary of organisations in regard to specific client types

Youth	Refugee & Asylum	Elderly	Immigrants	International Students	Mental Illness	Drug & Alcohol	Total Organisations
19	12	11	11	4	42	21	**44**

* Service types overlap and do not sum to total.

Regarding those clients at risk of homelessness, 93.8% (n=46) of mental health services assisted such clients, with 87.8% (n=36) of these organisations referring clients to homeless support agencies. Other assistance provided to these clients included legal advice 9.8% (4), settlement advice 2.4% (1), advocacy 58.5% (n=24), accommodation support 68.3% (n=28) and referral to ethno-specific/multicultural services 56.1% (n=23) (see Figure 2.2).

Of the mental health organisations surveyed, some assisted clients at risk of homelessness with a variety of other supports (n=16). Two clinical organisations provided further services, including case management and education about mental health issues, in-hospital acute care, residential rehabilitation, home-based acute treatment, clinic-based follow-up and a secondary consultation/education service to homeless agencies.

Community-based organisations that provided additional assistance did so through help with applications for public housing, priority housing and private accommodation, employment assistance, an alcohol and drug residential rehabilitation program, Personal Helpers and Mentors (PHaMs) program for homeless support, a living skills recovery program, emergency accommodation relief and a SAAP service.

Figure 2.2: Services provided by mental health organisations to CALD clients at risk of homelessness
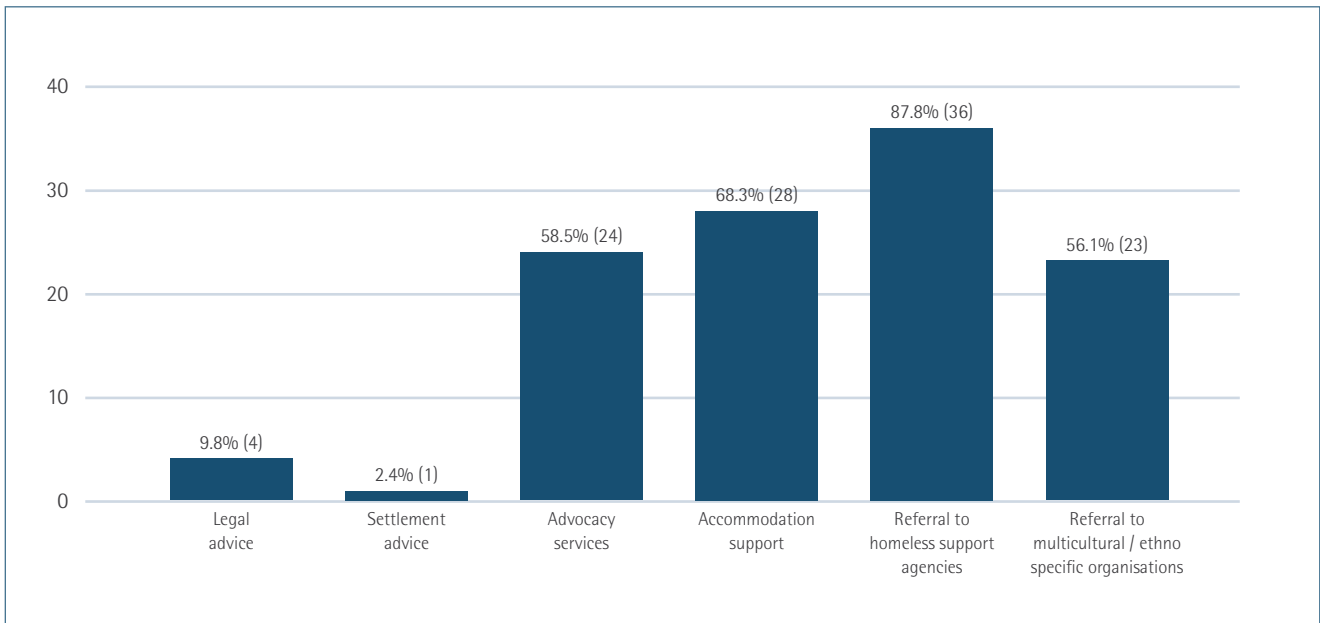
Service types overlap

Of the mental health services, 83.7% (n=41) indicated that they collect data on clients from CALD backgrounds, while 87.8% (n=43) indicated that they collect data specifically on clients from CALD backgrounds with mental illness. When asked how clients from CALD backgrounds were identified, services varied markedly in terms of their data collection techniques: 83.0% (n=39) collected information on country of birth; however, many of the services used multiple identifiers. For example, 66.0% (n=31) also allowed clients to self-identify as CALD (see Figure 2.3).

Figure 2.3: CALD identifiers used by mental health organisations

Multiple identifiers were used by agencies
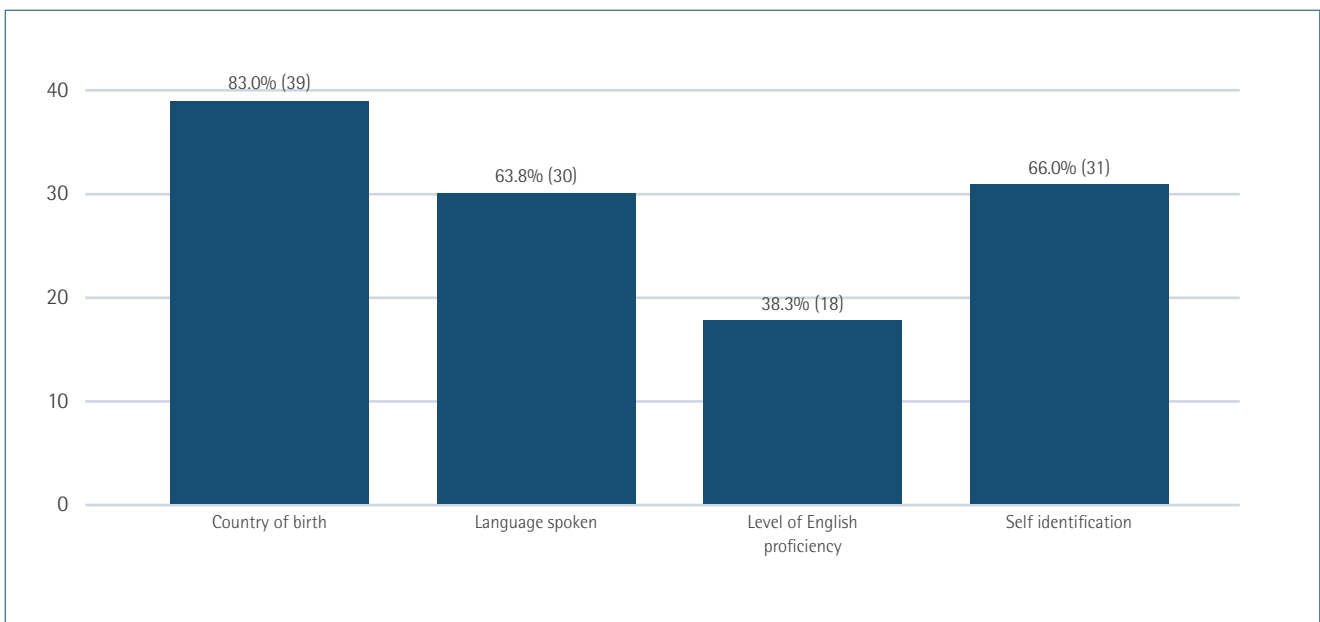
Homelessness amongst culturally and linguistically diverse people with a mental illness

The majority of mental health organisations 77.1% (n=37) also collected data regarding clients that were at risk of homelessness. Again, a variety of methods were used to collect this data and many organisations used more than one method to identify these clients. The most common method used was the intake process 71.1% (n=32), followed by registration forms 37.8% (n=17).

Regarding data collection on mental illness, only 6.1% (n=3) of services did not identify clients with a mental illness. Clients were identified by the mental health services as having a mental illness via formal and informal diagnosis, referral from another mental health service or self-identification as shown in Figure 2.4. Often services used multiple identifiers.

Figure 2.4: Identification methods of mental illness employed by mental health agencies

*Multiple identifiers were used by agencies

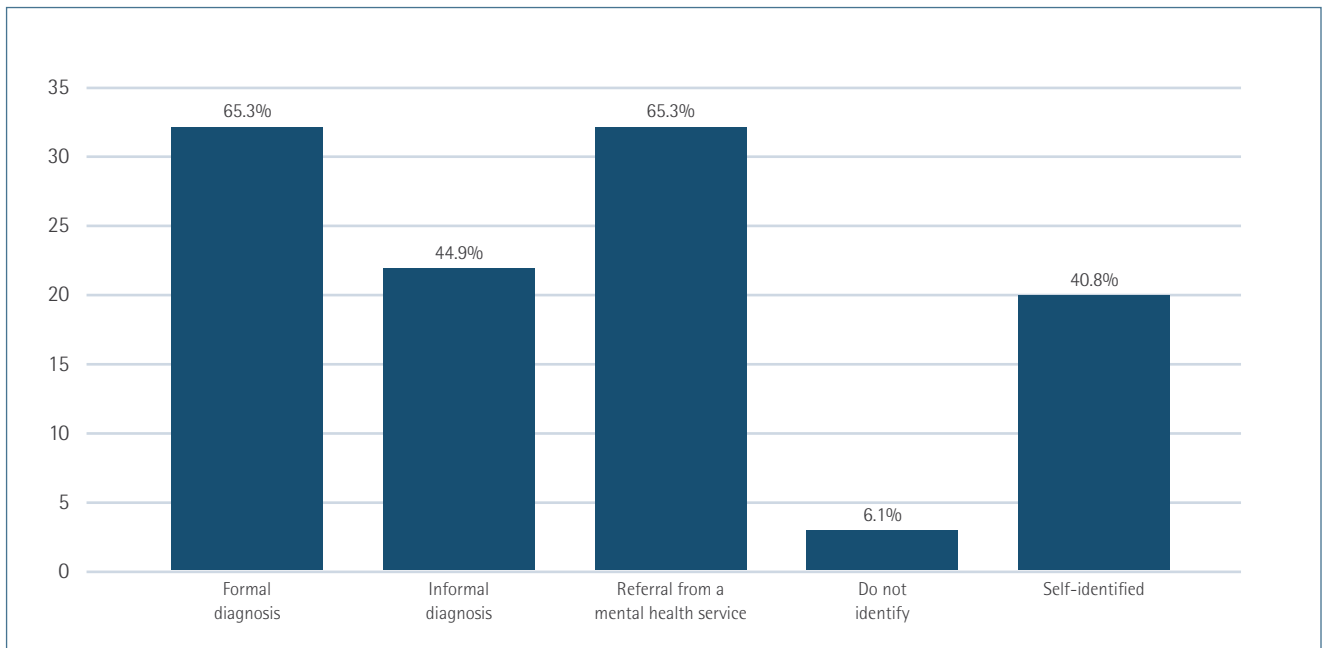As mentioned previously, of the mental health services, 83.7% (n=41) indicated that they collect data on clients from CALD backgrounds and 77.1% (n=37) collected data regarding homelessness. It should be noted that only 28 organisations were included in the following calculations. Prevalence calculations were made from responses to three questions:

• Over the past year how many clients with mental illness have used your service? (Total clients with mental illness).

• Over the past year how many clients from CALD backgrounds with mental illness have used your service? (Clients with a mental illness from CALD backgrounds).

• Over the past year how many of these clients were homeless or at risk of homelessness? (Clients with a mental illness from CALD backgrounds at risk of homelessness).

Organisations were excluded if they did not respond to the previous questions or did not explain their reasons for excluding this data (i.e. we do not collect this data). Prevalence data is presented in Appendix I, graphically in Figure 2.5 and is explored further in the discussion. Additionally, organisations responded on how accurate they thought their data was. This can be seen in Figure 2.6.

Figure 2.5: Prevalence figures for clients accessing mental health organisations over previous year

1465
11.75%

351
2.81%

12,462
100%

Total clients across services (n=12,642)

Total CALD clients with a mental illness (n=1465)

Total CALD clients with mental illness at risk of homelessness (n=351)
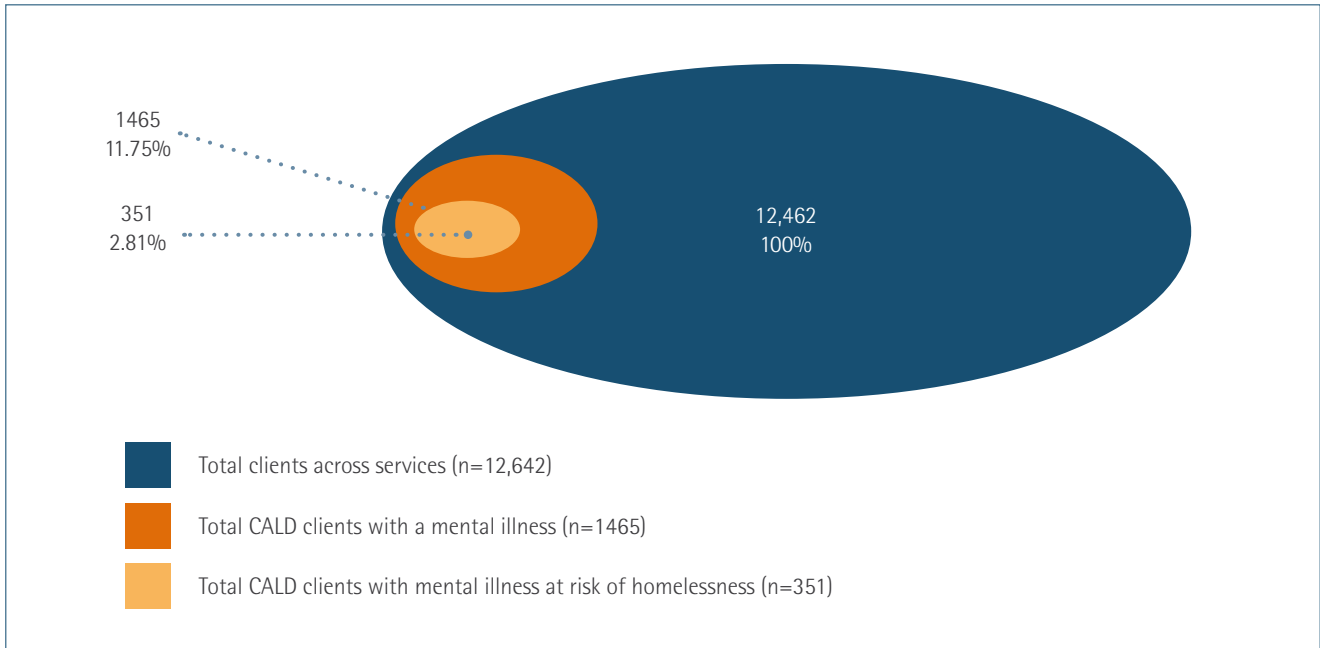
* Clients from CALD backgrounds and clients from CALD backgrounds at risk of homelessness with a mental illness expressed as percentage of total clients. ** Area not representative of percentage

Figure 2.6: Organisational confidence of data accuracy

25.0% (11)

2.3% (1)

2.3% (1)

18.2% (8)

13.6% (6)

38.6% (17)

Cannot comment

Unclear - some missing data, some approximation, etc.

These data are likely to underestimate the number of clients who are...

These data are likely to overestimate the number of clients who are h...

We don't collect this information / the answer is inaccessible from our...

Am confident in the accuracy of this data

multicultural
MENTAL HEALTH AUSTRALIA
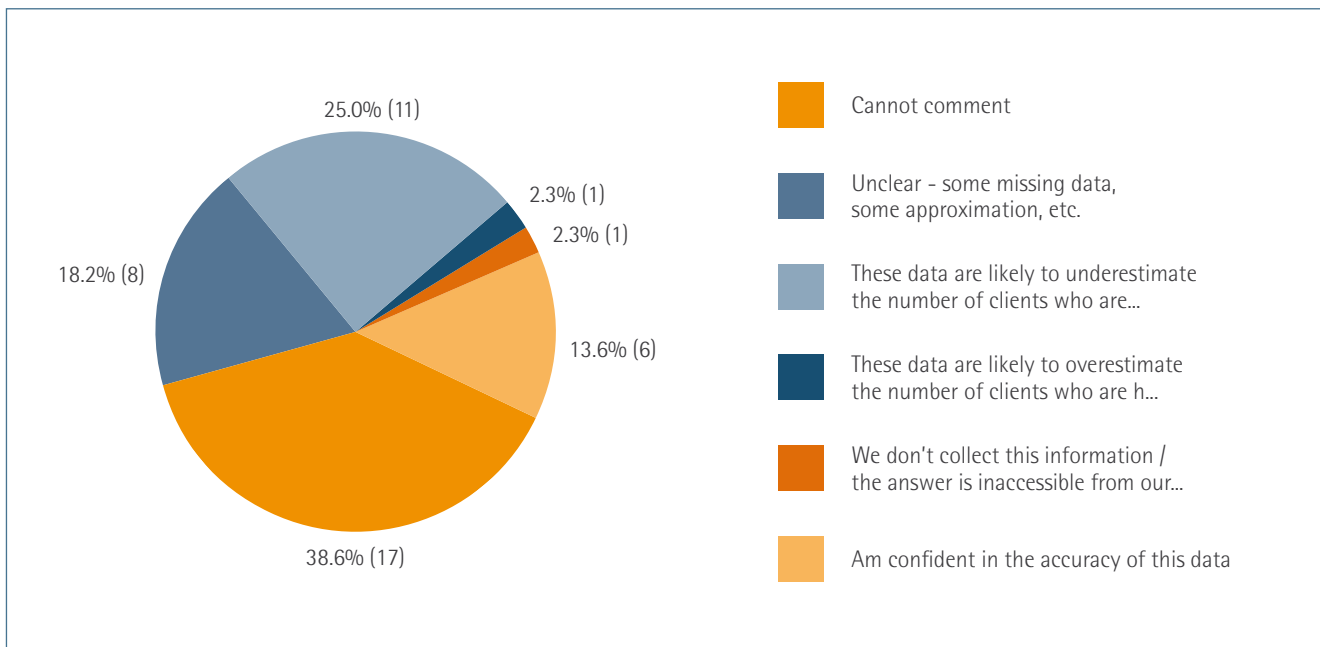
Many referral pathways to mental health services for clients from CALD backgrounds were identified. However, the most common referrals across services came from other mental health services 93.8% (n=45), followed by health services 81.3% (n=39), non-government organisations (NGOs) 75.0% (n=36) and homelessness organisations 70.8%

(n=34). When referring clients from CALD backgrounds to homelessness agencies for support, 61.4% (n=27) of respondents agreed that clients from CALD backgrounds faced additional difficulties in accessing the appropriate support. The challenges faced can be seen in Figure 2.7.

Figure 2.7: Difficulties faced by clients from CALD backgrounds after referral
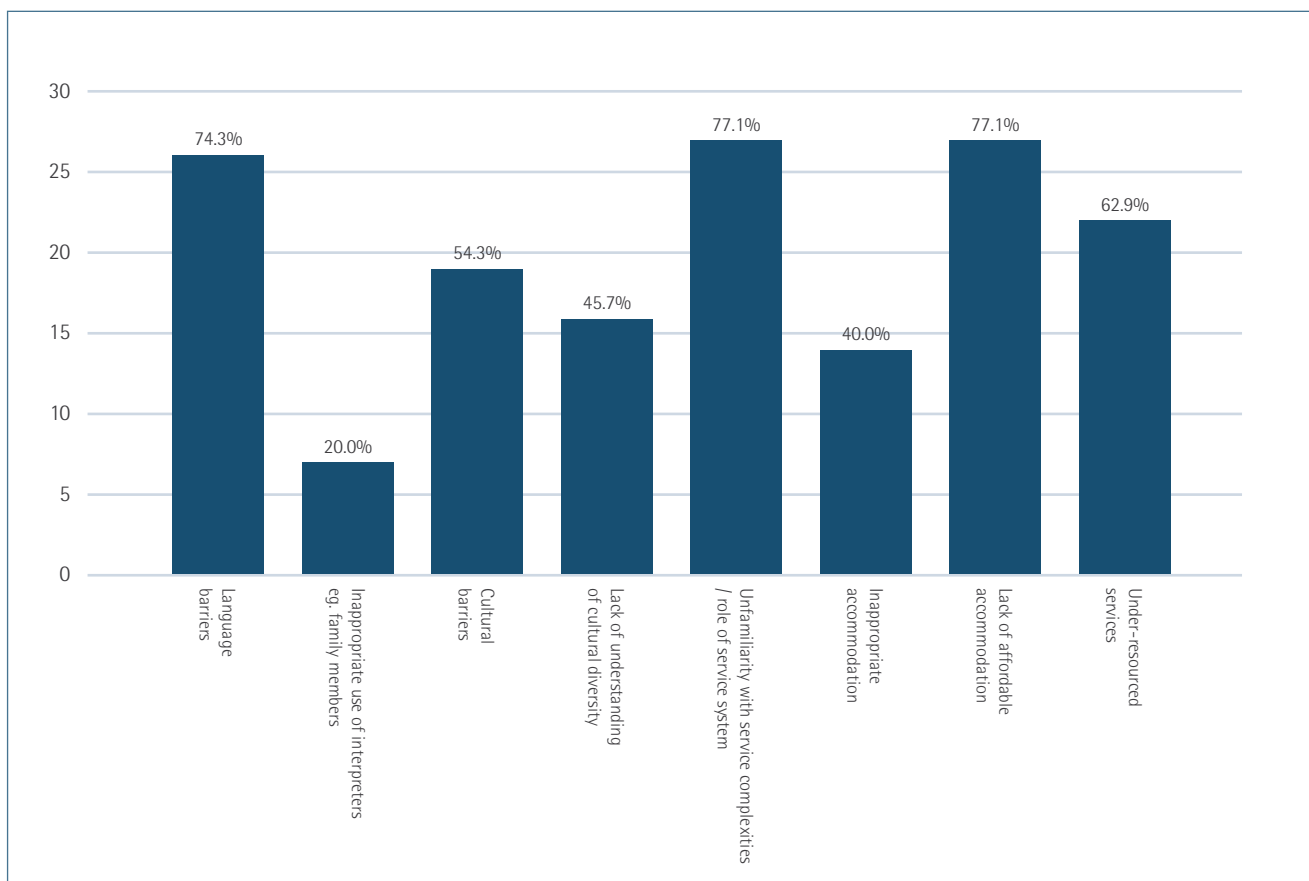
Multiple replies were used to collect data presented in figure

Organisations were also asked to comment on what they had found to be the causes of homelessness or at risk of becoming homeless (precipitating factors of homelessness) in regard to people from a CALD background with a mental illness. The five most common responses were: lack of appropriate housing 91.3% (n=42), economic reasons 89.1% (n=41), family breakdown/conflict 78.3% (36), substance use 78.3% (n=36) and symptoms of mental illness 71.7% (n=33).

Agencies also commented on what groups within CALD communities were most at risk of becoming homeless and the most common five answers were: people with mental illness 97.8% (44), people with dual diagnosis 88.9% (40), people on low incomes 71.1% (n=32), youth 64.4% (29) and victims of domestic violence 60% (n=27). For further details see Figures 2.8 and 2.9 respectively.

Figure 2.8: Perceived precipitating factors for homelessness of CALD populations with mental illness
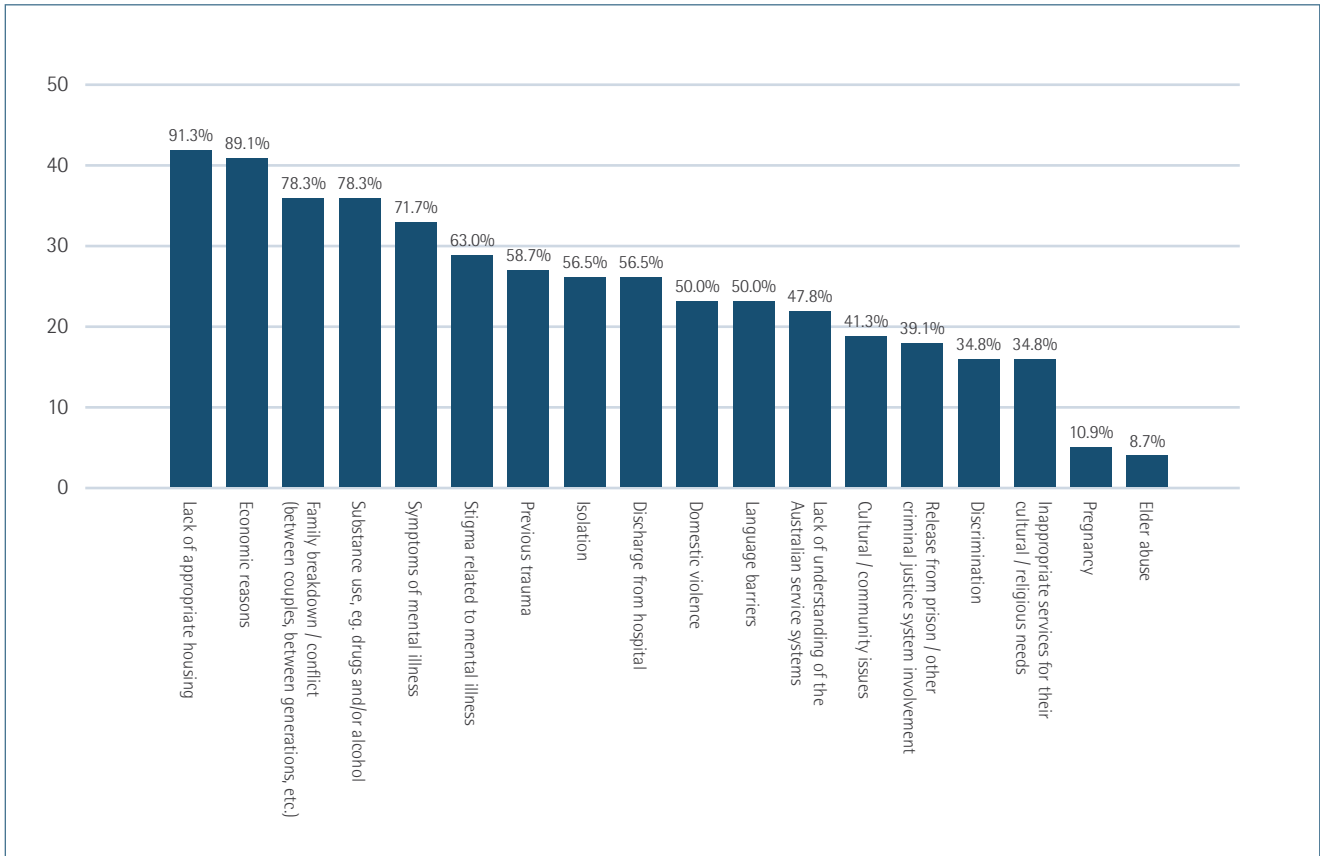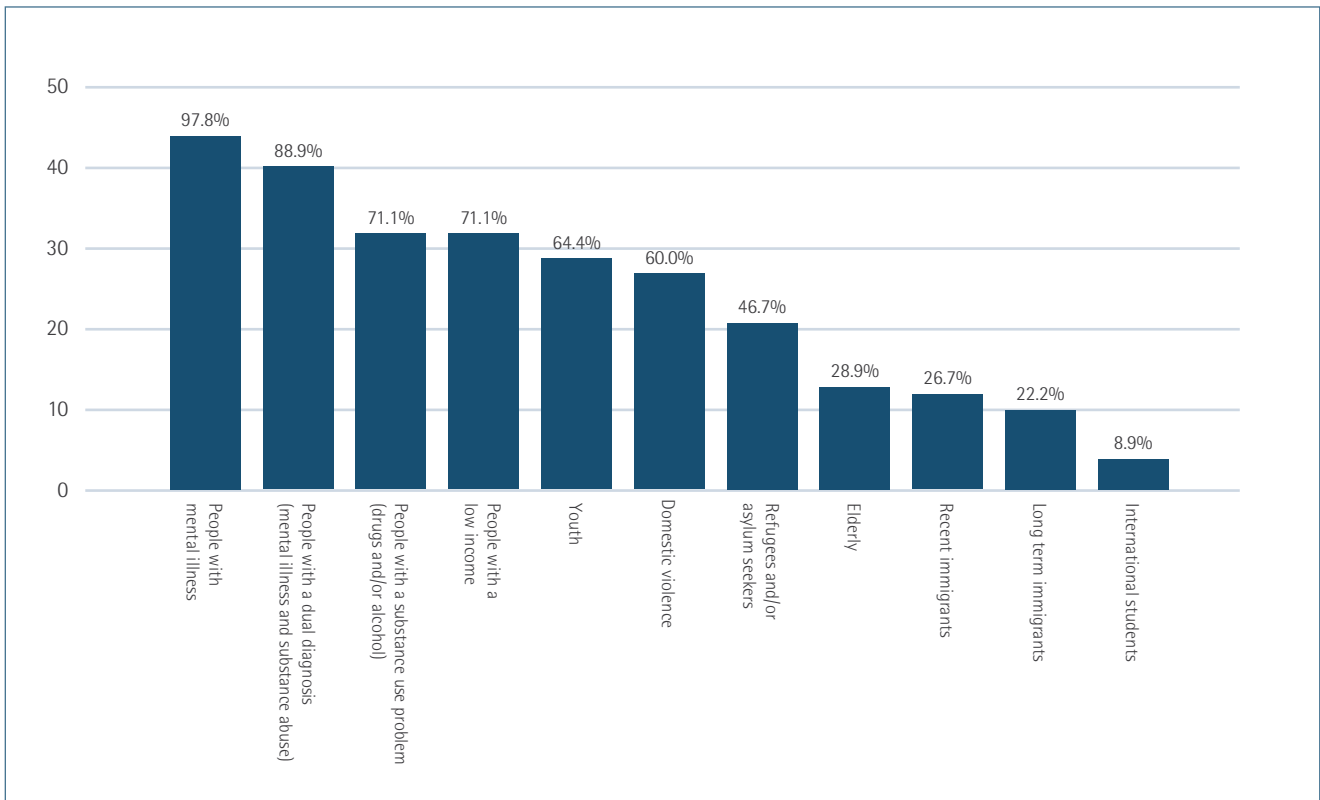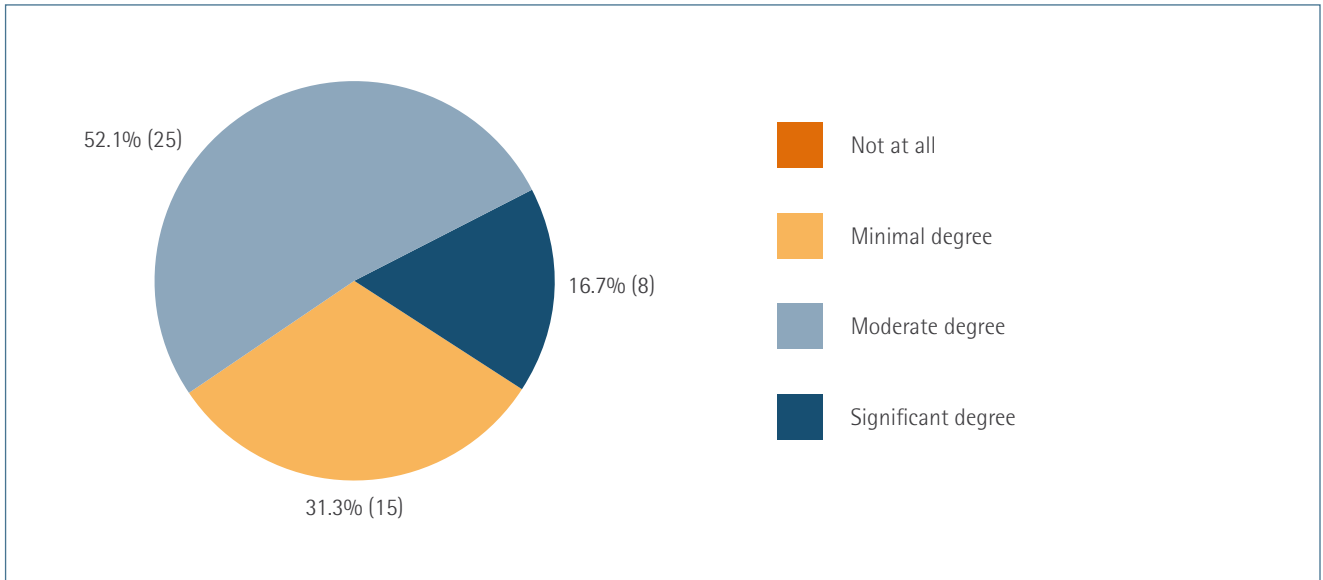

Figure 2.9: Perceptions of most at risk groups within CALD communities of becoming homeless

multicultural
MENTAL HEALTH AUSTRALIA   *Homelessness amongst culturally and linguistically diverse people with a mental illness*

Organisations were also asked about the extent to which their organisations had implemented access and equity policies for clients from a CALD background with mental illness and what examples were in place to illustrate this. These results can be seen in Figures 3.0 and 3.1 respectively.

Figure 3.0: Extent of implementation of access and equity policies for CALD/mental illness

52.1% (25)
16.7% (8)
31.3% (15)

Not at all
Minimal degree
Moderate degree
Significant degree

Figure 3.1: Examples which illustrate implementation of access and equity strategies

79.6% Staff attend professional development on cultural competence/responsiveness
73.5% Procedures have been developed that ensure appropriate responses to CALD clients
61.2% Interpreter usage
59.2% Data collection on CALD clients is undertaken
49.0% Review of the needs of CALD clients and CALD clients with mental illness
44.9% Consultation with ethnic communities
44.9% Resource directory of ethnic services is used
38.8% A continuous improvement strategy is in place and used
30.6% Cultural diversity group meets regularly
28.6% CALD data is analysed and used for future planning
18.4% CALD issues are a standard item in supervision with staff
16.3% CALD issues are a standard item in staff meetings
14.3% Food and accommodation meet the needs of CALD clients
10.2% Culturally sensitive accommodation options are sourced
6.1% CALD representation on management committee / board
2.0% Don't know

Appendix III

Survey responses from ethno-specific/multicultural organisations

A total of 38 ethno-specific/multicultural organisations responded to the survey, with 37 organisations identifying themselves and one choosing to remain anonymous. Of these responses, 30 were completed on behalf of the whole organisation, seven replied specifically in regards to their branch and one organisation provided data representative of a state- or territory-wide organisation. The state-by-state breakdown is as follows: 12 New South Wales, 15 Victoria, two Tasmania, three Queensland, three South Australia, one Western Australia and two Australian Capital Territory.

Most organisations worked exclusively with people who were from a CALD background 76.3% (n=29), and the remaining organisations 23.7% (n=9) were prompted to answer the survey questions only in regard to their clients from CALD backgrounds. Of 38 organisations, 15.2% (n=6) worked specifically with Macedonian clients (n=2), Cambodian and Vietnamese clients (n=1), the Jewish community (n=1), Assyrian and Chaldean clients (central Assyria) (n=1) and Chinese clients (n=1).

Ethno-specific/multicultural services worked with a diverse range of clients, including youth, older people, refugees/asylum seekers, immigrants, international students, people with mental illness and people with mental illness and drug and alcohol problems. Additionally, some respondents worked specifically with HIV-positive clients (n=1), people with disabilities (n=2), victims of torture and trauma (n=1) and carers (specifically women, n=1). For a summary of organisations working with a particular client type, please refer to Table 3.2.

## Table 3.2: Summary of organisations in regard to specific client types

Youth	Refugee & Asylum	Elderly	Immigrants	International Students	Mental Illness	Drug & Alcohol	Total Organisations
19	30	24	26	7	20	16	**37**

* Service types overlap and do not sum to total.

Of the ethno-specific/multicultural services, 92.1% (n=35) indicated that they assisted clients who were homeless, while 7.9% (n=3) did not assist these clients. Of 37 organisations, 62.2% (n=23) collected data regarding those at risk of homelessness, using a variety of data collections methods. The majority, 62.5% (n=15), collected information at the intake point. Services provided to clients that were homeless or at risk of homelessness included legal advice, settlement advice, advocacy, accommodation support and referral to homeless support organisations and mental health services. Again, agencies provided multiple services. Additional services provided by ethno-specific/multicultural organisations included mental health assessments (n=1), housing and budget assistance (n=1), temporary accommodation (n=1), emergency financial assistance (n=1), casework, information and referral (n=1), accommodation, utility payments, financial assistance, legal services and material aid (clothing and food) (n=1), emergency housing (n=1), assistance finding and applying for housing (n=1), alcohol and drug counselling (n=1), outreach support to homeless (n=1) and self-help groups (n=1) (see Figure 3.3).

multicultural MENTAL HEALTH AUSTRALIA

Figure 3.3: Services provided by ethnic/multicultural organisations to CALD clients at risk of homelessness
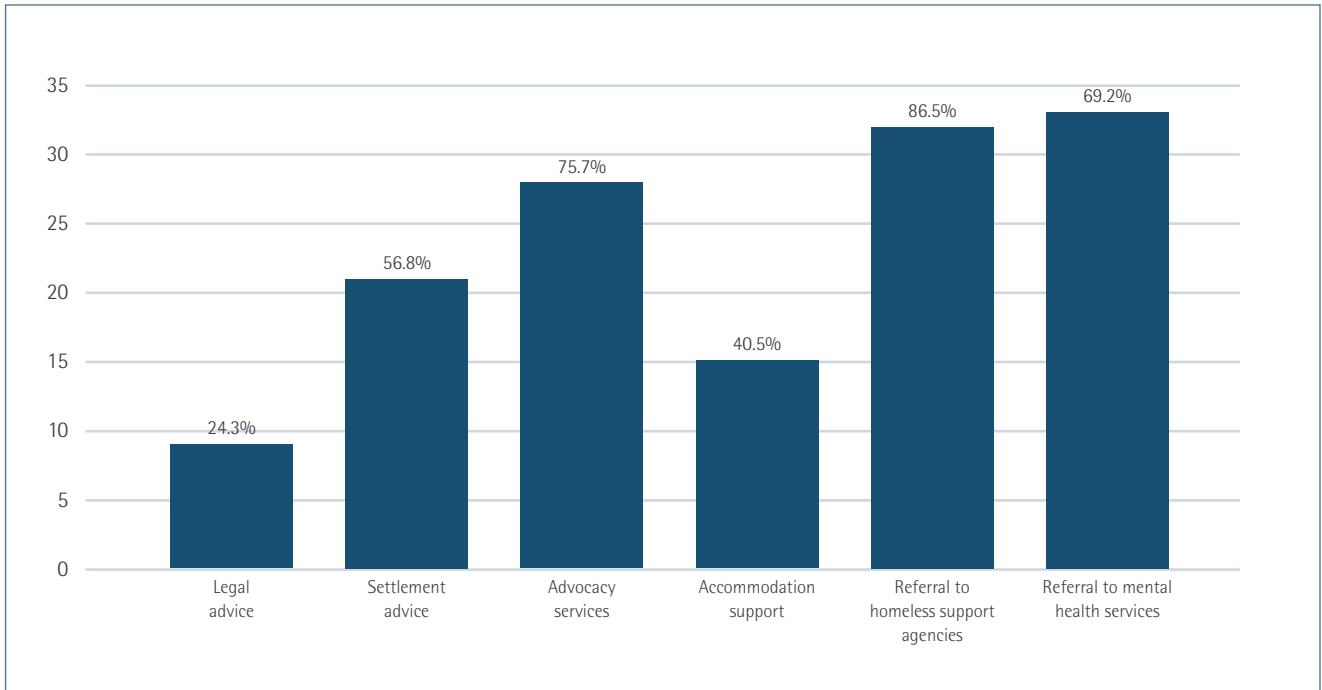
*Service types overlap

When asked how clients from CALD backgrounds were identified, services varied markedly in their data collection processes. 77.1% (n=27) collected information on country of birth; however, many of the services used multiple identifiers. For example, 74.3% (n=26) also identified clients by their use of a language other than English (see Figure 3.4).

Figure 3.4: CALD identifiers used by ethnic/multicultural organisations
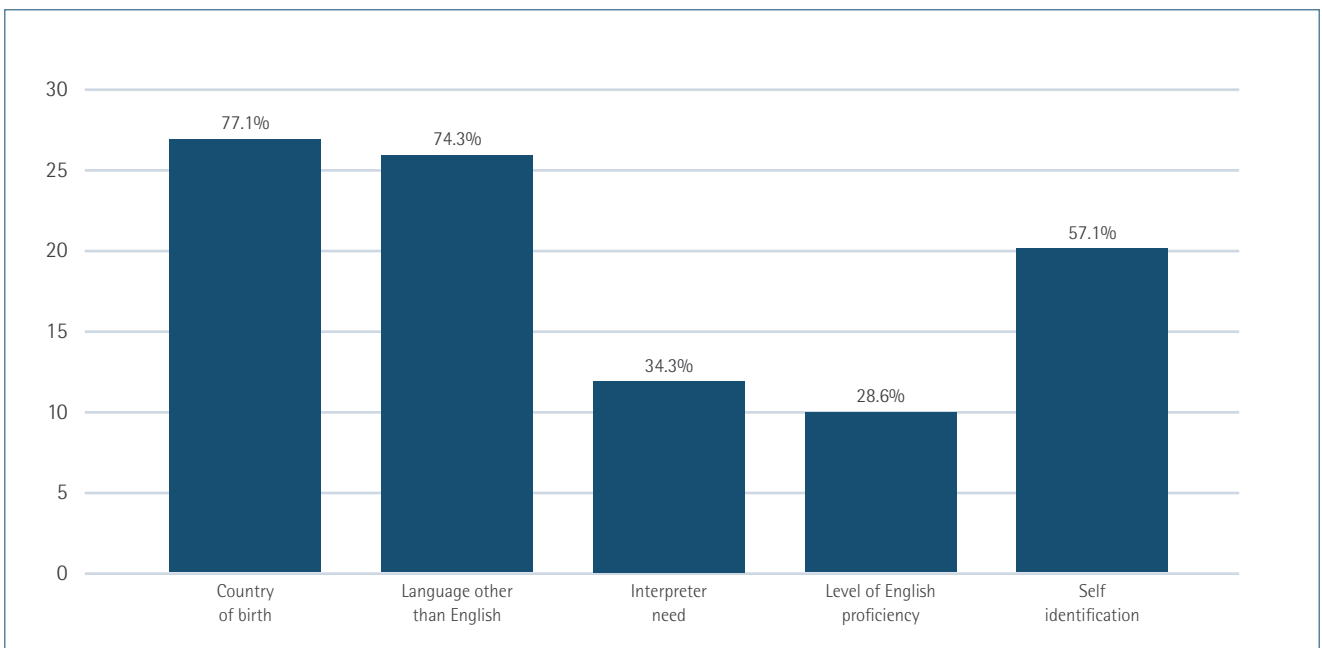
*Multiple identifiers were used by agencies

The majority of ethno-specific/multicultural organisations 82.9% (n=33) assisted clients with a mental illness. Multiple methods were used to identify those who had mental health issues, however many of the clients self identified 69.4% (n=25). Clients were otherwise identified via formal and informal diagnosis or referral from a mental health service, as shown in Figure 3.5. Clearly, a client could have a mental illness but not be formally diagnosed, or their formal diagnosis may not be known to the ethnic/multicultural service. Similarly, informal diagnosis, referral from a mental health service, and self-identification are inadequate as sole indicators of whether or not a client has a mental illness.

Figure 3.5: Identification methods of mental illness employed by ethno-specific/multicultural agencies
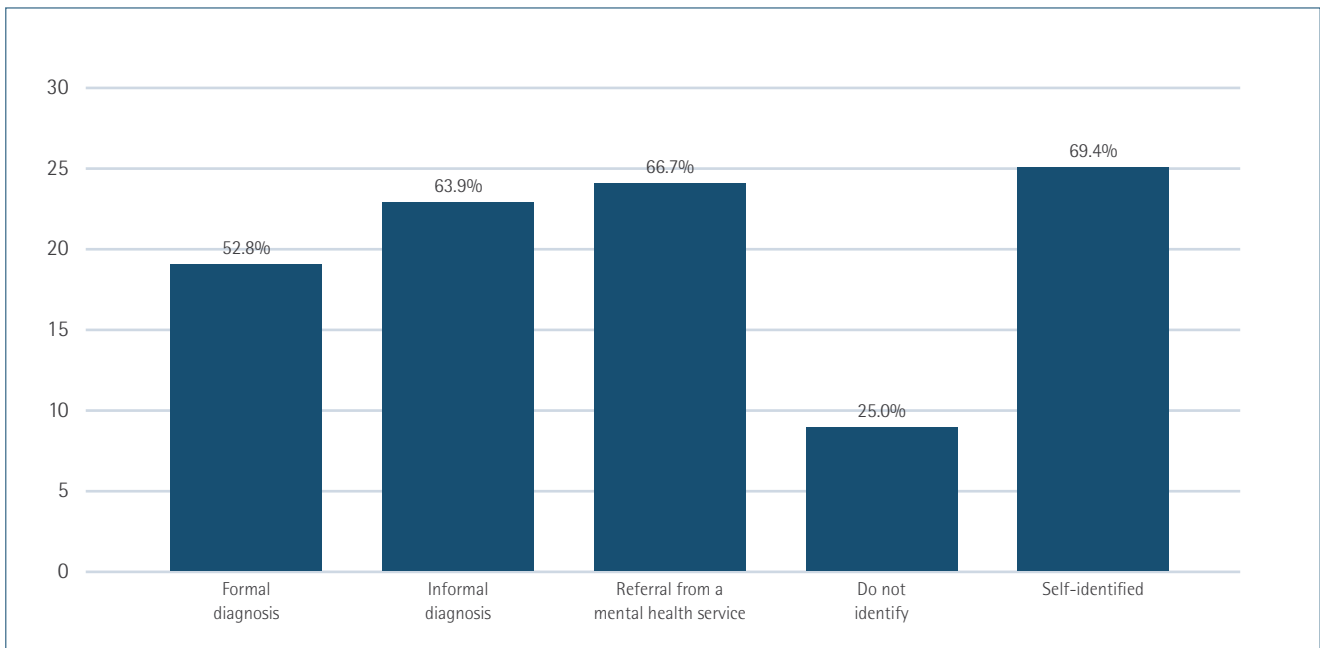
As mentioned previously, of the ethno-specific/multicultural services, 89.2% (n=33) indicated that they collect data on clients with a mental illness and 62.2% (n=23) collected data regarding homelessness. It should be noted that only 19 organisations were included in prevalence calculations, which were formed from responses to three questions:
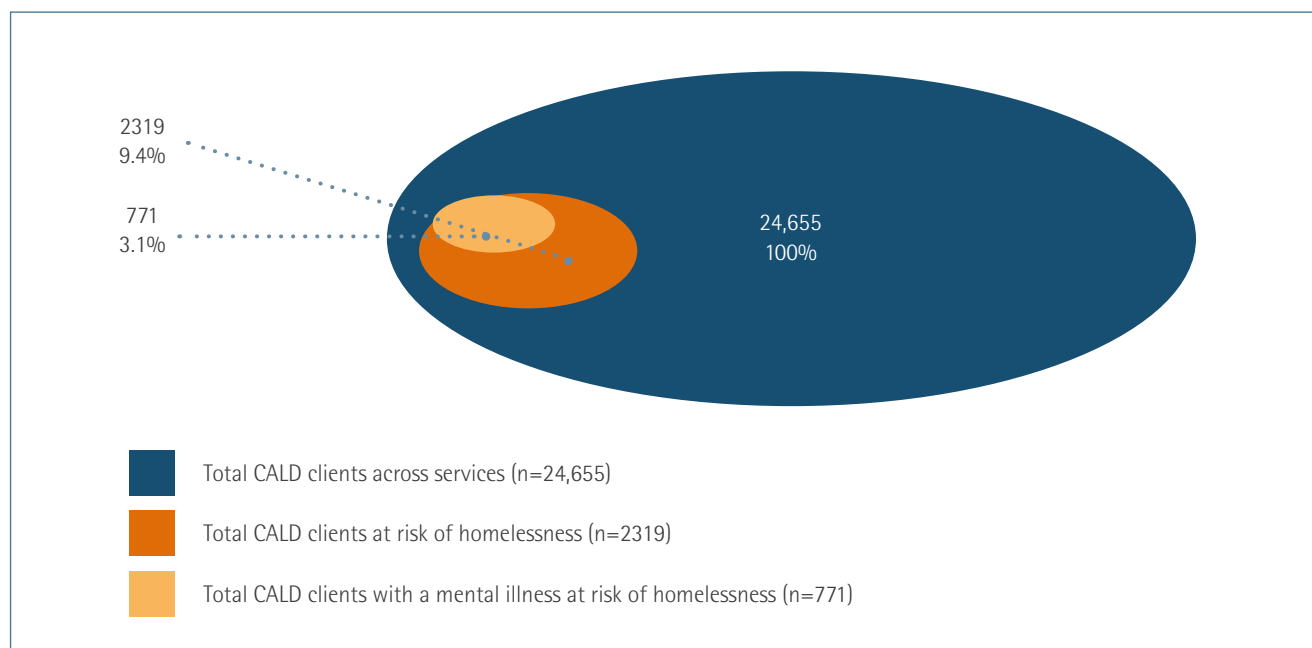
• Over the past year, how many clients from CALD backgrounds used your service? (Total clients from CALD backgrounds across services).

• Over the past year how many of these clients were homeless or at risk of homelessness? (Clients from CALD backgrounds at risk of homelessness).

• Over the past year how many of these clients* were homeless or at risk of homelessness? (Clients from CALD backgrounds with a mental illness at risk of homelessness).

* (It should be noted that preceding the final question was: Over the past year how many clients from CALD backgrounds with mental illness used your service?)

Organisations were excluded if they did not respond to the previous questions or did not explain their reasons for excluding this data (i.e. we do not collect this data). Prevalence data is presented in Appendix I, and graphically in Figure 3.6. Additionally, organisations responded on how accurate they thought their data was. For ethno-specific/multicultural organisations, the survey data was conflicting as some organisations gave multiple responses. However, what can be concluded from this is that only 14.7% (n=5) of organisations were confident of the accuracy of their data.

multicultural MENTAL HEALTH AUSTRALIA   Homelessness amongst culturally and linguistically diverse people with a mental illness

Figure 3.6: Prevalence figures for clients accessing ethno-specific/multicultural organisations over previous year

2319
9.4%

771
3.1%

24,655
100%

■ Total CALD clients across services (n=24,655)

■ Total CALD clients at risk of homelessness (n=2319)

■ Total CALD clients with a mental illness at risk of homelessness (n=771)

CALD clients and CALD clients at risk of homelessness with a mental illness expressed as percentage of total clients
**Area not representative of percentage*

Asked about referral pathways to health and mental health services, 58.1% (n=18) of ethno-specific services reported that in the majority of cases there was little difference in such pathways for clients from CALD backgrounds and those from the mainstream. However, 65.5% (n=19) felt that, in terms of ease of access to mental health services, clients from CALD backgrounds differed from mainstream clients. 89.2% (n=33) felt that many of their clients from CALD backgrounds faced difficulties in accessing the appropriate support from mental health services. Most organisations 91.2% (n=31) agreed that unfamiliarity with the service system was the most significant challenge facing clients from CALD backgrounds on referral.

Organisations were also asked to comment on what they had come to regard as the causes of homelessness or at risk of becoming homeless (precipitating factors of homelessness) in regard to people from a CALD background with a mental illness. Again, multiple answers were accepted for this category and the five most common responses were: family breakdown/conflict 84.2% (32), language barriers 81.6% (31), economic reasons 78.9% (n=30), isolation 73.7% (n=28) and lack of appropriate housing 71.1% (n=27) (see Figure 3.7).

Agencies also commented on which groups within CALD communities were most at risk of becoming homeless. The five most common answers were: people with low incomes 76.3% (29), people with mental illness 73.7% (28), people on low incomes from refugee and asylum seeker backgrounds 65.8% (n=25), victims of domestic violence 60.5% (23) and equally both youth 57.9% (22) and people with a dual diagnosis 57.9% (22) (see Figure 3.8). Other answers included:

"Recently arrived migrants who are not eligible for Centrelink and are not working; many asylum seekers have no work rights (after Government changes in July 2009). However, for clients who are too unwell (physically or mentally) to be able to work, there is no safety net, leaving people (including children) destitute and homeless."

"It is the experience of many agencies in the asylum seeker sector that long-term destitution and visa uncertainty often leads to the onset of mental health issues and increases the risk of homelessness."

Figure 3.7: Perceived precipitating factors for homelessness of CALD populations with mental illness
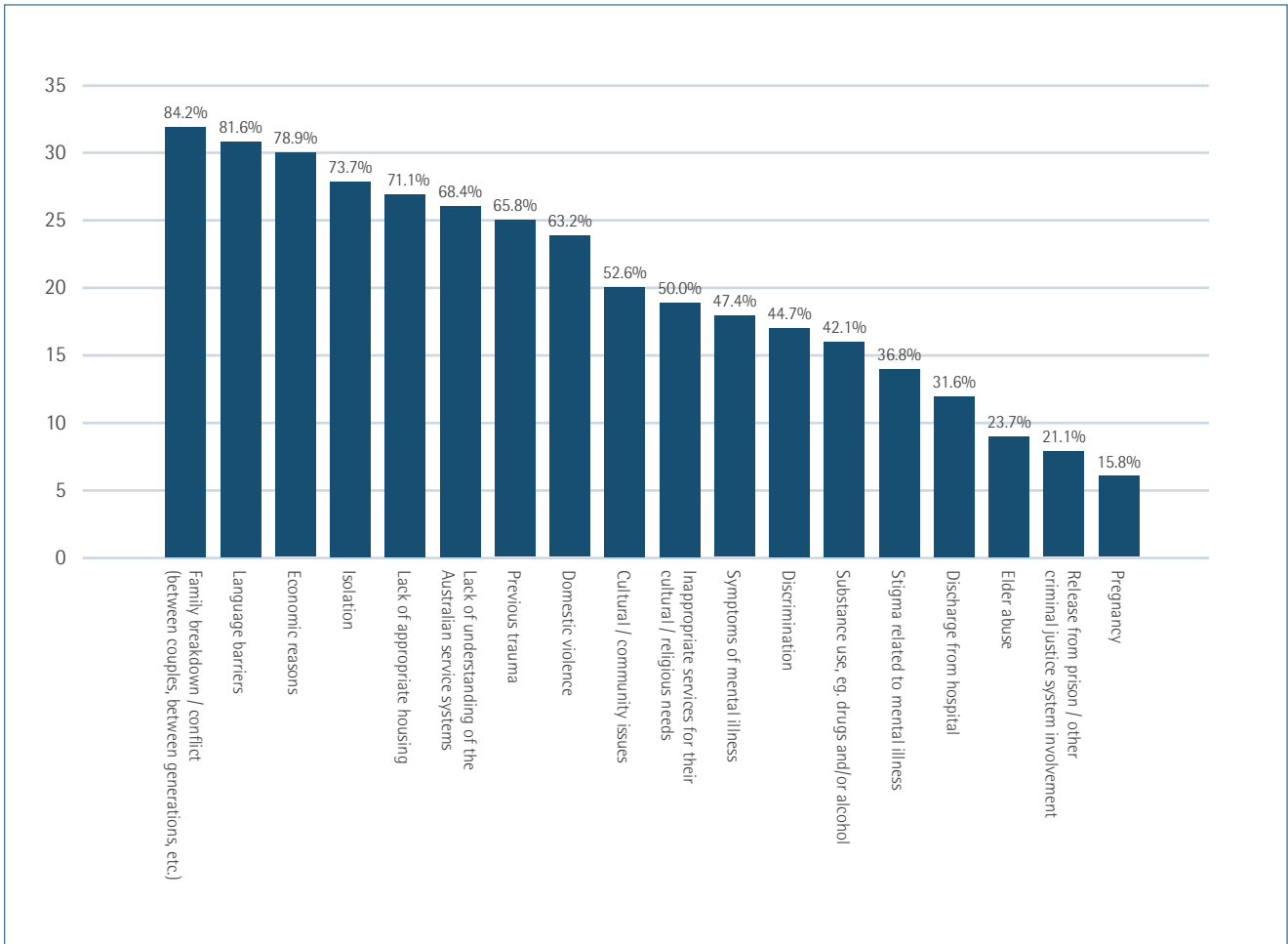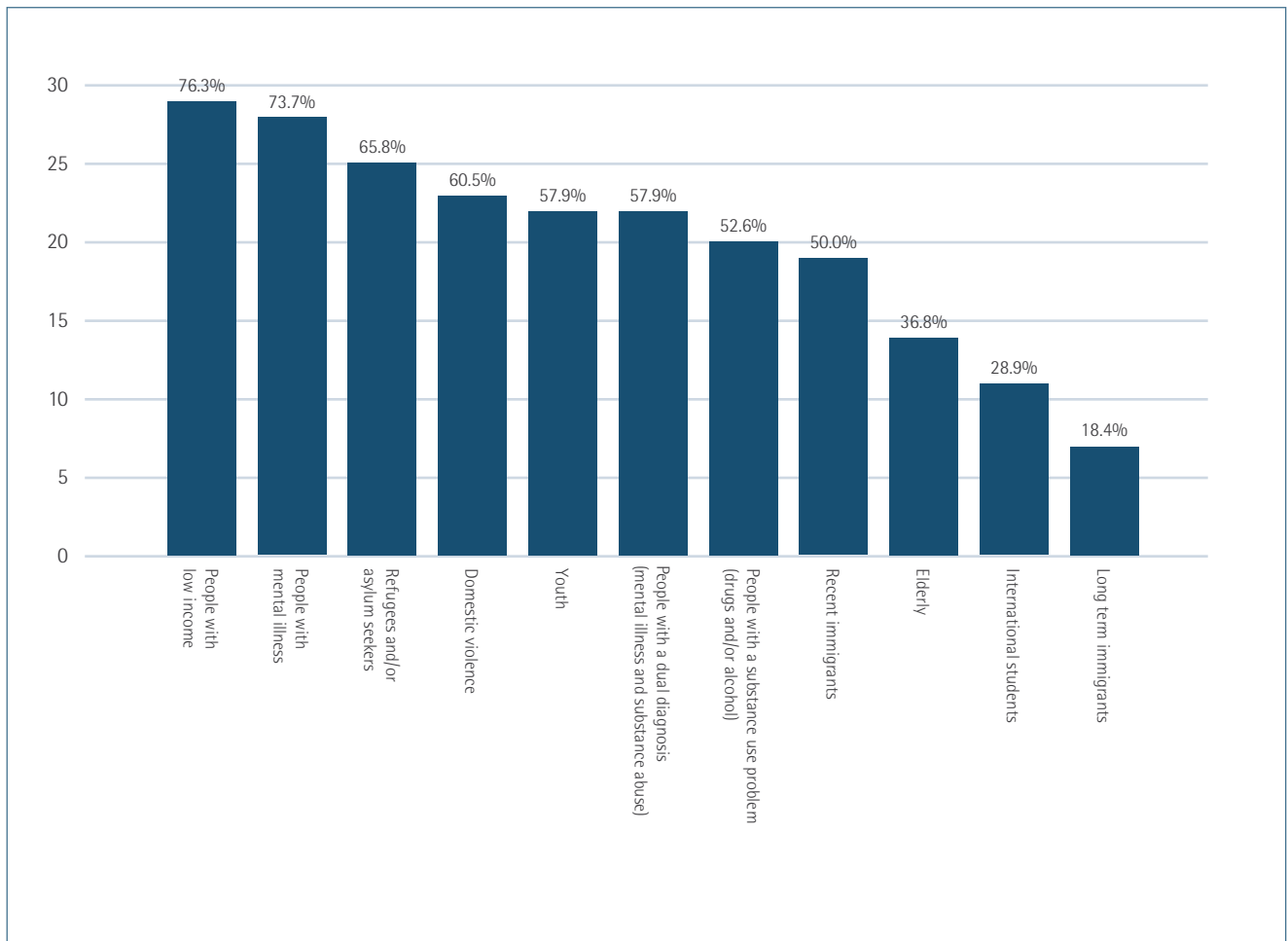
Figure 3.8: Perceptions of most at-risk groups within CALD communities of becoming homeless

Ethno-specific/multicultural organisations were asked if the mainstream homelessness organisations with which they worked had access and equity strategies and if they were involved in assisting with these strategies. Just over half (57.9% n=22) of the organisations who replied did not know if these strategies were employed and the majority (70.3% n=26) were not asked to be involved in assisting homelessness organisations with access and equity strategies. Of those who did assist other organisations (n=11), many were involved in strategies aimed at increasing equity of access, with the majority (90.9% n=10) advising on cultural responsiveness. Other

strategies included being members of a reference group (n=4), assisting community development projects (n=8) and providing cultural competency training (n=7).

When discussing access and equity strategies in regard to mental health organisations, 34.4% (n=11) were involved in assisting mental health services with these strategies. Seven organisations provided advice and training on cultural responsiveness and participation as reference group members. The remaining organisations (n=5) assisted mental health services with community development activities.

Appendix IV

Questions discussed during focus group

Extent of CALD data collection

The main source of information regarding homelessness is based on data collected from the ABS Census of population which is supplemented with Supported Accommodation Assistance Program (SAAP) data.

Do organisations have standard data collection requirements?

For what purpose are you collecting data and how are you using this once you have it?

The Victorian Mental Health Act 1986 highlights "respect for privacy and dignity" so clients need not provide information regarding background or country of birth in order to receive care. How does this impact on the collection of reliable data? Would this prevent a voluntary system of reporting?

Prevalence rates – CALD homeless and CALD mental illness

Homelessness Australia states that more than one in ten homeless people are from a CALD background. How does this compare with your local population and experience?

Anecdotally, it seems there are multiple definitions being used to decide those clients considered to be from a CALD background? Whom do you consider to be from a CALD background and why?

What criteria, if any, are used in your service to define mental illness?

Would standard definitions of CALD and mental illness across services be useful or would this impact on service delivery? If so, why?

Precipitating and perpetuating factors – homelessness, CALD and mental illness

Contributing factors to homelessness are listed as: family breakdown, intergenerational disadvantage, limited education, domestic violence, drug and alcohol use, mental illness, problem gambling, being in the juvenile justice or prison system, under care of the state. Which, if any, of these precipitating factors are more predominant amongst:

1) CALD populations?

2) Homeless populations from a refugee background?

SAAP national data shows that even though immigrants are generally under-represented in the use of services, North African, Middle Eastern and sub-Saharan populations were over-represented and at a greater risk of homelessness. The reasons for this are unclear; however, one suggestion is that these groups are more likely to be humanitarian entrants and less educated/skilled than entrants from Asia, Europe and the Americas.

Is this reflective of your experience or could this be related to other issues (i.e. the qualifications held are not recognised)?

Overcrowding and "couch surfing" among youth, particularly international students, seems to be increasing; what, if any, information is known about this group?

Access and equity

Government reports discussing the lower access rates of clients from CALD backgrounds in SAAP services suggest that this may be due to differing support groups and extensive family networks. Does your experience suggest this may be the case?

In your experience is there a particular group (i.e. youth, refugee, mentally ill, etc.) that are at a particular risk of not gaining access to services? If so, why?

In comparison to others, is there a particular group that has an easier path of access to services?

The literature review states that, "agencies can find it difficult to develop and employ cultural competence in individual staff members or across a service." Is this the case from your experience and if so, why?

Are there employment strategies that you are aware of around preferential recruitment strategies aimed at a cultural mix in your staff profile?

Referral pathways

The literature review notes that homeless people with a mental illness require "social support, housing and economic security." To what extent is this able to be implemented for clients from CALD backgrounds?

Do you feel there are any particular areas in referral or service delivery that create "bottlenecks" in providing access for clients from CALD backgrounds?

What partnerships, if any, exist between providers? In general terms, are these formal or informal arrangements?

What partnerships would be useful to increase access and provide better outcomes?

Appendix V

CALD data collection template

1. Cultural background

Name: .... Date: ....

Service: ....

Client country of birth: ☐ Australia   If other COB, please state: ....

Ethnic group: .... Year of Arrival: ....

Was either of your parents born overseas? ☐ One   ☐ Both   ☐ Mother   ☐ Father

If so, where? ....

Are you currently an: ☐ Australian Cit.   ☐ Permanent Res.   ☐ Immigration App.   ☐ Temp. Per.

☐ Res.   ☐ Refugee / Asylum Seeker   Visa Type: ....

2. Language, interpreter need, religious background

What language do you speak at home? ☐ English   ☐ Other: ....

What is your preferred language? ....

Indications for an interpreter?   ☐ 1. Unable to have an everyday conversation?
                                  ☐ 2. Able to have an everyday conversation, but not proficient enough to discuss personal information?
                                  ☐ 3. Able to communicate well, can readily discuss personal information?

Is there an interpreter / bilingual interviewer required? ☐ Yes (1-2)   ☐ No (3)

What if any is your religion?   ☐ None   ☐ Christian   ☐ Muslim   ☐ Judaism   ☐ Buddhism
                                 ☐ Hindu   ☐ Taosim / Confucianism   ☐ Other: ....

Do you practice your religion? ☐ Yes   ☐ No

3. Special needs

Do you have a disability or diagnosed mental illness? ☐ Yes   ☐ No

If yes, what?: ....

Do you require any special assistance regarding housing due to this condition? ☐ Yes   ☐ No

If yes, please list: ....

Do you have any special dietary requirements? ☐ Yes   ☐ No

Do you have any special cultural or religious needs? ☐ Yes   ☐ No

If yes, please list: ....

Appendix VI

Organisational cultural responsiveness tool

Key cultural responsiveness domain	Key features of domain	How does your service rate?	Action required
1. Evidence based service review	Data collection.	• Do you collect data regarding CALD clients? • Is the data you collect used to inform your service delivery?	• Include domains from data collection tool (Appendix V) in current intake form. • Review data and implement the most effective service delivery and resource allocation based on the cultural composition of your consumer base.
2. Effective cross-cultural communication	Working effectively with interpreters. Accessing translated material.	• Does your organisation have a policy regarding working effectively with interpreters? • Is the policy implemented? • Are staff informed of policy at orientation? • Do you have access to translated material of the major language groups in the region?	• Develop specific policies and practices regarding effectively working with interpreters. • Implement policy and review annually. • Develop service orientation programs inclusive of working effectively with interpreters. • Obtain and make available local printed or web resources, e.g. MMHA or VTPU websites, local ethnic/multicultural services.
3. Culturally informed and responsive workforce	Staff development, service flexibility and culturally sensitive practice.	• Do your staff receive professional development regarding working with CALD consumers? • Are CALD issues a regular part of your services practices? • Are CALD access issues addressed? • Do your service/staff demonstrate cultural sensitivity/safety in response to CALD clients?	• Implement cultural responsiveness training. • Review and evaluate CALD access and equity policies and procedures. • Establish policy implementation processes to address access • Develop orientation programs to address CALD access issues. • Develop and implement cultural responsiveness training programs. • Consider reviewing local cultural responsiveness training options.
4. Effective referral systems	Networks, partnerships and referrals.	• Do you have a local network and registry of CALD responsive services? • Are staff aware of referral pathways? • Do you have referral processes in place?	• Develop relevant partnerships with culturally responsive organisations. • Attend local CALD network/partnership meetings. • Develop a registry of referral resources. • Develop policy and practices to inform referral practices.

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