Out of mind, out of sight: government policy on migrants’ mental health, Australia 1960 - 2000

A thesis submitted in fulfilment of the requirements for the award of the degree of

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SCHOOL OF HISTORY AND POLITICS
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DECLARATION

I, Tilaka Wickramasinghe, declare that this thesis, submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the School of History and Politics, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

……………………………..

Tilaka Wickramasinghe
8 February, 2005
TABLE OF CONTENTS

ACKNOWLEDGEMENTS ___________________________________________ i

ABSTRACT ______________________________________________________ ii

ABBREVIATIONS____________________________________________________ iv

PART I:
‘YOU WON’T FIND MUCH IN THE LITERATURE ON THIS TOPIC’

INTRODUCTION____________________________________________________ 2

Chapter 1 Literature Review ___________________________________ 20

Chapter 2 Migrants and Madness _______________________________ 46
  2.1 Migrant Status______________________________________________ 46
  2.2 The Social Construction of Madness ____________________________ 60

PART II:
MULTICULTURALISM, MIGRANTS AND MENTAL HEALTH

Chapter 3 Mental Health and Migrants – the USA, Britain and Canada __ 74

Chapter 4 Mental Health and Migrants – Australia, 1961-1972 ________ 88

Chapter 5 Multiculturalism - 1972-2000_________________________ 102
  5.1 Multiculturalism, Health Services and Migrants _____________________ 102
  5.2 Transcultural Psychiatry_______________________________________ 121
  5.3 Politics and Policies of Health Care_____________________________ 129
Chapter 6  NSW Department of Health - 1960-2000 ________________ 141
  6.1 Administrative Arrangements_____________________________ 141
  6.2 Psychiatric Services ____________________________________ 147
  6.3 The Richmond Report____________________________________ 159

PART III:
ILLAWARRA AND THE SVEETLANAS IN SLINGBACKS

Chapter 7  History of Migration to the Illawarra _________________ 170

Chapter 8  Illawarra – Migrants and Mental Health Services, 1960-2000  177
   8.1 Mental Health Services in the Illawarra, 1960 – 2000 ____________ 177
   8.2 Mental Health Services in the Illawarra - Changes in the 1980s_____ 183
   8.3 Ethnic Community Groups, Migrants and Services ________________ 191
   8.4 Mental Health Services in the Illawarra - Some Views of the
       Region’s Mental Health Professionals ____________________________ 201
   8.5 Migrant Health in the Illawarra Region - Some Views of Migrants
       and Migrant Health Workers__________________________________ 214

Chapter 9  The Seven Svetlanas: In Their Own Words ______________ 227

EPILOGUE __________________________________________________________________________ 242

CONCLUSION ________________________________________________________________________ 255

APPENDIX A ________________________________________________________________ 259

BIBLIOGRAPHY ______________________________________________________________________ 260
ACKNOWLEDGEMENTS

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ABSTRACT

This thesis examines the health policies and services developed and delivered by Commonwealth and New South Wales governments for migrants during the period 1960 to 2000. While the thesis discusses migrant health policies in general, it principally examines mental health policies and services for migrants from non–English speaking backgrounds (NESB). It has selected the Illawarra region of New South Wales as the area for its case study.

Mental health has traditionally been the responsibility of state and territory governments with little assistance from the Commonwealth. Despite growing evidence of serious mental health problems in the migrant communities, governments were slow to recognise the need to resolve them.

The mental health of migrants became a serious issue during the post-World War Two period of migrant intake. From that era until the seventies the ideology of assimilation dominated Australian health and welfare policies and services, hence, migrant health did not receive special attention. With the introduction of multiculturalism, migrant services improved, partly as a response to the efforts of migrant communities themselves. But it has not been sufficient.

The Illawarra region of New South Wales has been an area which has benefited very little from NSW health department policies. Yet, it is one of the state’s regions which is home to a significant NESB migrant population. It is also a region with high levels of unemployment. The NESB population is culturally, linguistically and socio-economically disadvantaged. Mental illness, in such circumstances is an insurmountable problem which has not received due recognition.

In a society which discriminates against the mentally ill, mentally ill migrants suffer a double disadvantage due to their migrantness and their ‘madness’. If over three decades of multicultural philosophies have brought Australia cultural pluralism, it is not
reflected in migrant health and welfare. The problems remain, clouded by the haze of multiculturalism.

Mental health policies and services for NESB migrants remain inadequate to the present day. The distribution of services is discriminatory towards the Illawarra region. Current problems in the delivery of services to migrants are inherited from a monolinguistic and monocultural past exacerbated by ethnocentric practices and attitudes of Australian governments and society.
<table>
<thead>
<tr>
<th>Abbreviation</th>
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<tr>
<td>ACC</td>
<td>Australian Citizenship Conventions</td>
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<td>ACOSS</td>
<td>Australian Council of Social Services</td>
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<td>ACT</td>
<td>Australian Capital Territory</td>
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<td>AIMA</td>
<td>Australian Institute of Multicultural Affairs</td>
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<td>ARAFMI</td>
<td>Association of Relatives and Friends of the Mentally Ill</td>
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<td>AMA</td>
<td>Australian Medical Association</td>
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<td>AMES</td>
<td>Adult Migrant Education Service</td>
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<td>BMA</td>
<td>British Medical Association</td>
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<td>BHP</td>
<td>Broken Hill Proprietary</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<td>CIAC</td>
<td>Commonwealth Immigration Advisory Council</td>
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<td>CLIPPP</td>
<td>Consultation and Liaison in Primary-Care Psychiatry</td>
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<td>CLR</td>
<td>Commonwealth Law Reports</td>
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<td>COMHA</td>
<td>Committee on Mental Health Activity</td>
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<td>CPA</td>
<td>Care Programme Approach</td>
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<td>CW</td>
<td>Commonwealth</td>
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<td>CRSS</td>
<td>Community Refugee Settlement Scheme</td>
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<td>DCSH</td>
<td>Department of Community Services and Health</td>
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<td>DP</td>
<td>Displaced Person</td>
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<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
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<td>EAC</td>
<td>Ethnic Affairs Commission</td>
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<td>ECC</td>
<td>Ethnic Communities’ Council</td>
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<td>ECT</td>
<td>Electro Convulsive Therapy</td>
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<td>ER&amp;S</td>
<td>Electrolytic Refining &amp; Smelting Company</td>
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<td>ESB</td>
<td>English Speaking Background</td>
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<td>FECCA</td>
<td>Federation of Ethnic Communities Council of Australia</td>
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<td>GNC</td>
<td>Good Neighbour Council</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>IAHS</td>
<td>Illawarra Area Health Service</td>
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<td>IEC</td>
<td>Illawarra Ethnic Council</td>
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<td>Acronym</td>
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<td>IECC</td>
<td>Illawarra Ethnic Communities Council</td>
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<td>IMRC</td>
<td>Illawarra Migrant Resource Centre</td>
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<tr>
<td>IRO</td>
<td>International Refugee Organisation</td>
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<td>ITSOWEL</td>
<td>Italian Social Welfare Organisation</td>
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<td>LEAPS</td>
<td>Local Government Ethnic Affairs Policy Statement</td>
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<td>MJA</td>
<td>Medical Journal of Australia</td>
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<td>MM</td>
<td>Metal Manufactures limited</td>
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<td>NAATI</td>
<td>National Accreditation Authority for Translators and Interpreters</td>
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<td>NESB</td>
<td>Non-English Speaking Background</td>
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<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>NSW</td>
<td>New South Wales</td>
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<td>STARTTS</td>
<td>Service for Treatment and Rehabilitation of Torture and Trauma Survivors</td>
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<td>TAFE</td>
<td>Technical and Further Education</td>
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<tr>
<td>TIS</td>
<td>Telephone Interpreter Service</td>
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<tr>
<td>TMHC</td>
<td>Transcultural Mental Health Centre</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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PART I

‘You won’t find much in the literature on this topic’\textsuperscript{1}.

\textsuperscript{1} A reference made by a senior public health official in an interview with G.Mitchell, 4 April 2000.
Introduction

A conventional narrative dominates many accounts of Australia’s post-war migration history. Central to this historical narrative is the notion that post-war immigrants experienced few, if any, problems. Acquisition of a new language, adapting to a new culture, the finding of employment and the purchase of housing all proceeded with minimal fuss. Thus, these accounts describe Australia’s post-war migration as a remarkable human success story without victims, where governments and migrants triumph over the social, economic and political adversities that followed the end of the Second World War in Europe. Moreover, the arrival of more than two million migrants in Australia proceeded with none of the racial violence, hatreds and tensions which were to beset America and England. In other words, the arrival of migrants, and their transition into and through Australian society, according to conventional narrative accounts, was harmonious, peaceful and for the writer, John O’Grady (writing as Nino Culotta), the ‘migrant experience’ was even humorous.

This thesis challenges a central tenet of these conventional historical narratives of Australia’s post-war migration program. It questions the popular view of an untroubled migrant settlement and finds that government policies were either inadequate or inappropriate or both and failed to fulfill the social needs of migrants. This thesis deals with only one aspect of those social needs - the mental health needs of non-English speaking migrants. It argues that the multicultural policies of Australian governments have not adequately served the NESB populations, relying instead on a false belief in the resilience of migrants to deal with any health exigency.

This thesis, in essence, is an examination of the responses of two Australian governments- the Commonwealth and NSW state governments - to the mental health problems of migrants from non-English speaking backgrounds (hereafter referred to by the acronym NESB) in the last forty years of the twentieth century. It looks at the policies and services Commonwealth and NSW governments developed and delivered

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2 G.Sherington Australia’s Immigrants 1788-1978, 1980.
R.T.Appleyard British Emigration to Australia, 1964.
for NESB patients between the years 1960 and 2000. At the centre of this examination are two fundamental questions: What policies and service responses did these two governments deliver for NESB patients with mental health problems? And why these policies and services? The thesis also discusses migrant health policies in general in order to provide a broader context for mental health policies for NESB migrants.

The writer’s interest in migrant history stems from a personal experience in the early 1970s when she applied for permanent residency in Australia along with her family. At an interview held in her home country with a representative of the Australian High Commission, the interviewer appeared fully satisfied with the family’s proficiency in English, health status and employability. Everything seemed to point to a successful application when at the end the writer was questioned about her willingness to give up her national dress in favour of the more acceptable Australian mode of attire. On receiving a negative response to this question the interviewer was visibly ruffled and the interview ended abruptly. In a couple of days the family was informed that the ‘..High Commission regrets that the application has not been successful’!

This event took place before the era of multiculturalism when the White Australia Policy had not yet ended. It is interesting to note that after sixteen years of life in another developed country, the writer and family were readily granted permanent residency and eventually, citizenship in Australia, though yet in the unacceptable attire! This incident created in the writer a strong interest in examining migrant issues.

Mental health policies and services for patients from NESB did not develop in a vacuum in the latter years of the last century. Broadly speaking, when the post-war migration program commenced, governments had mental health policies and services as part of their general public health initiatives. If someone from NESB presented with a mental health problem, he or she was treated as if ethnicity, language and cultural background was identical to that of an Australian born patient. To understand how and

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why governments began to recognise that NESB patients required a different approach to that of the host population, this thesis surveys mental health policies and services for the general population, how they developed and changed over the years, and how accessible they were for NESB communities.

This thesis argues that for much of the period covered in this research, successive Commonwealth and NSW governments provided inappropriate policies and services in response to many immigrants who experienced mental health problems. This is not to argue that governments openly and willingly embarked on a series of policies and service provisions that had at their heart deliberate indifference to mental health issues of people of NESB. Rather, it is to argue that through ignorance and a false belief that cultural and linguistic matters are not important to effective health care, NESB patients did not receive, in the 1960s and 1970s, the treatment which they received twenty years later.

Mental health services in general for all patients for much of this period were in a state of neglect largely due to underfunding. Migrant mental health policies and services were accorded an even lower priority. This neglect was particularly evident in the Illawarra region where NESB communities have suffered discrimination in terms of gender, race, employment and educational opportunity. A brief recounting of one incident will highlight these problems. In the late 1970s and early 1980s, women began applying for jobs at the region’s largest employer, BHP steelworks. Increasing levels of unemployment, the perception of many women that they needed to supplement their husbands’ incomes and a growing desire to become more independent all contributed to the context of these job applications. Without exception, the application of each woman was rejected. The women sued the company and the matter eventually went to the High Court of Australia that found that BHP had systematically and illegally discriminated against the women and made orders for each applicant to be compensated.  

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8 For details of this case see: Australian Iron and Steel Pty. Ltd. V.Banovic (1989) HCA 56: (1989) 168 CLR 165 F.C. 89/
overwhelming majority of these unsuccessful applicants were migrant women. There is no comparable example for migrant men or Australian-born male applicants.

A labour market defined by gender was based on values prevalent in nineteenth century Britain whereby women were assigned the roles of mothers and wives. If in paid labour, they would perform domestic services. Men were providers who worked in the outside world. Sexist ideology continues to pervade Australia into the twentieth century and sexism combined with racism has resulted in social and cultural divisions. Multicultural policies have failed to address continuing structural inequalities in Australian society by stressing ethnicity and cultural difference over class difference.

The Galbally Report of 1978, considered a benchmark in the history of multiculturalism, did not refer to gender divisions in Australian society. No mention was made of gender and the related social disadvantages suffered by NESB women such as poor living and working conditions, language and cultural barriers and poor mental health resulting from the immigration process.

In 1978, Professor Jerzy Zubrzycki, a leading immigration planner, argued that the foundations of a stable society lay in the family with its conventional division of labour between the sexes. He believed that one of the causes of social problems was the disintegration of the family as the result of forty percent of married women joining the workforce. In short, he advocated unpaid female services that benefit men - an authoritarian male discourse representative of Australian national ideology. In 1982, in a submission to government on multiculturalism, Zubrzycki ignored gender inequalities in society and sited ethnicity alone as the source of immigrant disadvantage. From the time of settlement, Australian women of all classes and ethnic groups have had to

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10 M. de Lepervanche “Working for the Man” in Saunders and Evans op. cit, pp 82-87.
11 Ibid, p 88.
14 M. de Lepervanche op. cit, pp 89-92.
struggle against oppression, which has assigned them a subordinate position of unequal power.

This thesis is organised into three parts. The first part introduces the themes and approaches to the arguments and the research which supports those arguments. The largest section is a detailed literature review. It is clear from this literature that many researchers have identified a clear relationship between people emigrating to other countries and the same people presenting with various forms of mental illness. This part also sets out definitions, the administrative arrangements which describe how the NSW and Commonwealth Departments of Health developed and delivered public health policies regarding mental illnesses in the years leading up to 1972. In terms of chronology, this part covers the years between 1960 and 1972.

The second part is principally concerned with examining the development and introduction of the policy of multiculturalism at a Commonwealth and State level. This direction was an important change of policy because much of what followed from the late 1970s through to the 1990s was either significantly influenced by, or flowed directly from this initiative. Multiculturalism fundamentally changed the way in which policy makers and service providers saw their work. For health policies and services, patients were no longer white and Anglo-Saxon. The policy of multiculturalism liberated policy makers and service providers enabling them to see that recipients were part of a culturally and linguistically diverse population.

An examination of all NESB patients, in every NESB community, by all the Commonwealth and NSW governments in a forty-year period, is clearly beyond the scope of this thesis. An attempt to overcome this massive undertaking is made by using one region of NSW as its case study. Thus, the third and final part of the thesis looks at how the Illawarra health region, with its strong history of attracting NESB migrants, delivered services to and implemented policies for migrant patients with mental illnesses. It takes the Illawarra region as a place where its principal themes can be investigated as fully as if recourse were made to all migrant populations throughout NSW.

1.1 Literature
There is a vast literature on the relationship between immigration and mental health. The first part of this review deals with both Australian and international literature with the former being examined more closely. Unfortunately, Australian studies are limited and the resulting lack of data and statistics is perhaps one reason for the poor planning of mental health services for migrant communities. Yet, research both here and elsewhere indicates the existence of mental health problems in migrant communities. The second part of the literature review deals with literature examining the health policies of several governments. The literature covers the broad area of mainstream public health and mental health, a specialist subset within public health. In the early policy documents of the twentieth century, the mental health of migrants do not receive any attention. Until recent times, mental health policies in general have constituted only a minor part of national health policy. Migrant mental health has featured even less.16

As Minas argues, immigration itself is not the cause of increased risk of mental illness among migrants. It is the factors associated with migrant status which tend to place migrants in the high-risk category.17 This thesis views migrantness to a great extent as a social and political construct. The designation ‘migrant’ is a label which has come to signify difference and exclusion. The term has drawn boundaries which have created false differences and in turn, has marginalised some sections of society. These boundaries determine the rights and opportunities of the people they include and those they exclude. By the very nature of their social situation, the health and welfare of migrants has become a matter accorded a low priority by Australian governments.

Descriptive labels play an important part in the oppression of social groups. Migrants, in and by their migrantness, are rendered powerless in a society where non-conformity is equated with insanity while to be ‘normal’ is to be sane. Society sets standards which

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Looking Forward to Better Health, Better Health Commission, 1986 (neither of these documents accords migrant health in general or migrant mental health issues a high priority).
17 H.Minas et al Mental Health Services for NESB Immigrants, 1996, p xiii.
people must conform to or be deemed ‘deviant’. Those who are powerful in the
dominant society decide the behavioural norms of the society. Garton writes:

The provision of psychiatric therapy involves a complex web of power relations
whereby people who exhibit forms of behaviour considered to be “abnormal”
are constructed as patients... 18

Thus, both migrants and the mentally disordered can be socially constructed categories.

Pioneer French sociologist, Emile Durkheim, emphasized the importance of studying
social facts, such as social rules and customary beliefs which possess moral aspects for
they affect the welfare of individuals. His most outstanding contribution to social theory
is the concept of ‘coscience collective’ or collective consciousness, which refers to
group ideas or symbols, a system of beliefs, collectively held in common by the
members of a society, defining what their mutual relations aught to be. 19 In other words,
these are the norms by which a society functions.

Durkheim used the word ‘anomie’ to describe societies in which norms are unclear or
contradictory. He found that village life based on agriculture had well established
norms that governed the lives of members of agrarian societies. With the advent of
industrialisation and the migration of populations from the outskirts to cities, societies
underwent a certain degree of disorganisation as individuals found themselves with
inadequate normative direction. Durkheim described this state as ‘anomic’. 20

Parsons writes that the theoretical framework for the analysis of social systems
developed by Durkheim has remained central to sociology and related disciplines since
that time. 21 In 1957, Merton published a theory on deviant behaviour based on
Durkheim’s concept of anomie. He considered the situation of a society which provided
sufficient information regarding socially approved goals but gave scant attention to the
means by which they could be attained. Merton argued that the result of this would be
that individuals would resort to illegitimate means in order to reach these goals. Most

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19 Talcott Parsons, ‘Emile Durkheim’ in D. Sills (ed) International Encyclopedia of Social Sciences, vol. 4,
1968, pp 311-319.
20 R. Crutchfield ‘Anomie and Alienation’ in E. Borgatta & M Borgatta (eds) Encyclopedia of Sociology,
21 Sills, op cit
countries did not provide equal opportunities for all their citizens. ‘Thus, lower socioeconomic groups and various immigrants and ethnic minorities found themselves at a disadvantage in the pursuit of the fruits of economic success’. Durkheim used the concept of anomie to explain the occurrence of suicide. Later writers related the concept to explain deviancy in society and even extended it to account for patterns in the usage of health care services.\textsuperscript{22}

Immigration is associated with a profound state of anomie. Immigrants, in order to escape a sense of isolation in their new environment, soon discover that they have to learn to adopt the norms of the host society. They have accept these new standards in order to make their migration successful as their own norms and values may not help in the process of integration.\textsuperscript{23} This transitional period could be extremely traumatizing if an individual does not know what to expect or how to behave. It can lead to feelings of confusion and personal disorganisation thereby delaying the very goal the person is trying to achieve. In such a situation some migrants opt for ‘retreatism’ which Crutchfield describes as ‘…the choice neither to use the legitimate means nor to strive for the legitimate goals of a society’.\textsuperscript{24}

Research shows that there is a significant incidence of mental illness among Australia’s migrants.\textsuperscript{25} Poorly educated NESB migrants are the worst affected by mental health policies. This group is the least able to articulate its concerns to government and has a poor understanding of bureaucratic procedures. Governments are not persuaded that there is a significant electoral advantage in developing and delivering migrant specific mental health policies and services. In short, this group has been a marginal element of government policy making. Sometimes, NESB persons are unaware of the existence of facilities. Or, they are unable to utilise whatever services are available mainly because of language difficulties. In the absence of an efficient and readily available health care services.

\textsuperscript{23} Ibid
\textsuperscript{24} Borgatta & Borgatta op cit p 97
\textsuperscript{25} Vide Literature Review, Part 1, See pp 20-45
interpreter service, the psychiatric treatment that they receive rarely goes beyond prescription pharmaceuticals and electro-convulsive therapy.26

Research carried out in Australia in the 1960s pointed to a serious incidence of mental illness among migrants.27 Yet, the Commonwealth government chose to ignore these findings because it did not suit its ideology. The government did not recognise or cater for the special needs of migrants because migrants were not ‘different’, or if they were, they would soon be the same as all other Australians. For example, the Report of the Commonwealth Immigration Advisory Council in 1961 on the incidence of mental illness among migrants - flawed as it was - was eagerly accepted by the Commonwealth government not only as evidence of a fool-proof screening procedure of migrants but as confirming the fact that assimilation was successful; migrants were no different from the Australian born in their mental health status.28

In NSW the most significant event during this period, from the viewpoint of this thesis, was the 1961 Royal Commission of Inquiry into its largest psychiatric hospital, Callan Park Mental hospital. This mental institution whose origins date back to 1878, had attracted disturbing claims about the treatment of patients. Admission and treatment procedures in this hospital made no linguistic or cultural concessions for NESB patients - a mirror image of the Commonwealth government’s assimilation policies; an unacceptable approach in a hospital with a large number of migrants in the resident population.29 The Royal Commission found conditions at the hospital were deplorable. Yet, despite this disturbing evidence, the enquiry changed nothing for migrants. It was over a decade later, after the introduction of the Commonwealth government’s multicultural policy, that some attention was accorded to migrant health and welfare issues. The instrument of change was the Galbally Report of 1978.30

26 Interview with G Mitchell op.cit.
28 Vide Literature review, Part 1, this Thesis.
29 Australian Archives, Series no A 1658/1, Item no 556/1/5.
Migrants, though vulnerable, tend to be a resilient group of people who respond well to help and guidance. Migration on the whole, be it voluntary or otherwise, is a traumatic experience. Some migrants cope with it better than others do. Research carried out both overseas and in Australia has established a link between mental illness and the migration experience. Southeast Asian migrants, particularly those of refugee status, are prone to psychiatric disorders because of the physical and mental trauma that most have suffered before fleeing their mother country. They are faced with serious adaptation problems due to the wide cultural and linguistic gap between them and the Australians. Lack of job skills aggravates the problem even further. Westermeyer and Williams observe that:

Refugees who are depressed or otherwise distraught mentally or emotionally are not efficient at learning a new language, job skills or culturally appropriate behaviour. Thus, the psychiatric disorder delays the adjustment, and the delayed adjustment in turn retards recovery from the psychiatric disorder.

History has shown that population movements are nothing new and such exoduses are to be expected in the future. The objective must be to give humanitarian aid to genuine refugees and migrants. While some migrants suffer major psychoses a large number display less severe symptoms such as anxiety and minor behavioural disorders brought about by migration stress. This latter group if treated with kindness and understanding could overcome their neuroses and become potential assets to the community. Far more productive than hysterical and inhumane responses would be policies which repatriate those who could legitimately be returned and absorb the rest. Such migrants would be motivated to make their best contribution to the country which gives them asylum. Collins observes, if Australia has achieved multiculturalism without serious social turmoil, it is not due to an enlightened government. ‘Australia has managed to avoid serious racial conflict directed towards migrants more by default than by design’.

31 O.Odegaard, H.Murphy, J.Krupinski and Burrows, Jayasuriya etc vide Literature Review, this thesis.
33 Collins op cit, p 108.
Minas writes that there is no satisfactory, universally acceptable definition for mental illness. Mental illness could involve mental distress or suffering resulting in impairment in the individual’s biological, mental or social functioning.\textsuperscript{34} Jayasuriya argues that mental illness ‘refers primarily to gross, detectable abnormalities of functioning with or without an organic substratum, as well as those “functional disorders”. The latter are said to be “refractory to all procedures of understanding and empathy” and incapacitates one from performing crucial roles such as earning a living’.\textsuperscript{35} Jayasuriya goes further to describe the concept of ‘mental health’ as a reference to ‘active adjustment or mastery of one’s environment, the maintenance of a stable integrated personality, and the ability to perceive correctly the world and oneself’.\textsuperscript{36}

1.2 Multiculturalism, migrants and mental health

The thesis traces the development of mental health policies in two distinct periods - from 1961 to 1972 and from 1972 to the mid 1990s. In the first period, policies were overwhelmingly monocultural and unresponsive to migrant communities. During this period the ideology of assimilation pervaded health and welfare services. Governments made no provisions for translation, no bilingual material was produced and no special resources allocated to overcome migrant difficulties in settlement.\textsuperscript{37} Until the advent of multiculturalism, health and other government services continued their long-established procedures unmindful of the migrant population. In health care there was no provision for ethnic health workers or health care interpreters. Indeed, positions with these designations did not emerge in the NSW and Commonwealth Health departments until the late 1970s. It was not uncommon for a NESB woman to use her young child - sometimes as young as six or seven - to ‘interpret’ for her when consulting a medical specialist; a procedure largely unsatisfying for her, confronting for the child and unprofessional for the specialist. Yet, as unsatisfactory as this widespread practice may

\textsuperscript{34} H.Minas “Mental Health in a Culturally Diverse Society” in J.Reid and Trompf (eds) \textit{The Health of Immigrant Australia}, 1990, p 253.
have been, both patient and clinician had few options in the absence of a trained and professional health care interpreter service.\(^{38}\)

The thesis documents events stemming from multicultural policies and their effects on the health and welfare of NESB communities. From this point onwards the focus is on NSW in general and the Illawarra region in particular, beginning with a survey of early psychiatric services in New South Wales and a brief history of the administrative arrangements of the NSW Department of Health. 1983 was a turning point in the formation of mental health policies in NSW when the NSW government decided to investigate the possibility of alternative housing and service arrangements for patients with mental illnesses. An inquiry, headed by David Richmond, a senior career public servant, recommended sweeping changes to the NSW mental health system.\(^{39}\)

The thesis makes a detailed survey of the development of mental health policies, with a special look at community health, in countries such as America, Britain and Canada, which have NESB populations similar to that of Australia. This study shows that Australia has been slow to develop community mental health services. Unlike Canada, Australia has taken long to consider health policies favourable to its migrants. In Canada, transcultural psychiatry had its beginnings in the 1950s\(^{40}\) and in Britain, in the 1970s\(^{41}\). In Australia, the first transcultural psychiatric unit which was in Victoria, was not opened until 1988.\(^{42}\). NSW started a similar service in 1993.\(^{43}\)

The development of health policy is closely linked to the political system. This thesis shows how the prevailing political philosophy moulded health policy and demonstrates the not always beneficent role of the medical profession in deciding health policy. For instance, government opposition to the recruitment of foreign doctors was based on the resistance by the Australian Medical Association (AMA) to their employment. For the

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\(^{38}\) Interview with G. Mitchell, former Director of Migrant Health, Illawarra, 11 April 2000.
\(^{39}\) Inquiry into Health Services for the Psychiatically Ill and Developmentally Disabled, The Richmond Report, 1983.
\(^{41}\) S. Fernando Race and Culture in Psychiatry, 1989.
AMA, ethnic health policy was not a priority. And governments implement policies which are in highest demand as these will ensure more political support.

This thesis argues that mental health policies and services for migrants are both inappropriate and inadequate. In the history of mental health services for NESB patients in the Illawarra, these factors become especially acute, despite the region having a significant migrant population. In the Illawarra there is a general paucity of mental health services which is greatly magnified for NESB communities because they are culturally and linguistically disadvantaged. The thesis outlines the development of services and the changes which it underwent as a result of migrants themselves lobbying for conditions more beneficial for them. Most importantly, this thesis draws attention to the plight of NESB persons who are incapacitated and debilitated by illness, made vulnerable by other social problems and whom policy makers easily overlook.

The prominent migrant commentator James Jupp argues that the Australian immigration policy was based on:

> general attitudes in which a prejudiced scale of values is important. This scale of values, which places the British at the top and “aboriginal natives of Asia, Africa and the Pacific’ at the bottom, is determined by the concept of “assimilability”....Physical assimilability is still central to Immigration Department policy, with the gradation from blond to black being steadfastly maintained as one of the several criteria used.\(^{44}\)

Social commentators, health administrators and historians have long been concerned about the relationship between migrants and mental health. Since 1788 immigration has been the foundation of Australian society. Immigrants, for whatever reason, left their homelands and travelled to Australia in their hundreds of thousands to live and work and make it their home. In the present decade Australia continues to be an attractive destination for migrants as is evident from the large number of ‘boat people’ who enter the country illegally. According to the Department of Immigration and Multicultural Affairs, in the ten years up to October 1999, 4785 illegal asylum seekers have been

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\(^{44}\) J. Jupp *Arrivals and Departures*, 1966, p 115.
caught trying to enter Australia. In the financial year 1997-1998, 157 illegal immigrants were detained. In 1998-1999, the figure rose to 926. By July 1999 the number had risen to 1700.\textsuperscript{45}

Australian immigration falls into two categories - the pre-war period which began in the mid-nineteenth century and the post World War Two large-scale immigration program. Between the 1850s gold rush and the depression of 1890, thousands of Chinese migrant workers were employed in the goldfields and Pacific island immigrant labour was introduced into the Queensland sugar plantations. There were also British immigrants recruited for road building and construction schemes and some Mediterranean migrant workers in pearling and timber cutting.\textsuperscript{46}

In 1901 the new federal parliament passed the \textit{Immigration Restriction Act} which excluded non-European immigrants - the White Australia Policy. Up to World War Two, migrants to Australia mostly came from the United Kingdom. After the war, the Labor Government adopted a policy of expanded immigration for two major reasons. First, it saw a need for an increased population for reasons of defence. Second, and more important, the additional population was essential in order to bolster the workforce needed to maintain the economic growth and national development which the country was committed to in the fifties. This increased demand for labour brought about a dramatic expansion in immigration.\textsuperscript{47}

By 1947 the government’s plan to admit mainly British immigrants failed due to shipping shortages and Britain’s own post-war problems. From 1947 to 1951 Australia admitted about 165,000 eastern European refugees from IRO camps and hundreds of thousands of unskilled and semi-skilled migrants from southern Europe. From 1960 onwards Lebanese and Turkish migrants were admitted.\textsuperscript{48}

\textsuperscript{45} Sydney Morning Herald, 8 November 1999 and 20 November 1999.
\textsuperscript{46} M.de Lepervanche “Australian Immigrants 1788-1940” in E.Wheelwright and K.Buckley (eds) \textit{Essays in the Political Economy of Australian Capitalism}, 1975, pp 82-88.
\textsuperscript{47} J.Collins \textit{Migrant Hands in Distant Lands}, 1988, p 1.
Besides the health of migrants the other important factor which concerned selectors was the ‘suitability’ of migrants to merge into Australian society. Those who displayed the ability to pass unnoticed among the host population - those who were less ‘different’ were the obvious selection. The writer’s personal experience illustrated this. Australia’s migration policies have ever been lacking in foresight. For almost seven decades during the White Australia era it sought migrants who were compatible in language and colour. As a result many migrants who could have served the country well fell outside the net. It was an ill-fated policy which brought Australia nothing but condemnation from the international community and probably caused considerable retardation to its progress and prosperity.

In December 1972 Gough Whitlam’s Labor government, the first Labor administration in twenty-three years, officially abandoned the White Australia policy. Within eight years, 22% of all immigrants were coming from South East Asia - the very region that Australian governments had long told its citizens posed a racial, economic and cultural threat to Australia! These new arrivals included refugees from Vietnam, Laos and Cambodia.49 By 1989, Asians constituted 43.9% of all migrants.50 In the 1991 population census, of the four million overseas-born Australians, more than two million came from non-English speaking backgrounds. In 1993, this percentage had increased to 51.9%.51 Although Federal governments have long abandoned the White Australia policy, its sentiments are still pervasive. This is clear from the support Pauline Hanson’s One Nation Party received in the 2001 Federal election.52 The most important policy statements in her election manifesto were anti-immigration, anti-Asian immigration in particular, and these proved to have the most support.53 Her support, no doubt, drew on the discriminatory and intolerant planks of the old White Australia policy.

52 Pauline Hanson won the Ipswich seat in Queensland, in a federal bye-election in 1996, capturing nearly a quarter of the vote. In early 1997 she formed the One Nation Party, from “The Rise and decline of Pauline Hanson’s One Nation” in www.wsws.org/articles/1999/hans-m09.s
That anti-immigrant sentiment still prevails is evident from responses to the recent arrival of asylum seekers. Correspondence in the news media is evidence of the attitude of the writers who suggest deportation or incarceration as penalty for the offenders. Australian identity has always contained elements of racism. In the past, the country’s immigration laws and policies have upheld this racist tradition. Time has brought about change yet some Australians would be slow to shed exclusionist views.

1.3 Illawarra and the Sventlanas in slingbacks

In the immediate post-war years, the Illawarra region became one of Australia’s major areas which migrants found attractive. The region’s economy was dominated by the nation’s largest industrial complex - the steelworks of the Broken Hill Proprietary company (BHP), the copper works of the Electrolytic Refining and Smelting company, (ER&S), Metal Manufacturers Limited (MM), a copper manufacturer, and the Australian Fertilisers Limited which used spent sulphuric acid from ER&S to make superphosphate. The industrial complex had a major inner and outer harbour and to the west, the Illawarra Escarpment, a mountain range rich in high quality coking coal where mines worked deep coal seams.

It is not an exaggeration to say that these industries attracted significant numbers of immigrants from the United Kingdom and Southern and Eastern Europe in the post-war years and without their labour, the economies of the region, the state and the nation would not have developed as they did. By 1981, 29% of the population in the Wollongong local government area alone was overseas-born and 16% of the total was born in non-English speaking countries. Italian, Greek, Turkish and Yugoslav

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“The Speech that Changed Australia’s Political Landscape Forever” in www.onenationwa.org.au
Pauline Hanson.speech.hi, 10 September 1996.

55 The title of this section is taken from a play Svetlana in Slingbacks by Valentina Levkowicz. See H.Thomson’s review “Mad migrants and a satire of middle-aged suburbanites”, The Age, 29 April 2002.
56 For further details see G.Mitchell’s unpublished doctoral thesis, University of Wollongong, 1981.
especially from Macedonia) migrants were a major part of the component. 53.3% of the population was either born overseas or had one parent born overseas.\textsuperscript{58}

Moreover, the Illawarra region has made significant contributions to the provision and development of mental health policies and services for immigrants whose first language is not English. It has had a migrant health unit since the late 1960s and while it has responded to migrant mental health problems in accordance with the state government’s policies, it has also refined and extended many of those policies with unique contributions to service provision.\textsuperscript{59}

One of the major sources for this thesis is transcripts of interviews with mental health professionals and other mental health service providers in the Illawarra region. Interviewing mental health staff is an obvious strategy. Less obvious, more confronting and significantly rewarding in terms of building a detailed picture from both sides of the service delivery divide, are the interviews carried out with NESB migrants who have suffered mental illness. Their experiences in the mental health system revealed their limited access to services principally due to language and cultural barriers. The context for migrants’ experiences and their acute insights into their specific mental health problems comes from a broad array of secondary sources.

Interviews with early NESB migrants to Wollongong have provided the background for the special study of the Illawarra region which begins with a brief history of migration to Wollongong. This section of the thesis is divided into two parts - migrant health services in general and mental health services in particular. The main source of the material for the first section comes from the archival papers and the documents of the region’s peak ethnic community agency, the Illawarra Ethnic Communities Council (IECC). The second section relies chiefly on oral evidence gathered from interviews with mental health professionals and other health and welfare service providers of the Illawarra region.

\textsuperscript{58} Australian Bureau of Statistics 1981.
\textsuperscript{59} Interview with Lisa Schofield, Co-ordinator, IMRC, Wollongong, 17 January 2001.
The study of the Illawarra region concludes with detailed oral evidence drawn from interviews with female NESB migrants who are experiencing various forms of mental illness. Each of these interviewees came to Australia from Macedonia. The selection of this ethnic group was deliberate and considered. According to the 1986 Census, Yugoslavs (including Macedonians) comprise the largest migrant group that has emigrated to and settled in Wollongong. They were also, along with the Italians, representative of NESB migrants who suffered a high rate of mental illness. Hospital admission numbers were similar for the two communities. Macedonian women, in particular, feature prominently among those suffering from mental disorders. Moreover, until recent times, Macedonians had received the least health and welfare resources. There is also a gender issue, Macedonian women being more isolated and presenting with more health problems than other NESB females.

The seven female migrant interviewees – the Svetlanas in slingbacks - suffer from mental disorders but are currently stabilised on medication. They are representative of NESB people who have suffered not only due to their illness but also as a result of indifferent, inadequate or inappropriate services. In particular, the experiences which they recall with private general medical practitioners illustrate the extent to which the discipline of family medicine is out of touch with mental health issues and the mental health system.

The terms ‘migrant’ and ‘immigrant’ are inter-changeable and have been defined in many different ways in different contexts, but for the purpose of this thesis they refer to individuals who are not Australian citizens by either birth or descent and who have entered Australia with the intention of residing in this country. The following section begins to set out the major themes and arguments of the thesis by looking at the literature on migrants and mental health.

While this thesis is about more than the experiences of seven brave and vulnerable women, I want to emphasise how central their experiences are to my story. Their

61 Interview with A.Mitic, Ethnic Mental Health Worker, Wollongong, 9 July 2003.
62 Ibid.
   Interview with G.Mitchell, former Director of Migrant Health Services, Illawarra, 11 May 2000.
words, their experiences and their histories inform and flow through the text of this thesis. They introduce each major section and chapter. While these women bring a unique perspective on the complex relationship between migration and mental illness, each informed by an individual personal experience, their experiences are in fact those of many migrant men and women. Sadly, their stories could be reproduced thousands of time over. Moreover, at every step and turn of this thesis, their voices are present. Thus in the broad-ranging survey of research into this complex relationship, we hear these women speak. In the analysis of policies for and services delivered to patients from NESB, again we hear the women speak.

They are present again in those sections which deal with the changes to mental health services in NSW. And they find full voice when the thesis turns its attentions to the case study set in the Illawarra region of NSW. Given what each of these women have experienced and how the ‘system’ has grappled clumsily and sometimes ineffectively with each of their conditions, it is a triumph of the human spirit that each woman was able to recount her experience with such clarity and insight. These individual triumphs of the seven women place into sharp relief a so-called modern health system which has found itself seemingly incapable of delivering a mental health services to patients from NESB. Their oral testimonies work primarily as a series of texts which provide a commentary of the past practices of Federal and State health systems. To a lesser extent, they also provide a signpost to ways forward for those services. For patients from NESB with mental problems, the future does not need to be a repetition of the past as expressed by these women.

This work accepts the challenge made by Peter Burke in a recent essay when he called for historical writing to look at first-person accounts and narrations in literature. It draws considerable benefit from the detailed first-person narratives of migrant patients who have experienced on the one hand, mental health problems and treatment by a health system which sometimes has given new meaning to ‘inappropriate’ and ‘insensitive’ treatment and who on the other hand have succeeded in part in spite of rather than because of a health system which voters and patients have long entrusted
with care and compassion. Their stories challenge the existing orthodoxy of what a health ‘care’ does.

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Chapter 1

Literature Review

This chapter surveys the literature on immigrants, immigration and mental health. The literature reinforces the view that mental illnesses occur more frequently among immigrants than individuals of the host community and those who do not emigrate. This relationship between migration and mental illness has been identified in many international and national studies. Despite the groundbreaking work of such studies, the results have not always been translated into policy considerations or clinical services.

This chapter has two parts. The first part examines the considerable research produced by outstanding researchers, both in Australia and overseas, during the last five or six decades on the relationship between immigration and mental health. Early Australian research was carried out by members of the medical profession who observed immigrant patients in their individual practices. The limited nature of these studies combined with the fact that the researchers lacked sociological training brings into question the validity of their findings. Nevertheless, they deserve consideration for their pioneering work on the subject.

The second part of the literature review briefly focuses on those works which examine government health policies in general and mental health in particular. This section reveals the inadequacy of mental health policies and services for the general population and government indifference – both State and Federal - towards the mental health problems of the migrant population.

In Australia the first important epidemiological research relating to immigration and mental illness was carried out by Krupinski and his group at the Victorian Mental Health Research Institute in the 1960s. Murphy64, Burvill65 and Jayasuriya et.al66 have

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criticised this work for its methodological shortcomings. Despite these methodological considerations Australian findings are consistent with findings overseas that psychiatric illnesses occur with greater frequency among immigrants than in those who do not emigrate and those in the host population. The literature is unequivocal that migration is a threat to mental health.

Borrie defines migration as a movement of people from a settled homeland to another country, undertaken with the intention of permanently leaving the original homeland and settling permanently in the new country. The process of migration has been taking place almost from the beginning of human existence. Yet, changing from one environment to another brings with it a host of problems both for the migrant and the receiving country. When migrants choose to settle in a more complex society than that which they have left behind and have to deal with higher levels of technology, urbanization and industrialization, they encounter serious problems of adaptation. If it is less complex, then there are different problems of adjustment. The greater the difference between the new country and their own, the more difficult will be the process of adjustment and integration into the new society.

Last classifies migrants according to ethnicity, socio-economic status, cultural background and religion; and whether their migration was voluntary or enforced. He finds that patterns of behaviour, health and sickness vary from group to group.

Migration requires a strong motive. People usually leave their homelands due to some form of compelling pressure - economic or political, or even the pressure of a rising population on space and resources. Social deviants may emigrate to escape restrictions to their liberty. Thus, incoming migrant groups may contain rebels from society, malcontents and criminals.

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69 Ibid.
Whatever the reason for migration, migrants share the basic desire for improving their lot in life. Evans states that:

> It is not unreasonable for the migrant to expect improvement in life style, personal development and physical health. Quite often these expectations are at least partially realised and, therefore, the positive benefits of migration should not be ignored. On the other hand, the migration process is stressful and sometimes hazardous. Migration also compels the migrant to adjust to a new lifestyle which often brings with it a new set of health risks.  

One of the earliest studies on the subject of immigration and mental health was carried out by Odegaard in 1932, on Norwegian immigrants to the United States of America. These studies based on mental hospital admission rates for immigrants in Minnesota, find that:

1. The mental and physical stresses brought about by the immigration process can cause psychiatric illnesses in persons who would otherwise have remained well;
2. Persons already suffering from forms of mental illness have a tendency to migrate related to their unstable personality.

Malzberg studied schizophrenia in New York’s immigrant community from 1949-1951, and in Canada from 1950-1952 producing results similar to those of Odegaard’s study. Malzberg, whose study was based on mental hospital admission rates, finds further that there is a direct association between admission rates and other predisposing factors such as age, sex, social status and cultural incompatibility. He also finds that immigration introduces a more difficult process of adjustment for females.

Murphy’s 1955 study of post-war refugees to Britain shows that they had very high mental hospitalisation rates. He emphasises education, occupation and social class as variables that are most likely to result in higher mental hospitalisation rates for migrants

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71 O.Odegaard *op cit*, p 157.
than for the native population. Immigrants are traditionally lower class and show a much higher hospitalisation rate than the upper and the middle classes. Using data from Israel, Murphy shows that the lower educational status immigrants from Asia and Africa have higher hospitalisation rates than the local born Jews. Whereas, European and North American immigrants whose educational and social status is similar to that of the local population show similar hospitalisation rates as the local born, despite their heavy war-time experiences. Murphy concludes that many migrants undergo considerable social stress not only due to loss of kin and country but because they occupy low status jobs and cannot adequately satisfy the demands for rapid acculturation expected of them.  

Murphy, writing in 1965, presents many variables which could influence mental hospitalisation rates for immigrants. He states:

> Among these are sex and marital status, social class and the associated factors of occupation, education and income; geographic location and residence; cultural, religious and racial variables; the different types of household and family, and, less easily defined, the various other membership groups to which an individual orients himself. All of these variables have been shown to influence the risk of mental hospitalisation; not all, but many have been studied in relation to the mental hospitalisation rates of migrants.

In Bagley’s critical review of the literature on immigration and mental health (1968), he draws similar conclusions to Murphy. He goes further to state that research from Britain shows that as migrants become better educated and qualified they will experience more discrimination through being denied the higher status jobs for which they are qualified. The likely outcome of this would be an increase of psychiatric illnesses in the migrant community.

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73 Murphy op cit, pp 10-19.
75 C. Bagley “Migration, Race and Mental Health; a review of some recent literature” in Race, 1968, vol 9, no 3, pp 343-350.
Bagley, disagrees with Odegaard’s conclusion that schizophrenics are more likely to emigrate. He cites the research of Goldberg and Morrison (1963) and Turner and Wagenfeld (1967) to show that schizophrenia is:

an illness of insidious onset which progressively cripples a person’s capacity to plan rationally and think ahead. It seems possible, therefore, that the schizophrenic would be unable to carry out the complex tasks of organising and financing emigration.\textsuperscript{76}

Bagley’s final conclusion from his review of the literature on psychosis and emigration is that:

....schizophrenic and paranoid illnesses occur with greater frequency among immigrants than in individuals who do not emigrate, and with greater frequency than in individuals in the host community......An adequate explanation of these illnesses probably lies in the stress to which immigrants are subjected, although in a minority of cases it is possible that mental illness in migrants may itself be the cause of migration.\textsuperscript{77}

In 1987 Francis Creed reviewed the existing literature concerning psychiatric illness among migrants and came to the following conclusions:

1. A small number of people will migrate during the course of a mental illness and be admitted (to a psychiatric hospital) in the host country;
2. Some will become ill and be admitted during the first year or two after migration and it is possible that the immediate stresses of the move, together with prior susceptibility are important;
3. There are those who become ill years after migration and it remains an open question whether they are more susceptible to develop illness than the native population.\textsuperscript{78}

\textsuperscript{76} Ibid, p 351.
\textsuperscript{77} Ibid, pp 353-354.
Creed argues that most studies of mental illness in immigrants have been concerned with hospital admission rates and have not measured social stressors sufficiently. He believes that hospital admission rates do not indicate accurately the extent to which mental illness is prevalent in the community. Besides, admission rates are of little value unless we understand more fully the process of referral and admission among different cultures. Somatization, i.e. physical symptoms arising out of mental conditions, may be a common phenomenon among immigrants which is why the number of migrants receiving psychiatric treatment may not accurately reflect the rates of neurotic illness.79

Creed is critical of the literature which, he says, seldom identified the environmental factors which are associated with the onset of psychiatric illness. He also finds that most studies overlooked the significance of the presence of a family history of psychiatric illness in migrants. He concludes from the literature that the ‘predisposition to develop psychotic illness appears to be as important as the stress of migration.’ His opinion is that future studies would benefit if researchers separate more clearly, the social stressors involved in and following migration.80

Political refugees such as the displaced persons have suffered enforced migration. Such immigrants have experienced severe trauma or torture and lost their families and homes. For them, migration is the only option. Between 1947 and 1951 the Australian government recruited 168,199 immigrants from the refugee camps of war torn Europe, under the Displaced Persons scheme.81 Price states that in the years 1947-51, refugees made up some 40% of Australia’s settler intake.82 In 1956, 27,000 Hungarian refugees were admitted following the rebellion in that country. The rest of the immigrants during this period were of British or European origin coming mainly through assisted passage schemes sponsored by the government. There were also a number of private settlers from Britain.83

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79 Ibid, pp 190-191.
80 Ibid, pp 185-191.
81 E.Kunz, Department of Immigration unpublished statistics, in Displaced Persons, 1988, p 43.
Last finds that most post-war, voluntary migrants who came to Australia from the economically depressed and overcrowded Mediterranean countries were attracted by Australia’s developing economy and open spaces. Those migrants who came from the affluent, western European countries probably feared a future war or were adventurous, restless for change and excitement, challenged by the unknown.84

According to Last, ‘......In general it is the young and the fit and the socially unencumbered who migrate. In the case of assisted passage immigrants to Australia, physical fitness is further ensured by medical selection’.85 Initially, the government gave priority to single, unattached, employable male migrants to strengthen the workforce. But soon the policy changed towards bringing out entire families.86

Odegaard in his research found that early psychotic types have a tendency towards restlessness and social maladjustment resulting in the decision to emigrate.87 Last confirms this finding when he says immigrants may be people who ‘....have been unable to find a satisfying place in the society of their homeland, either because of their own inadequacy, or because no opportunity exists there for full employment of their particular talent. They may seek a “promised land” where all their troubles will vanish as if by magic....It is axiomatic that people satisfied with their lot do not migrate’.88

The twentieth century has seen unprecedented movements of people between countries, be they refugees fleeing from wars or voluntary migrants in search of better living conditions and career opportunities. Leaving behind friends and family and a familiar environment in order to start a new life among strangers, in strange surroundings can, at the best of times, be a stressful experience. Adjusting to the new environment can bring considerable emotional and physical strain which will necessarily impair the proper functioning of the migrant as an efficient member of society. This has an impact on the

85 Ibid.
86 A.Stoller op cit, p 420.
88 Last op cit, p 420.
host country as well, often making demands on its social welfare system and health care system.

Murphy, writing in 1974, says: ‘Health matters have not usually been accorded much thought during the discussion of immigration policies in recent decades, and within the health field questions of mental health have been largely ignored....’. He goes on to add that mental health questions should receive greater consideration first, because of the relationship between mental health and successful resettlement, and second, because of the heavy cost of supporting someone who develops a chronic mental disorder.  

Although Australia has had an extensive assisted immigration program since 1945, Australian research has concentrated on the social, cultural and economic aspects of migrant life rather than on possible health problems of migrants. Research has been carried out in the field of mental illness but the link between mental illness and immigration has not been investigated until recent times. The earliest signs of interest in the health status of immigrants came from some members of the medical profession. The Medical Journal of Australia occasionally discussed migrant health issues beginning around the mid-fifties. The first articles on the topic were written by I.A.Listwan in 1956 and 1959. They were followed by those of J.M.Last in 1960 and 1961, and S.Minc and E.G.Saint in 1963. These researchers, with the exception of Last, were themselves migrants from non-English speaking background and wrote with great understanding and sympathy about problems of migrant health. Saint was the first writer to highlight the need for an interpreter service. But their pioneering work was largely ignored by subsequent researchers.

The Polish psychiatrist, Listwan, studied a group of psychiatric patients in the outpatient clinic of Sydney Hospital (1952-1955). He makes the following observations:

1. Paranoidal states are twice as common in migrants as in native-born;
2. Migrants suffering from paranoidal states come mostly from eastern Europe;
3. Patients with paranoidal states are predominantly young unmarried

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89  H.Murphy “Mental Health Guidelines for Immigration Policy” in International Immigration, 1974, vol 2, no 4, p 333.
Listwan argues that paranoidal states occurring in migrants are due to social factors, i.e. migration stresses. They are purely environmental and have a good prognosis. The patients improve remarkably when social adjustments and re-education are undertaken. Listwan maintains that these reactions should not be treated as actual mental disorders and that people thus affected should be considered “quickly recoverable potential assets to the community.”

In 1959 Listwan published the results of his study of emotional disorders in immigrant groups. He observes that migrants arriving in a new country suffer collective anxiety neurosis, partly due to migration stresses and partly to the neurotic reaction in the host group, called prejudice. The reaction of the migrants could result in regression, paranoia, escapism, depression, inferiority complexes and even hysteria. Listwan suggests that emotional disorders in migrants should be treated on a social level. Education is of primary importance both to the migrants and the host population. This should include accurate information about their respective countries, the removal of prejudices, reduction or abolition of migrant camps and above all, the curbing of sensational press reports.

In 1960, Last published a discerning article on the health of immigrants, based on observations drawn from his medical practice. Like Listwan, he advocates kindness and understanding towards migrants in order to break down their collective neuroses. He stresses the role of the general practitioner as the educator of the community away from prejudice against the immigrant. In 1961 he published a second article dealing with problems encountered by migrants during the process of assimilation. He finds that several forms of mental illness, such as severe paranoia, could be related to social, cultural and linguistic isolation of the migrant. He opens up several worthwhile avenues.

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92 Ibid, p 777.
for future research such as the child-parent conflict in relation to the cultural changes of migration and the part it plays in delinquent behaviour.  

In 1963, E.G. Saint writing to the Medical Journal of Australia, drew attention to the sub-standard living conditions for migrants arriving in Australia. He argues that such living conditions results not only in the high incidence of acute and chronic infection but in psychiatric illness as well. Poor living standards could lead to severe depression especially in female migrants. He stresses the need to establish a good working relationship between doctor and patient. To achieve this he urges the employment of skilled interpreters. He recognises the need for medical practitioners to learn a European language in order to work harmoniously with their patients. He goes so far as to state “...for ignorance of European languages and lack of interest in non-Anglo-Saxon culture we ourselves must accept some responsibility.”

In 1963 Minc published an article dealing with ‘new Australian’ patients and their medical problems. Minc, who had previously lived in Russia, Poland and Italy, was familiar with foreign cultures and had a good understanding of immigrant patients. His findings are based on observations and data collected during twenty two years of medical practice in Australia. He finds that major anxieties in migrants are caused by the stresses of immigration and assimilation. Often their anxieties are aggravated through the lack of a supporting group, that is, the deprivation of physical and moral support. They present to the doctor with psychosomatic problems. In these circumstances, says Minc, the doctor should be tolerant and reassuring. Like his earlier colleagues, Minc too emphasises the importance of the doctor’s role in the supporting group that the migrant lacks in the new country.

The above studies were carried out by individual doctors based on their experiences with migrant patients in their own practices. The limited nature of their studies which were confined to a select group means that they were of very little statistical validity. Yet, they highlighted the fact that there were mental health problems among immigrants.

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94 J.M. Last op cit, pp 420-424.
which need further investigation. Unfortunately, they failed to create much concern or interest within their own profession or with the Commonwealth government. The only worthwhile investigations into immigrant health came from Victoria in the sixties, carried out by Jerzy Krupinski and his associates.

Martin comments that the sixties were in general notable for the lack of cumulative research. After 1962 there were articles published by Krupinski, Stoller, Cade and Schaechter in Victoria. This research which was the only cumulative body of work, came from the Mental Health Authority of Victoria. In the 1970s there was a renewal of interest in migrant health issues with the emergence of new writers such as Cox, Moraitis, Zigouras and Bottomley. Writers of migrant origin tended to portray non-English speaking migrants as an exploited class in Australian society bringing into prominence class and cultural explanations of the health of migrants.

In comparison to overseas studies, Australian research dealing with migrants and mental health is poorly developed. Most of the research has been carried out in the field of schizophrenia and not in the less severe forms of mental illness such as the neuroses, personality disorders and emotional disorders.

Cade and Krupinski studied all first admissions to the Royal Park psychiatric hospital for approximately one year (1959-1960). Their principal findings, published in 1962, are as follows:

1. Depression occurs more frequently among immigrants than among the Australian born;
2. The incidence of schizophrenia is higher among southern and eastern European immigrants than among British immigrants and the Australian born;
3. The affective psychoses occur more commonly among eastern European males and eastern and southern European females than among the rest of the population;

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4. The incidence of alcoholism is highest among British immigrants, the Australian born and among eastern European males.\textsuperscript{99}

Krupinski, Cade and Schaechter made a further study of immigrants admitted to this same hospital in Victoria from 1961 to 1962. Their principal findings published in 1965 are as follows:

1. The incidence of mental breakdown is highest in young, single males. This is due to the migration of unstable men who break down in the early years of their economic struggle and professional men unable to gain recognition of their qualifications;

2. The highest incidence of schizophrenia in male migrants occurs in the groups resident for 1-2 years and 7-14 years. Early breakdown can be related to pre-migration instability together with immigration stress. Later breakdown seems to be related to immigration stress, employment difficulties and lowering of social status;

3. For females, the highest incidence of schizophrenia occurs in the group resident for 7-15 years. It declines thereafter while the incidence of depression continues further. Older, married, non-assimilated females, are the group most vulnerable to schizophrenic disorders. This is attributed to lack of assimilation and language skills, leading to isolation within their own family;

4. The highest incidence of all diseases occurs in upper class migrants and in unskilled workers. The former, after migration, belonged to a lower class;

5. Eastern Europeans have a higher incidence of schizophrenia than others; this could be related to severe wartime experiences;

6. Southern European females have little or no language skills;

7. There is no incidence of alcoholism among Southern Europeans;

8. The incidence of psychosis prior to migration is appreciable amongst the group under investigation.\textsuperscript{100}


\textsuperscript{100} Ibid.
Many researchers found a close association between assimilation - which was the official policy in Australia until the seventies - and mental illness in immigrants. Hammet, a psychiatric social worker attached to the Victorian Mental Health Authority, who spent twelve years closely studying the subject of assimilation, states that culture change which is an essential feature of assimilation can be very harmful to migrants when it takes place before they are ready for such a change. It can mean the stripping of previous identification symbols which helped in personal identification. Culture change can lead to a great deal of stress and, depending on their psychological make-up, migrants would react to this change with compliance, aggression or detachment. Compliance does not always come naturally to migrants. Sometimes, adjustment may only be superficial; the inwardly suppressed emotions can lead to personality disorders. Some migrants react by turning aggressive, thus, subjecting themselves to further stress of their own making. Detachment or withdrawal is a very destructive reaction. It may end in paranoia or a self-destroying apathy. Hammet concludes that all three reactions can lead to serious mental health breakdown and the loss of the migrant’s inner security at the precise moment when he or she needs it most. Assimilation stress brings conflict between their old identity and the new way of life.\textsuperscript{101}

Martin supports Hammet’s views on the dangers of assimilation. She states that compelling migrants to assimilate before they are emotionally ready for it can bring about feelings of loneliness, insecurity and confusion about one’s identity. Assimilation blurs the migrant’s distinctive status in the community until it finally disappears. Not all migrants assimilate with pleasure and sincerity. In some, the stresses of conforming lead to aggression or the harbouring of hidden hatreds. Others withdraw into neurotic or psychotic illnesses or suffer psychosomatic disorders. The seemingly well-adjusted migrant can also suffer personality disorders due to suppressed stress brought about by trying to adapt too rapidly.\textsuperscript{102}

Krupinski argues that it is not feasible to force assimilation on immigrants since it could seldom be achieved in the first generation. In a study of immigrants in Victoria he found that southern Europeans, whose main reason for immigrating to Australia was to

improve their very low standards of living, had grave problems with regard to assimilation. They had little or no command of English and assimilation problems were especially responsible for the mental breakdown of females in this group.  

In a study made by Adler and Taft, they find that immigrants face many problems regarding assimilation. To a great extent assimilation depends on the “attitudinal climate” displayed by the host community; that is, attitudes developed by Australians towards immigrants and by immigrants with regard to both themselves and Australians. A third of the Australians in the study preferred ‘monistic assimilation’, that is, the total eradication of the immigrant’s culture and the absorption of the Australian culture until only the latter remains identifiable. The immigrants, however, preferred ‘interactionist assimilation’, which means the tolerance of cultural differences with gradual absorption of the new culture through social interaction. The Australians felt that it was only ‘a short step’ towards the necessary adjustment whereas to the immigrants it was a distance ‘large enough to require considerable change’. 

Adler and Taft also find when migrants experience prejudice, real or perceived, it tends to affect their progress towards identification with the host population. They cite the example of Baltic immigrants whose experience of perceived prejudice made them poor assimilators of Australian culture. Some immigrants who were keen to assimilate later gave up the assimilation process when they met with opposition from Australians.

Stoller relates the foregoing factors to the presence of stress in Australian immigrants. He states that for some immigrants, often in poor economic circumstances, adjusting to a new culture can cause stress to a degree that they cannot accommodate without injury to their physical and mental health. This does not mean that stress always produces ill effects. In some immigrants, depending on their personality, the stress is successfully resolved and they come to terms with the new environment. For other individuals already in a state of anxiety, the added anxiety of adapting to a new country can lead to

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103 J.Krupinski “Sociological Aspects of Mental Ill-health in Migrants” in Social Science and Medicine, 1967, vol 1, pp 277-278.
105 Ibid, p 82.
psychiatric disorders which may occur in the early years or later, after apparently successful resettlement, because their internal resources have been so heavily taxed. 106

Murphy finds lower rates of mental illness among immigrants in countries where there is less pressure for rapid assimilation. In Australia, when assimilation and integration was the official policy, migrants were expected to imbibe the local culture as rapidly as possible. The Australian public was prepared to accept the newcomers on condition that they made themselves as much like the Australians as possible in the shortest time. In the United States, similar attitudes prevailed. In Canada such public attitudes have never been prevalent, nor have they been able to influence official policy. Murphy finds that the immigrant population of Canada was producing proportionately not more mental hospitalisation, but less, than the host population. This pattern differed significantly from that generally found in Australia and the United States. It is possible that although a migrant could attempt to maintain ethnic group membership in all three countries, the climate of opinion in the latter discouraged this by making it seem disloyal, whereas in Canada such behaviour was regarded neutrally or even with approval. 107

Early surveys of mental illness among immigrants have pointed to high rates of psychiatric disorders, such as schizophrenia, among Eastern European refugees who had suffered from severe war experiences. In the seventies and eighties a few Australian researchers such as Kunz and Krupinski turned their attention to the important question of the mental health status of refugee immigrants. This gave rise to some community based studies of ethnic minorities who sought psychiatric treatment. Notable among these are the study of psychiatric disorders in East European refugees (1973) by Krupinski et. al and a later study by Krupinski and Burrows of a group of Indo-Chinese refugees (1986).

The aims of the first study were:

1. To determine the degree to which war experiences are responsible for the high rates of mental illness in eastern European refugees;

106 A. Stoller “Stress in Australian Immigrants”, in Commonwealth Department of Health Archives, File no 69/1780, Subject: Mental Health of Migrants - Background Information, 26 February 1969.
2. To determine other advantageous and disadvantageous factors which play T
significant roles in the adjustment of refugees in Australia.108

Their findings were as follows:

1. The World War 2 refugees are not a homogeneous group in terms of their
past war experience or psychiatric illnesses;
2. Jewish refugees who had suffered the worst wartime persecution had the
lowest rate of schizophrenia, although this was several times higher than
that of the Australian population. They reported the highest rates of
psychiatric symptoms of the neurotic type. Psychiatric illness did not deter
them from socio-economic activities, they showed considerable upward
mobility compared with their compatriots who had migrated to Australia
prior to World War 2;
3. The second most severely persecuted group, the Poles, Russians and
Ukranians, showed high rates of psychiatric illness in proportion to the
severity of their war experiences. They came from low, mostly peasant,
social backgrounds and have remained in unskilled and semi-skilled
occupations in Australia;
4. The third group of refugees, predominantly of middle-class background,
from Baltic countries, Czechoslovakia, Hungary and Yugoslavia and
showed marked downward mobility in Australia. They had suffered the
least from war persecutions hence, their high rates of mental disorders
were unrelated to their war experiences; they were associated with loss of
social status and migration stress.109

Krupinski et.al also found that most psychiatrically ill refugees underwent symptom-
free periods which meant that their illnesses can be regarded as late sequelae of
persecution or migration stresses. They argue that assimilation and integration did not
protect the refugees as was seen in the third group whose psychiatric morbidity was due
to stresses of migration despite their free contact with the Australian-born. They

108 J.Krupinski, A.Stoller and L.Wallace “Psychiatric Disorders in East European Refugees now in
109 Ibid, pp 46-47.
conclude that the reason Jewish refugees had lower rates of schizophrenia than the other groups could be due to the fact that those who showed psychotic traits would have been the first to be selected for the gas chamber. Those who survived would have had a considerable ‘ego strength’ to cope with their lives. The survival of the toughest and the loss of all their possessions would make them courageous in their business activities and not even mental disturbances could retard their socio-economic advance.\(^{110}\)

From these studies one can deduce that severe war experiences lead to high psychiatric morbidity. The first two groups of refugees suffered psychiatric illnesses related to war-induced trauma while psychiatric morbidity in the third group whose war experiences were minor, or none at all, was associated with loss of social status and stresses of migration.

In the seventies when multiculturalism had become official government policy, Australia accepted large groups of immigrants of Asian background. The annual intake of Asian migrants had risen from about three thousand per annum in 1960 to twelve thousand in 1975/76.\(^{111}\) In addition to the normal migrant intake, Australia had resettled an average of 711 Vietnamese refugees annually between 1975 and 1977. In 1978 this rose to 5,000; during 1979, 1980 and 1981, the number was closer to 12,000 annually.\(^{112}\) Most of these refugees have faced forcible dislocation as a result of war and persecution. Their mental health status and needs have attracted increasing attention in recent years. In 1986 Krupinski and Burrows made a study of Indochinese refugees over a period of two years.

The study focused on three groups of Indochinese refugees; pre-adolescent, adolescent and young adults in Melbourne. The authors found that the rate of psychiatric disorder at the first interview was double that found in the Australian population of the same age and gender. During the two years of the follow-up period they noted a significant decline in psychiatric morbidity. At the final interview the rate was only a half of the figure reported in various Australian community health surveys. Refugees who showed

\(^{110}\) Ibid, pp 45-46.
signs of anxiety and depression at the first interview were symptom-free after a year or two in Australia.\footnote{Jayasuriya et al. find the results of the above study are in sharp contrast with others reported from overseas and Australia. They cite Stein (1986) who indicates that in America, after the initial period of resettlement of Indochinese refugees, they undergo a period of renewed stress and increased morbidity. They refer to an Australian study by Klimidis et al. (in press) which focuses on a group of Vietnamese patients who had been in Australia for an average of four years and were still presenting with psychiatric symptoms at an out-patient clinic. The rate of referrals for those who had been in Australia between three and eight years was twice that of those who had been in the country for two years or less. The rate of referrals diminished again for those who had been resident for nine to ten years. They point out that the two groups studied by Klimidis et al. and Krupinski and Burrows differ substantially both demographically and diagnostically.\footnote{Boman and Edwards in their study of Indochinese refugees found a direct relationship between the incidence of psychiatric disorders in migrants and their downward mobility. Both in Australia and the United States there is considerable underemployment with refugee migrants filling menial positions and working long hours, not infrequently because their professional and technical qualifications are not recognised. In addition to status dislocation, the lack of effective social support networks, a perceived want of sympathy from the host population together with feelings of loss and bereavement make refugees vulnerable to higher levels of psychiatric dysfunction.\footnote{The above survey of both global and Australian literature dealing with the relationship between immigration and mental health does not establish conclusively the proportion of migrants who develop psychiatric illnesses due to the stresses of migration and the}}

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The above survey of both global and Australian literature dealing with the relationship between immigration and mental health does not establish conclusively the proportion of migrants who develop psychiatric illnesses due to the stresses of migration and the
proportion that has a constitutional predisposition to such illness. What the research does support is the view that psychiatric illnesses occur with greater frequency among immigrants than in individuals who do not emigrate and in those of the host country. There is sufficient evidence to show that immigrants constitute a high risk group and need special assistance from the countries that have admitted them.

D.S. Thomas in his critical review of the concept of migration and mental disease states:

Migrants variously defined do indeed differ from non-migrants, also variously defined, in respect to the incidence of mental disease, and the weight of the evidence favours an interpretation that migrants represent greater risks than non-migrants. But many exceptions have been noted, many ingenious attempts have been made to explain it away. Closer examination of both generalisations and exceptions show so many inconsistencies in definitions, so few adequate bases of control, so many intervening variables, so little comparability to time and place, that the fundamental cause of the discrepancies may well be merely a non-additive nature of the findings of the different studies.116

Once the problem has been identified the next obvious step is finding a solution to it. The responsibility for this lies largely with the government and to a lesser extent, with the community - health professionals, social workers and community leaders. Government policies should validate its claims of social justice and equity. Untreated mental illness means not only human suffering but also an indirect economic cost to the community in terms of the loss of productivity. The role of the community is also important in eliminating loneliness and isolation of the migrant. Lack of social acceptance and lack of economic opportunities can mean dire consequences for the migrant. Mental health service provision incurs enormous costs to the community. Ultimately, the migrant’s problems become the problems of the population at large.

The second part of this literature review deals with government policy documents and other monographs. Little has been written about the Australian Commonwealth governments’ mental health policies at the beginning of this century but many writers have examined and analysed health policies in general and mental health policies of recent decades. The health of migrants has been a sadly neglected issue and does not even receive a mention in most of the early literature. In the fifties and sixties the government accorded migrant health matters a low priority. The only interest shown was in the screening procedures for the selection of migrants. Infectious diseases occurring among immigrants, the incidence of tuberculosis in particular, gave rise to the greatest concern. Martin states that governments were not interested in the health of migrants; rather, they were concerned that migrants bring with them diseases which they would pass on to the Australian population.117

Bates and Linder-Pelz affirm that:

....people’s position in society, which is determined by their attributes such as age, sex, socio-economic status and ethnicity, in turn determines their access to resources such as power, prestige and money, which in turn affects what educational, occupational, leisure and health experiences they will have. This why some people get the best there is available, while others by comparison are not as well off.....ethnicity as a factor...divides people into relatively advantaged and disadvantaged groups in health matters.118

During the period 1947 to 1972, government policy was that migrants should acquire the existing culture as soon as possible and become indistinguishable from the Australian population. Bates and Linder-Pelz write that ‘...The general belief at the time was that when migrants learned English and entered the workforce their assimilation would naturally follow. It did not occur to the government that any particular effort should be made to assist migrants to achieve this desired assimilation’. Migrants were expected to find and use mainstream Australian institutions. Failure to do so proved that they were “unmotivated people (who) deserved to sink to the bottom of the social

117 Martin op cit, 1978, pp 146-150.
“For the first twenty five years of the post-war immigration program, the delivery of health and social services was made on a totally monocultural model. Not until 1973 did the Department of Social Security start translating its welfare forms into languages other than English”.  

Garton’s history of insanity in New South Wales is one of the earliest works to deal with the political construction of mental illness. Although his book ends in the 1940s, it establishes standards for measuring official policies on the treatment of the mentally ill in Australia. Garton highlights three issues central to the development of mental health policy in New South Wales, namely, the early moral reform movement, the creation of a distinct system of mental asylums and most importantly, the “medicalisation” of insanity.

In the late eighteenth century criminals and the insane were provided for in the same institution. This situation changed when nineteenth century moral reformers argued that insanity was a moral problem and lunatics were capable of reform. These attitudes led to the creation of lunatic asylums geared to the moral reform of inmates. Laws were developed governing the committal of the mentally ill to institutions. The policy was moral reform for the insane and the asylum became the foundation of lunacy reform.

The mid-nineteenth century, medical theories regarding insanity changed. While moral reformers believed that insanity was located in the mind, doctors argued that insanity was a physical disorder situated in the brain. Their theory was that since insanity was a disease of the brain it could only be treated by doctors who specialised in such studies. It was a theory based on assertion rather than on empirical facts. Thus, the medical profession became agents of the state; they determined who was mentally ill and how they should be treated. Garton sees psychiatric incarceration and therapy as social and political processes.

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120 Ibid, p 37.
121 S.Garton Medicine and Madness, 1988, p 17.
This was a period when psychiatry became a privileged profession and psychiatrists were powerful enough to lobby the government to ensure that they had complete control over mental health care in the state.\textsuperscript{124} As early as the 1880s psychiatrist Ferderick Manning had argued that the treatment of the insane should be a function of the state so as to maintain social order; making him one of the earliest proponents of the interventionist state.\textsuperscript{125} By the 1930s psychiatrists were not only influencing state social policy but were playing a major role in the system of criminal jurisdiction as well. They had wrested control of social policy from philanthropists and non-medical moral reformers and replaced it with state intervention in social life.\textsuperscript{126}

Mental health policy up to the 1940s was based more on the improvement of the status of the psychiatric profession than on the needs of the community. The introduction of private practice for psychiatrists saw the mentally ill population divided into two distinct categories. Those with serious, hereditary mental conditions, considered incurable were ignored by the psychiatric profession and left to languish in custodial care, while those with curable, neurotic conditions received their attention. The latter were mostly from the privileged section of society who could afford to pay for their treatment.\textsuperscript{127} The sections of society most disadvantaged by these policies were the unemployed, domestic servants, immigrants and the aged.

In analysing the government’s financial policies of the sixties, Lewis shows that the Commonwealth government’s financial assistance to the states in the area of mental health has always been very limited. Mental health has been historically looked upon as the responsibility of individual states. In 1964, in response to criticism from the states, the 1955 States Grants (Mental Institutions) Act was replaced by an Act whereby the Commonwealth government paid a subsidy of £1 for every £2 spent by the states on mental health, without an overall limit for the next three financial years. In 1970 the Commonwealth government extended the 1964 Act for a further three years. But this aid was limited to capital expenditure only. The states and the federal opposition were vociferous in their criticism of this Act which they saw as extremely inadequate. It only

\textsuperscript{124} Ibid, p 147-148.  
\textsuperscript{125} Garton \textit{op cit}, 1988, pp 34-35.  
\textsuperscript{127} Garton \textit{op cit}, 1988, p 111.
provided for extra beds and buildings and completely ignored the need for training and employment of staff and the development of community facilities. 128

Lewis writes that in the 1960s there was a change of policy in the mental health system when freedom of movement was allowed to patients instead of strict custodial care. These changes took place, to a great extent, due to a change in attitude of society towards the mentally ill. The idea that mental illness should carry no stigma, promoted by the mental hygiene movement during the interwar years, was beginning to take root. The community as well as the psychiatrists began to have new concepts regarding the care of the mentally ill. The focus now shifted from custodial care to maintaining patients in the community. Victoria was the first state to implement these changes. In New South Wales the system did not change significantly until after the 1961 Royal Commission inquiry into conditions at Callan Park mental hospital. 129

Lewis states that the “open door” policy of the sixties brought “great advantages, violence declined, tension was much reduced and escapes ceased to be a major problem”. The 1960s focused on community psychiatry which helped to rehabilitate mental patients and to reduce hospitalisation of new patients. Supportive services such as social workers, clinical psychologists and occupational therapists were added to the psychiatric team. Also during this period, the advent of psychotropic drugs meant that serious symptoms could be brought under control to facilitate the re-integration of patients. 130

In 1973 the Whitlam Labor Government allocated considerable funds for community services such as counselling, education and rehabilitation. Yet these programs accounted for only a small part of Commonwealth expenditure on health - 58 million dollars in a health budget of 2900 million dollars in 1978-79. In 1973 the Labor Government replaced the States Grants (Mental Institutions) Act of 1970 with the Mental Health and Related Services Act. Funding for mental health was increased to almost double that provided by the Liberal-Country Party government. Community health programs were enhanced. During the Whitlam Government’s last year in office it funded 90% of

128 Lewis op cit, p 77.
129 Ibid, p 75.
operating costs and 75% of capital costs for the community health program. In 1977, the Fraser Coalition Government reduced this to 75% and 50% respectively. In 1978 the Fraser Government reduced the funding further to 50% for each component. Thus, the Commonwealth shifted more of the burden back onto the states. 131

Lewis sees the inauguration of the Health Commission in 1973 by the Liberal-Country Party Government of New South Wales, and the establishment of the position of Principal Advisor, Mental Health, as a genuine attempt to update psychiatric services in the state. But this appointment was a failure as none of the administrators appointed during a period of six years was able to effect a change or an improvement in psychiatric services. By 1978 there was a pressing need for a strong and able director to head the NSW psychiatric services. In 1979 a Division of Mental Health was created and a new director appointed. 132

Lewis sees government financial stringency as a historical problem. After 1975 in spite of reduced federal funding for mental health services, the community health services program continued to flourish. Crisis intervention teams were introduced which facilitated the work of community mental health workers in caring for patients outside hospital. In 1975 regional directors took over the control of mental health services creating a clear distinction between the staff of the community centres and those of the hospitals. Thus, there was a shift away from hospital care for the mentally ill to community based services. 133

While Lewis’ book provides a comprehensive study of psychiatry in Australia in the social context and successfully covers a wide range of topics such as the development of mental health policy and psychiatric treatment and services, it is lacking in some important areas. The sixties and seventies was a period during which there was an influx of immigrants from South East Asian countries. That a number of these migrants suffered mental disorders has been well documented in Australian research in mental

130 Ibid, p 76.
131 Ibid, p 79.
132 Ibid, p 94.
133 Ibid, p 95.
illness.134 In spite of the fact that New South Wales has had a large migrant community for several decades, Lewis makes no mention of mental health services for migrants. Perhaps this is a reflection of state and Commonwealth government indifference to a problem of such magnitude rather than a sin of omission on the part of the author. In his closing chapter Lewis expresses the hope that concern about society’s responsibility for less powerful groups such as the handicapped, children, women and homosexuals will grow rather than diminish.135 The same could be hoped for the immigrant population - and more, - that governments would bestow increased interest and expenditure on migrant mental health than has been done in the past.

Crichton in Slowly Taking Control, (1990), traces the evolution of Australian health policies from 1788 to 1988 and examines the political and social issues that governs them. She argues that between 1900 and 1970, in Australia, the medical profession became the dominating force in the organisation of health care. In the sixties the sovereignty of the medical profession came to be challenged by new concepts that viewed health care not merely as a matter between doctor and patient but as a personal and community affair. The Australian system of financing and managing health care gradually evolved from a private entrepreneurial-philanthropic basis to a government funded and controlled service.136

Crichton says that 1949 to 1972 was a period during which the medical profession’s control over hospital and medical services was particularly strong. This was because they had the support of the Liberals as this ideology fitted with Liberal government policy. The 1948 Labor government’s policies for a national health service funded from general revenue was done away with and contributory insurance was introduced in 1949, which benefited only the middle classes. A large section of the poor, the unemployed and pensioners were left unprovided. In 1951 the Pensioner Medical Service - a second class system - was introduced for those receiving social security benefits. The BMA at all times kept strict control over government decisions in the

135 Lewis op cit, p 193.
health care field and safeguarded their rights to private practice. The introduction of
health insurance gave psychiatrists also the right to private practice. 137

Crichton states when the Labor Government came to power in 1972 it introduced some
innovative health policies which gave greater priority to the needs of the under-
privileged such as Aboriginies and migrants. Medibank was introduced. Medibank was
a health insurance program, financed by a special levy on taxable incomes, which
benefited everybody including those who were not previously covered by insurance.
Means testing for hospital treatment was abolished with everybody qualifying for free
out patient treatment and ward care. The Commonwealth government offered the states
fifty percent cost sharing as an encouragement.138

The AMA was vehemently opposed to Medibank and to most of Labor’s health
policies. It was determined to prevent the launching of Medibank. The AMA persuaded
Liberal politicians to block the health insurance Bill which was rejected by the Senate
twice in 1974. As a result, it had to be funded entirely out of general revenue. Crichton
maintains that the medical profession was unwilling to give up its dominance over
health services and viewed Medibank as a threat to its supremacy.139

When the Liberals returned to power at the end of 1975 they set about the reversal of
Labor policies. The financing of Medibank from a government levy was changed to
private contributions. Private insurance companies were reinstated and private hospitals
encouraged. This was a ploy to win the support of the AMA. The Medibank program
was adjusted over and over again to fit the CPI index and not to benefit the consumer.
Little was done towards the development of preventive services or health promotion.
Consumer participation in policy making declined. Services for the elderly and disabled
were neglected. 140

Crichton states that in the sixties and seventies psychiatrists lobbied to obtain the same
recognition for their profession as did other specialists in general hospitals. They

137 Ibid, pp 46-49.
138 Ibid, p 73.
139 Ibid, pp 75-82.
wanted to be firmly established in the medical care system. As a result psychiatric wards were opened in general hospitals. But community attitudes towards the mentally ill were changing. People were more tolerant of the mentally ill. The availability of drugs which controlled psychiatric illnesses meant that patients could satisfactorily reestablish themselves at work or in their homes. By the mid-seventies politicians were under pressure to discharge long term patients from custodial care.\textsuperscript{141}

In the field of mental health, Crichton sees the deinstitutionalisation of the mentally ill as the most important development of the early eighties. New South Wales led the other states in the returning of psychiatric patients to the community. However, though public attitudes had changed, the shortage of funding impeded the development of community services. A few improvements took place. Some psychiatric hospitals remained open to treat those patients who could not be cared for elsewhere. In 1988 when Liberals came to power in New South Wales the program of deinstitutionalisation was suspended.\textsuperscript{142}

Crichton’s studies reveal that the medical profession has been a very powerful group in the formation of health policies. During the years of Liberal government doctors have successfully influenced decision making and intervened in policies which would not be beneficial to them. During Labor’s office they have challenged and disrupted health policies in their own interest. Crichton states that the construction of health policy depends upon the power of groups to direct attention to their problems.\textsuperscript{143} Up to the 1980s mental health policies have constituted only a minor part of national health policy. Mental health policies for migrants have been non-existent until the mid-eighties when the larger migrant communities organised themselves into pressure groups and demanded their rights.

\textsuperscript{141} Ibid, p 105.
\textsuperscript{142} Ibid, pp 104-106.
\textsuperscript{143} Ibid, p 193.
Chapter 2

Migrants and Madness

2.1 Migrant Status

I came to Sydney in 1962, at the age of twenty four. I got no help from the government as there was no social security at that time. Because of my proficiency in English I obtained a clerical position in a cosmetics factory. To tell the truth, I felt unwanted. I experienced a lot of prejudice from Australians. I have even been called a ‘dirty wog’. But you get used to being called names. I learnt to be indifferent.

Anica

I arrived in Wollongong in 1968 with my mother and found work in a factory. But it did not last long. My supervisor did not like me and I was asked to leave after a few weeks. I then got a job in a metal goods factory in Sydney and had to commute daily at great inconvenience.

Desanka

My husband and I came to Wollongong in 1982. I didn’t have a job and didn’t know anybody there. The Greek family whose house we shared were very kind and helpful. I seldom went out and was very lonely.

Dostana

I arrived in Australia with my mother and two sisters in 1977. We lived in Cringila but I had to travel to Sydney, to my factory job. I had to give up my job after three years when my children were born. I never went back to work. Life was very difficult due to the language barrier. Only my father could speak some English.

Milica
I think it was in 1970 that I arrived in Wollongong with my husband and two little children. That same year my husband died of a genetic heart condition. I was pregnant with my third child. I could not go out to work. Life was extremely hard for me. BHP Steel, for whom my husband had worked two years, gave me a lump sum of $2000. I received a monthly benefit of $32 for the children. There was $12,000 owing on the house. The children were always sick. There were bills to be paid and no one to help me.

Dana

In 1967 I came to Wollongong with my two children, to join my husband who was already working there. I found Australia a strange country. We had no knowledge of the language but later I picked up some English from the ladies I worked with at Port Kembla hospital laundry.

Elica

Migrant Status

Significant research indicates that migrants suffer more mental health problems than the host population. Researchers have concluded that this could be traced largely to the destabilising experience of migration itself.¹⁴⁴ Despite these findings, health authorities and agencies have not always accorded migrants in post-war Australia, the same access to, or delivery of, health services as that of the host population.¹⁴⁵ This chapter seeks answers to the question why Australian governments’ responded to migrant health problems in this manner. One of the major reasons is that language, power and knowledge have socially cast migrants into devalued roles. A selection of writings from various authors that follows shows how they have regarded ‘migrantness’ historically.

¹⁴⁵ Martin op cit, 1978, p 146.
Australia has a long history of race discrimination. In the 1850s, white gold diggers attacked Chinese miners. In the 1890s white farmers in North Queensland opposed the introduction of Kanaka labour. Racial prejudice is amply illustrated by the Immigration Restriction Act and the Pacific Island Labourers Act, both of 1901.\textsuperscript{146} Migrants, whether they have come voluntarily or as refugees, have not always enjoyed an equitable status with the host population. Federal and state governments and many Australian citizens have looked upon migrants as ‘outsiders’ who eagerly accept low paid, menial jobs - any job at all, to earn a livelihood - people who understand neither the language or the customs of their host. The attitude of the host population is that migrants are a group of people who, however poor their standard of life in Australia may be, are far better off here than in their home country. As such, they do not need too much consideration. They can get on with their lives as long as they do not in any way come into conflict with the host society. Put simply, their national and racial origins can often result in the host country constructing their ‘migrantness’ in terms of a second class or lower status. This, broadly, has been the attitude towards non-English speaking communities in Australia. Their ‘migrantness’ makes them almost invisible.

However, Martin argues that migrants did exist; Australia’s commitment to economic development dictated that migrants be accepted as a normal part of demographic expansion. The view promoted by commonwealth governments was that ‘...migrants were lucky to have found a home in Australia, away from the tensions and economic desolation of post-war Europe; they were essential to economic growth and they were assimilable’.\textsuperscript{147}

Jupp is scathing in his criticism of the government’s motives. He deplores the manner in which NESB migrants were treated on arrival during the post war period. He says ‘...it was a coolly calculated drive to draft workers into Australia without upsetting the domestic labour or housing situation....It was less than human in splitting those families on arrival in Australia, sometimes for as much as two years’. He goes on to add that a number of professionally qualified NESB migrants among the displaced persons (DPs)

\textsuperscript{146} R.Ward \textit{A Nation for a Continent}, 1977, pp 35-37.
\textsuperscript{147} Martin \textit{op cit}, 1978, p 27.
had two years of bonded employment in manual work imposed upon them as the price for the government’s humanitarianism. Many skilled and highly qualified migrants were dumped into outback construction camps and regarded as cheap labour. Even after release from the bond they were unable to find any but factory work.\textsuperscript{148}

The foregoing is an example of the government’s hypocritical attitude towards migrants. While the Commonwealth government conceded the economic advantages of the migration program it stressed the largely humanitarian component of the project.\textsuperscript{149} Splitting up of families thus disrupting the family lives of newly arrived migrants was neither humane nor charitable. Research has identified stress factors related to separation from family as one of the causes of mental disorders in migrants.\textsuperscript{150} Besides, the very act of denying migrant workers the life style enjoyed by the Australian workforce placed migrants in a lower social category from the outset. Thus, government policies condoned and encouraged discriminatory attitudes within Australian society.

Murphy, in his study of DPs, is critical of Australia’s treatment of refugees which he found unsatisfactory. Of the hospitals he visited, only one had a doctor who could speak the DP’s language or who used an interpreter. The other hospitals had no trained staff who could speak to NESB persons and had ‘decided that interpreters were not useful’. He deplores the helplessness of NESB patients in this situation as the tendency was to classify all patients as psychotic even if they were mildly neurotic or had some other minor complaint. He comments on the shortage of psychiatric hospital beds and the extremely over worked condition of the staff. Above all, he is very critical of the official policy of denying to NESB migrants any service which was not afforded to the general population. He concludes:

\textit{...the only way in which a DP immigrant is likely to obtain treatment for a mental complaint is by making a nuisance of himself. He will then be certified insane and receive some form of shock therapy which will relieve him of some

\begin{flushleft}
\textsuperscript{148} J.Jupp \textit{Arrivals and Departures}, 1966, p 8.  \\
\textsuperscript{149} L.Crisp \textit{Ben Chifley}, 1960, pp 319-320.  \\
\end{flushleft}
of his capacity for worrying about life, but, since it is not augmented by any other therapy, will not remove his neurosis...\textsuperscript{151}

Martin notes the limited and often superficial communication between migrants and Australians. Immigration and employment officers were mostly monolingual. They were concerned about the recruitment of migrants; their settlement problems and migration experiences did not greatly interest them. State governments believed that migrants were the Commonwealth government’s ‘problem’ as it was the latter who had recruited them. The Good Neighbour Councils, set up in every State to help migrants, catered only for the British. They did not accept NESB migrants as members until the sixties and their staff were almost entirely English speaking.\textsuperscript{152} Jupp confirms this comment when he says that prejudice influenced even agencies which were supposed to assist in migrant settlement. The Good Neighbour Council, (GNC) in particular, contained members whose views were ‘less than tolerant’.\textsuperscript{153}

Gwenda Tavan observes that although the main aim of the GNCs and the Australian Citizenship Conventions (ACC) was to help migrants to settle down and adopt the ‘Australian Way of Life’, both organisations were unwilling to involve migrants in their work, which was clearly a suspicion of their difference. As a result, non-Europeans were not invited to the conventions until 1953.\textsuperscript{154} She goes on to add that it was not the objective of GNCs to include non-European migrants in their welfare and assimilation strategies. Rather, it was their conviction that the participation of non-European migrants in council proceedings would undermine Australian dominance in the councils. Contrastively, British migrants were encouraged to offer their advice and opinions to improve the workings of the councils.\textsuperscript{155} These attitudes show clearly the preferential status given to British migrants.

\textsuperscript{152} Martin \textit{op cit}, 1978, pp 28-29.
\textsuperscript{153} Jupp, \textit{op cit}, p 119.
\textsuperscript{155} Minutes of the Fifth Conference of Presidents and Secretaries, GNCs, June 1953, in G.Tavan \textit{op cit}, p 81.
Thus, NESB migrants had poor status in Australian society. Australian nationalism has enduring racist elements. During the period when assimilation policies prevailed thousands of migrants were expected to shed their identity and merge with Australian society. This policy implicitly asserted the superiority of Australian culture. Migrants must learn to be like ‘us’ and share in ‘our’ progress. Immigrants were given the lowest paid and most unpleasant jobs - at the bottom-most rung of the ladder so that they would not lower the standard of the existing Australian working class which was steeped in a history of trade unionism and racism. Assimilation was in reality a front for segmentation and structural racism.\(^{156}\)

The label ‘migrant’ denotes difference and exclusion. ‘Migrantness’ is part of a discourse that creates boundaries and relationships of domination and subordination. Pettman says that ‘....nation,race and ethnicity are not only imagined, or part of political discourse....They are social constructions, and they both constitute and represent unequal power relations’. The dominant group becomes the cultural norm while the others as seen as ‘deviant’.\(^{157}\)

Edgar further confirms this when he emphasises that deviance is produced by society; it is not ‘ some sort of personal defect or abberation’. Unequal distribution of resources makes it possible for some groups to emerge as dominant and impose their views on others. Deviance is behaviour which the dominant group labels abnormal. He says:

> Those in positions of authority will be the major definers of deviance. And because they possess their authority by virtue of the fact that other people see their power as legitimate, their definitions will be shared by others.....when a label is attached the ‘deviant’ is treated accordingly. His (sic) rights are curtailed; he (sic) is stigmatized.\(^{158}\)

Boundaries which simultaneously include and exclude people determine the opportunities and rights of the people they contain and those they exclude. Boundaries drawn by the dominant group around themselves imply that inclusion is good and

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\(^{156}\) S.Castles et al Mistaken Identity, 1988, pp 110-114.  
exclusion bad. Thus, they create false differences and marginalise categories such as migrants, Aborigines and women.\textsuperscript{159}

Migrants come in search of a better life or, as in the case of refugees, to escape their enemies. When they arrive, their first impact with the host population will be likely to cause ‘culture shock’ as they are faced with different cultural and social behaviour. At the same time, the host population sees the migrant as the ‘stranger’ whose cultural life heightens their own sense of identity and threatens it. ‘We’ are different from ‘them’. If ‘they’ happen to be in a minority, they can be ‘treated’ calmly or ignored.\textsuperscript{160}

Pettman argues that nation making involves ‘...determination of who “we” are, and where “we” belong; and simultaneously defines “them” and the difference that threatens us’.\textsuperscript{161} Vasta describes a discourse on ethnic differentiation as a form of discrimination which is also related to the notion of national identity. She says.

Migrants experience racism both structurally and in many everyday practices, simply because of their ethnicity, their migrantness. Again, ethnicity and gender relations are analytically placed as relations secondary to class. But immigrants experience their class and gender relations ethnically, due to the racist practices of the dominant group.\textsuperscript{162}

She also states that migrantness becomes an issue when a dominant identity is imposed upon a group or when a group is excluded from a national identity. Then, ethnicity becomes a ‘site of struggle’.\textsuperscript{163}

Since the 1970s the Australian government has adopted a policy of multiculturalism. But, whether Australia offers genuine cultural pluralism is debatable. Edgar states that the idea of pluralism is ‘a balance of power... it is naive to suggest that a country with

\begin{itemize}
\item \textsuperscript{158} D.Edgar \textit{Introduction to Australian Society}, 1980, pp 310-313.
\item \textsuperscript{159} Pettman \textit{op cit}, pp 3-4.
\item \textsuperscript{160} Edgar \textit{op cit}, p 280.
\item \textsuperscript{161} Pettman \textit{op cit}, p 5.
\item \textsuperscript{162} E.Vasta “Dialects of Domination” in E.Vasta and S.Castles (eds) \textit{The Teeth are Smiling}, 1996, p 68.
\item \textsuperscript{163} Ibid, p 67.
\end{itemize}
many ethnic groups is therefore pluralist.\textsuperscript{164} In a truly pluralist society, no single culture is dominant. Callan argues that:

Australians have shown a great deal of skill in keeping power and decision making out of the hands of migrant communities. Indeed, some propose that the tolerance of cultural difference will exist only while ethnic minorities in Australia have no real power. In turn, ethnicity without power reduces any chances of access to positions in the major institutions of the majority, and subsequent social mobility.\textsuperscript{165}

Thus, social inequality and disadvantage continue to be a problem for migrant communities. The migrant’s inferior status is decided by the dominant culture. Australia’s nationalism has always contained racist elements. It implicitly asserts the superiority of Australian culture.

The Australian national identity has been based on exclusion and restriction; the exclusion of the native owners of the land from the beginning of settlement and the restriction of immigration and naturalization designed to maintain the intrinsic British character of the nation. The Immigration Restriction Act of 1901 is an example of exclusionist policy. Vasta says ‘...it is still a myth to think that Australian national identity is multicultural. It is predominantly Anglo, but also unstable as it is constantly challenged by the realities of multiculturalism. Nevertheless, there is still a dominant ideology of Anglo-ness as well as an official but unrecognised everyday racism...’ \textsuperscript{166}

Vasta cites the example of Annita Keating, wife of the then Prime Minister, who was presented at Sydney’s 2000 bid for the Olympic Games as ‘the authentic voice of Australian multiculturalism’. Although she is of migrant background, being a privileged middle class person, she cannot be considered a suitable representative of the ‘migrant voice’. None of the migrants who had helped in the development of multiculturalism were considered deserving of being presented to the public. She says this is ‘a good illustration of “pulling out an appropriate ethnic” for the appropriate occasion’.\textsuperscript{167}

\textsuperscript{164} Edgar \textit{op cit}, pp 277-278.
\textsuperscript{165} V.Callan \textit{Australian Minority Groups}, 1986, p 76.
\textsuperscript{166} Vasta \textit{op cit}, p 70.
\textsuperscript{167} Ibid, p 71.
Multiculturalism does not mean that racism has disappeared. In recent times some migrants have achieved upward mobility by participating in multicultural programs. Yet, there is clearly a ‘glass ceiling’ for people of non-English speaking background, who act as advisers rather than policy makers, who are mostly Anglo-Australians. This perpetuates the racism of Australian institutions.168

Castles et al. write:

...there are important differences in patterns of social organisation, and these differences are found in the ordinary, taken-for-granted institutions through which basic human needs are satisfied: ways of everyday life, work and welfare, social structures, economic and political institutions, and so on. At this level, there is no true plurality of cultures in Australia today.169

Further more:

..migration is often just a necessary strategy for reasonable survival....migrants when they arrive, have to adjust themselves to learning the everyday tactics required for existence in Australian industrial society....migration to Australia is inevitably going to involve a cultural leap or break if migrants come from a significantly different culture. And, at this level, Australia is not a multicultural society....The dominant culture defines the place of minority languages in Australian society, their social character and the functions they perform. They are relegated to the domestic sphere, for private or spare-time usage because they are unnecessary for elementary survival 170

De Lepervanche and Bottomley state that for some Australians white superiority is a fact of life.since they grew up with a ‘White’ Australia policy that lasted into the sixties. Australian discourse since the nineteenth century has reified the idea of race which ‘....continues to inform our common sense even though the terms we use may

168 Ibid, p 70.
169 S.Castles et al op cit, p 123.
have changed. This process of racialisation ...remains a powerful ideological device that inheres in the political life of Australia’.171

‘Race’ is no longer an officially recognised category; ‘ethnicity’ is the current term which signifies cultural differences between groups. Ethnicity draws boundaries around migrant groups to exclude them from the dominant culture. Morrissey writing about migrantness as ideology says that social forces shape ideas into ideology and in this process ‘somebody gains and somebody loses’. He adds:

...the degree of the individual migrant’s cultural exoticness (in Australian eyes) is the major factor which determines the number and type of problems that migrant will have in adapting to this country. It is the “migrantness” of an individual which explains his or her position rather than any intrinsic dynamic of Australian capitalism.172

In other words, the migrant’s culture is perceived as that which creates all the problems for him or her; not the migrant’s class relation within Australian society. ‘Migrantness’ as a social category remains to the present day, even if in a muted form.

Morrissey argues that:

The notion that it is the migrant’s ethnicity which is the explanation for his or her social situation and behaviour is dominant in public and sociological discourse.....studies of migrant health and in particular mental health rarely question this assumption by paying attention to the socio-economic position of the migrant in Australia. In industrial relations again, a great deal of work simply assumes that cultural factors (such as problems of communication), rather than the structural position of migrants in the work force, are the ultimate source of disadvantage.173

173 Ibid, p 76.
Through this ethnicity model migrants are socially constructed into a powerless and exploited group.

Pettman agrees that in terms of power relations, ethnicity signals minority status. She argues that migrant groups are new social forms whose members experience exclusion and exploitation and are treated differently by the state. Ethnicity is not merely an expression of culture but ‘rather the political signification of culture within social relations of dominance.’ Boundaries disguise many salient features. The ascendancy of the dominant culture is obscured, ‘...race and ethnicity become something only minority groups have. The race and ethnicity of the dominant groups is normalised and naturalised, as if they are somehow outside culture and politics, and simply represent society’ 174

Creation of ideology occurs mostly in educational institutions and the media. These institutions influence state policy makers. They tend to label difference as deviance - as the ‘Other’, in relation to the dominant group’s definition of themselves. Such positions of power are unequally distributed. Migrants with their different culture have no access to positions where definitions are made. Bates and Linder-Pelz argue that people are socially stratified according to their ability to gain access to ‘..resources that are scarce and highly valued, such as wealth, power, prestige and health; their access to these resources is largely affected by their age, gender and ethnic origin’.175 Migrants, totally devoid of power, are socially constructed as a category in terms of ethnicity and cultural difference and relegated to positions of dependence and subordination. In this way they are controlled and contained while at the same time exclusion and discrimination are obscured by the veil of ethnicity.

Kevin Brown writes that ideologies are ‘not simply tricks or illusions but arise from and work on and in the contradictory conditions of material life’. Educational institutions, employment agencies, welfare agencies, trade unions and politics decide how resources are distributed among members of society. It is at these points of entry to the social system that oppression is maintained. The stress on cultural groups has produced

175 Bates and Linder-Pelz *op cit*, p 15.
‘notions of natural difference, us/them divisions….which have played important roles in other racist ideologies’. Thus, culture becomes the reason for perpetuating dominant and subordinate positions in society.

‘Migrantness’, as constructed by the dominant culture, results in the devaluation of migrants as members of society. Racist discourses and labels generate a set of relations whereby migrants are socially disadvantaged. The experience of Australian migrants from the early days of post-World War Two migration onwards, until recent decades, is an example of migrant disadvantage and total powerlessness. Migrants had no voice in any political decisions made concerning them. Some decisions did not seem to consider them at all. During the period when government policies were based on assimilation, migrants existed only to the extent that they should cease to be ‘ethnics’ and merge beyond recognition into the Australian culture. Jupp states that the greatest difficulty that the government had to overcome was the non-acceptance of the migrants by the Australian community and the assimilation of such migrants to Anglo-Australian norms.

Ferguson concurs:

...when we interact with someone from what we perceive to be a different cultural background we tend to focus on them and how their behaviour fails to conform to the norms - our norms. We overlook the impact of our own background in terms of how we relate to other people and the effect our background and behaviour have on them....Research worldwide has demonstrated that people tend to develop powerful mental images of other groups....Once a frame of reference is established it is resistant to change despite new information....the negative image of the group persists.

In this way, stereotypes are formed. The dominant group becomes non-accepting of the minority group. When the minority group happens to be migrants, mutual

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misunderstanding ensues and migrants tend to withdraw and remain within the safety of their own cultural boundaries. Prejudice and discrimination play an important part in separating migrants from the dominant culture. Negative attitudes in the dominant group bring about prejudice which is then expressed as discrimination against the new comers. While prejudice and discrimination at a personal level is unwholesome, these same attitudes if manifested in the powerful institutions of a society result in systemic disadvantage and deprivation for migrants.179

The foregoing excerpts selected from various writers illustrate how categorisation occurs in society. Negative labels attract additional stigmas to migrants who are already aware that they are different from the host society, but not necessarily inferior. Adaptation to the new home land and establishing a stable relationship with the host population becomes problematic as the migrant’s self image is incompatible with that given by society. Migrants often leave behind their extended families in their own homelands, thus, lacking support networks on arrival. When they encounter rejection and discrimination in the host environment, this, together with lack of economic opportunity leads to psychological trauma. Lack of social acceptance is known to manifest as behavioural problems which, in turn become a burden not only to the migrant but to the health services system of the host country.

To be a migrant and to be mentally ill is to be doubly disadvantaged. To be, in addition, female, is even worse. From the time of the arrival of the post-1945 immigrants, well into the seventies, psychiatrists controlled mental health policy in New South Wales in the interests of their profession, not that of the mentally ill. Private psychiatric clinics flourished. Services were largely oriented towards paying patients who sought voluntary admission to private institutions. Psychiatrists defined who was insane and who should have access to treatment.180 Mental health policies were not designed to include migrants who were poor and socially disadvantaged. Psychiatrists were not interested in patients needing special treatment. In short, they were not interested in any patient who could not afford private mental health care. For migrants who were

180 Garton op cit, 1988, pp 15-16.
mentally ill, coming into this setting, there was only one alternative and that was admission into the state’s psychiatric hospitals for custodial care and often, to oblivion. Garton shows that poverty, destitution and gender became an important factor in deciding who was committed to a mental hospital.\textsuperscript{181}

Mental health policy on the whole has not been an important part of Australian health policy. Historically, much of the ongoing care of the mentally ill has rested with the States with meagre funding from the Commonwealth. The various states differed in their approach to services and it was not until 1992 that Federal, State and Territory governments combined to produce a National Mental Health Policy and Plan.\textsuperscript{182} The mentally ill have traditionally suffered discrimination. Research and studies in mental illness have not received the attention or sponsorship from either public or private sector as have heart disease or cancer or immune deficiency disorders. Due to ignorance of the nature of mental illness, the public tend to fear and discriminate against the mentally ill even when there is no cause for anxiety. Such community attitudes only serve to further stigmatise them. Ovadia and Owen state that those with psychiatric disabilities encountered discrimination in every facet of life: housing, education, employment. By 1990, not one state in Australia had outlawed discrimination on the basis of psychiatric disability. Structural discrimination existed also in government programs, where those with psychiatric disabilities were excluded from eligibility (e.g Nursing Home Benefits, Supported Accomodation Assistance Programme, Disability Services).\textsuperscript{183}

Ovadia and Owen very correctly point out that providing mental health services for migrants entails more than the provision of interpreters, bilingual counsellors and ethnic health workers. They say, ‘.The help that is needed must involve providing freedom from injury, poverty, discrimination, the opportunity for productive work, education

\textsuperscript{181} Ibid, pp 102-104.
Health workers who can provide appropriate health care for NESB migrants is an essential part of services, but it is equally important to address the problems which arise as a result of the low socio-economic status of many NESB migrants.

Miles claims that studies have revealed a strong correlation between social class and mental illness. She writes:

...the areas having the highest mental hospital admission rates were those with the greatest numbers of people in the lowest social classes....the correlation between social class and sickness rates is not confined to mental disturbance but is a feature of health and sickness statistics generally.\textsuperscript{185}

Most NESB migrants are disadvantaged both economically and socially. They need help to overcome anxiety, isolation and insecurity which are problems inherent to most migrants. As Ovadia and Owen write:

Many of the preconditions for mental health - affordable accommodation, adequate income, meaningful work - are not under the control of the health system. They are influenced by broader social and economic policies...which are the responsibility of all the participants in social life.\textsuperscript{186}

The mentally ill population is perhaps the most irrelevant section of society. Governments have not been eager to increase spending on mental health care. The mentally ill are not considered valued members of society. To be a migrant who is mentally ill is to be in a position worse than that of the rest of the population. If formulating policies that benefit the mentally ill is complex, costly and irksome, accommodating mentally ill migrants, especially NESB migrants with their different needs, would not be at a premium. Hence, it remains a neglected area.

\textsuperscript{184} Ovadia and Owen, \textit{op cit}, p 191.
\textsuperscript{185} A. Miles \textit{The Mentally Ill in Contemporary Society}, 1981, p 164.
\textsuperscript{186} Ovadia and Owen \textit{op cit}, p 194.
Lapses in the mental health system and the unsatisfactory delivery of mental health services flow on from indifferent policies designed for a section of society traditionally considered deviant and stigmatised. Changing discourses of mental illness and the role of the psychiatric profession in influencing public perception of the nature of mental illness have played an important part in stigmatising and isolating sufferers. These ideas will be discussed at length in the following section.
2.2 The Social Construction of Madness.

The room I worked in was small, with no ventilation. The temperature was around forty degrees. I worked under terrible pressure as my employer was very demanding and drove me hard. One such day, I collapsed at work. My employer sent me straight to Callan Park hospital saying ‘she is ready for a mental home’. At that time I did not know that Callan Park was a psychiatric hospital.

Anica

I have not had many negative experiences in Australia because I keep to myself most of the time and mind my own business. I don’t communicate with outsiders for fear that I might say something wrong and be judged for that. Adjusting to life here is not easy. You seem to arouse strange reactions in people even while performing simple tasks like buying a loaf of bread. You get the feeling that you are doing everything wrong.

Milica

One day I went to my neighbours and asked them to take me to hospital as I felt very ill. There, a doctor checked my pulse and said there was nothing wrong with me. He sent me home with no medication. The trouble is, we could not communicate with each other because of the language barrier so he could not diagnose me. My neighbours started laughing at me. They made a joke of it and started spreading the story that I was out of my mind.

Nada

The history of ‘insanity’ or mental illness is to a great extent, a history of power relations between individuals who are deemed ill and those who are in control of them and their lives. The history of insanity is more than the history of asylums, the development of lunacy laws and the emergence of the psychiatric profession. What needs investigation is the reason why these developments and changes took place and in
the first place, what were the means of identifying and categorising people with mental illness.

Madness is both an objective disorder which afflicts members of society and a socially constructed state, diagnosis or label affixed by the medical and psychiatric professions to certain members of society. Cocks and Allen argue that knowledge, articulated through language establishes that people with disabilities are different from other ‘normal’ members of society. Through this knowledge the ‘different’ or ‘other’ members of society are considered of less social value than those in a position to judge them. Thus, the powerlessness of people with disabilities is more a function of the evaluative language that describes them rather than a result of their own mental impairment. Labels which describe people with disabilities play an important part in the oppression of such people. Individuals thus labelled occupy a devalued position in society. At the same time, labels dictate the practices through which that position is maintained.187

‘...The fact that hard and fast criteria for “mental illness” do not seem to be available is not a state of affairs we should deplore or try to remedy. Mental illness is not a “myth” simply because nobody can define it operationally...’188 The idea that insanity is a social construction is not to deny that there do exist some people with genuine mental disabilities. However, it is the social context of these people which decides how they should be treated. The current views of the society in which they live will determine the improvement or the exacerbation of their conditions. ‘Discourses’ play a significant role in the construction and treatment of patient populations.

In *Madness and Civilisation* Foucault argues that discourse plays an important role in the creation of knowledge about madness. He defines discourse as a group of rules proper to discursive practice. Discourse determines the language by which an event or person is described. Discourse gives legitimacy to such statements. People who function within such discourses are not aware of the legitimacy of their statements in

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relation to the real world; they abide by the truth established through the rules of the discourse.189

Discourses change over time, argues Foucault. The same type of events and people acquire different meanings at different times in history. In other words, it is not the people or their condition that has changed but the perception of it according to the rules of the discourse. He cites an example from late medieval Europe when people with mental illnesses and similar disabilities were placed in a ship and set to wander around freely in search of their reason.190 Yet, in the seventeenth century these same people were confined to institutions. Foucault argues that this is not because the people or their behaviour had altered but because the discourse regarding madness had changed.191

Garton in his social history of insanity traces the development of two broad traditions which exist within the historiography of medical literature on insanity. The first, the progressivist tradition, argues that modern theories of mental illness have been arrived at through the passage of ignorant and superstitious ideas about madness which existed in ancient times, to the certainty of scientific knowledge. He states that it is a linear evolution which culminates in modern psychiatry - ‘a tale of important discoveries and great medical men, one that obscures the social context in which ideas are produced.....’ 192

Within this tradition was a group of reformers who argued that insanity was a moral problem and that lunatics could be reformed. These new ideas led to the demand for improved living conditions inside asylums and the creation of new asylums geared to the moral reform of the mentally ill. Garton calls this phase a period of reform ‘characterised as the passage from “barbarism” to enlightened humanism, the foundation for modern treatments for the mentally ill’.193

190 Ibid, pp 7-12.
192 Garton op cit, 1988, p 2.
The second tradition, the social control tradition, argues that ‘psychiatry is one arm of an increasingly active bourgeois state concerned with regulating social relations and repressing working-class resistance for the maintenance of a capitalist social order’. Social upheavals resulting from the industrial revolution created a need for new forms of control such as the police, prisons and lunatic asylums. Using these forces states controlled working-class unrest during periods of high unemployment. 194

Of these two traditions the progressivist tradition did not take into account the discourse theory. Cocks and Allen in their literature on intellectual disability state that:

> the growth of knowledge of intellectual disability should not be characterised as a steady accumulation of the ‘truth’ and a stripping away of false ideas. Rather, one set of ‘true’ statements has been progressively replaced by others. ….we should not see the development of thinking about intellectual disability as a progression from lack of knowledge to perfect knowledge through the application of scientific investigation, but as the replacement of one set of contingent, socially grounded rules for determining true and false statements about intellectual disability with another set 195

The above statement on discourses can be applied to the growth of knowledge about mental illness. Cocks and Allen suggest that an example of people who speak within such discourses may be nineteenth century doctors. 196 In Foucault’s example of the ‘ship of fools’ the disabled and the mentally ill were transferred from the ship and confined in asylums, not because their behaviour had changed but because society’s attitude towards them had changed. That is, discourses of madness had changed. Historians who pursue the progressivist tradition disregard the social context in which theories and ideas are produced.

The social control theory arose early in the twentieth century, from Foucault’s analysis of the relationship between power and knowledge. Foucault argued that power and

194 Ibid, p 3.
knowledge were inevitably interconnected. An increase of knowledge in any field was accompanied by an increase in power in that same field. For instance, ‘..the growth of penology and criminology was closely associated with the development of panoptic principles of surveillance and control.....development of psychology and psychiatry was seen in terms of forms of knowledge, related to an extension of power over the subordinate populations of urban Europe’. 197

Grob argues that the creation of asylums represents an effort to impose a rationalised system of order on the insane to ensure a degree of conformity. The authority of the asylum physician was not derived from science but rather from the moral and social order relevant to the values of bourgeois society. The importance of psychiatry was not due to its contribution to the understanding of human behaviour but was derived from its relationship to the sources of power and domination. He claims that Foucault’s writings became the inspiration for those who emphasised the social control functions of psychiatry and asylums and ‘the demands generated by a capitalist social order that insisted on conformity to a unitary standard of citizenship and behavior’. 198

Garton, on the other hand, believes that in Foucault’s scheme ‘power and knowledge are integrally linked and mutually dependent. But this is not the power of state and class, as in the social control theory, rather it is the micro-politics of moral behaviours, bodily capacities and human attributes’. Garton points out that social control theory does not investigate the social impact of institutions. Social control theory assumes that social systems can operate without forms of control. This is most unlikely. All societies have laws which organise social life. Social control theory assumes that control is merely a convenient labelling system - ‘madness’, ‘crime’, ‘delinquency’ - attached to individuals who violate conventional behavioural norms; the function of these labels being to legitimate the existing social order. 199

198 G.Grob The Mad Among Us, 1994, pp 273-274.
199 Garton op cit, 1988, p 4.
Garton emphasises that these assumptions ignore the problems of classification. He insists that historians cannot disregard the importance of classification; the processes by which some behaviours come to be categorised as ‘madness’, and how these categories change. Social control theory also tends to ignore the reality of disturbed behaviours and the importance of the social impact of institutions. Garton states that Foucault’s work on the history of modern scientific knowledges throws light on how these knowledges were organised and allied with specific social institutions. He cites the example of the science of psychiatry which depended on the establishment of lunatic asylums for its survival. He says ‘It was only after the confinement of a population deemed insane that medicine was capable of classifying, describing and analysing the specific characteristics of an “insane” population’. He stresses that this power and knowledge that are thus linked are not the power of state and class as the social control theory would have it.\textsuperscript{200}

In the nineteenth century when a doctor labelled a person ‘insane’ the word did not necessarily describe the condition of the individual thus labelled. Cocks and Allen state that the authority behind such judgements depended upon the social prestige and the value of the person making the statement and not upon the actual condition of the person they were assessing. They draw upon Foucault’s investigative work in the formation of scientific knowledge and state that ‘...to know about something was to have power in relation to the objects of knowledge, and to be knowledgeable was to be powerful’. And, ‘....when scientific knowledge has been highly valued, those people who become the objects of medical, psychiatric and other scientific discourses have been, and still are, particularly vulnerable to this form of power relationship’.\textsuperscript{201}

All of the above emphasise the importance of the role which society plays in the construction of knowledge about mental illness. The establishment of a discourse of mental illness makes it possible to distinguish individuals who are ‘mentally ill’ and do not conform to the norms and standards described by the discourse. Cocks and Allen state that discourse theory serves a purpose in society. Materialistic societies benefit from social devaluation by social stratification, and thereby, economic and political

\textsuperscript{200} Ibid, p 4.
\textsuperscript{201} Cocks and Allen \textit{op cit}, pp 286-287.
gains based on a society whose members are not accorded equal value. Also, ‘...their devalued identity is kept within society to act as a necessary “other” in contrast to whom the rest of society confidently believes itself to be ‘normal’.” 202

The latter part of the nineteenth century was a time when science presented a challenge to religious belief and spiritualism. In Europe, the aftermath of the religious wars of former centuries had convinced the people of the dangers of religious zeal. The upper classes were ready to reject theories of religious psychology and the practice of spiritual healing. In such a climate, attempts by physicians to define madness as an exclusively medical problem and province ‘were aided by and dependent upon the larger social changes which......were bringing about the disenchantment of the universe; promoting a more secular outlook on a world increasingly seen as orderly and rational; and undercutting the earlier emphasis on a spirit-drenched cosmos’.203

Secularisation in social thought led the educated middle classes to seek scientific explanations of the natural and social world. In the late nineteenth century Charles Darwin’s theory of the survival of the fittest had a great impact on the western world partly because it came at a time when European thought was ready to accept the superiority of scientific knowledge over religious philosophy. This Social Darwinism became the basis of a struggle for supremacy between human populations. Intelligence and moral tendencies were believed to be inherited.204 Skin colour was seen as important in deciding the hierarchy of races.205 Non-Caucasian people were considered ‘primitive’ and ‘backward’ in comparison to the Caucasian population.

These new ways of thinking pervaded Australia as well. The decline of the birth rate in the early twentieth century and perceived threats of invasion from Asian neighbours made the formation of a genetically healthy and strong Australian population an important issue. This was the beginning of eugenist thinking which maintains that all mental and physical defects are hereditary. Australians now sought increased state

203 A.Scull “Museums of Madness Revisited”, in Social History of Medicine, April 1993, vol 6, no 1, p 6.
204 Garton op cit, 1988, p 54.
intervention in solving the problem of racial decay and the building of a genetically healthy nation. 206

The new eugenist discourse stated that heredity was the major underlying cause of mental illness. The mentally defective should not be allowed to breed lest they endanger the future health of the nation. In the light of these new developments the medical profession, and psychiatrists in particular, grew in power as society looked to them to safeguard the national health. Psychiatrists became part of the eugenist movement. They influenced government social policy concerning the intelligence testing of children and the segregation of ‘defective’ and ‘backward’ members of society. Their expertise was so highly valued that their advice was sought by educationists, social reformers, racial hygiene associations and other charitable groups. Psychiatric hygiene would ‘help to prevent the realisation of mental disabilities and thus reduce the “social chaos” caused by defectives and the neurotic’. 207

In Australia, by the beginning of the twentieth century, psychiatric discourse dictated that psychiatrists alone, through their superior scientific knowledge, were capable of identifying and categorising people with mental illness. Psychiatrists believed that their science held the answer to all society’s ills. The causes and cures of insanity were central to their discourse. Those individuals they deemed ‘insane’ were confined in asylums where doctors observed their symptoms and worked out remedies for their afflictions. 208

Thus, doctors became the agents of the state. The medical profession and science became as important as the police and the judiciary. Doctors concentrated their attention on those of the insane whom they believed they could cure. Those they regarded as incurable were relegated to custodial care under severe conditions. Cocks and Allen argue that ‘...medical knowledge established the doctor as the most privileged, knowledgeable person within that discursive system.....It located the doctor as the active, intervening party; the patient’s role was to remain passive....and allow the

206 Garton op cit, 1988, pp 55-56.
207 Ibid, p 80.
208 Ibid, pp 54-55.
doctor direct access to the symptoms and conditions of the ailment so as to alleviate or remove them.\textsuperscript{209}

Garton goes so far as to say that the confinement of people to ‘therapeutic environments’ furnishes the doctors with ‘objects for empirical study to validate and develop knowledge of “mental disease”. The provision of psychiatric therapy involves a complex web of power relationships whereby people who exhibit forms of behaviour considered to be “abnormal” are constructed as patients with doctors as their legitimate saviours.\textsuperscript{210}

The development of governmental policies for the mentally ill has, to a great extent, been dependent on the views and beliefs of the psychiatric profession which, in turn, changed as new discourses of insanity replaced the old. From the time of the establishment of lunatic asylums in the nineteenth century doctors insisted on their right to treat the mentally ill. The medical theory of insanity was that mental illness had a physical basis and as such, doctors were the correct persons and the only persons, who were qualified to treat the mentally disordered. In the mid-nineteenth century the medical profession undermined the efforts of social reformers and ‘moral therapists’ to care for the insane with their claims that only the medically trained possessed the expertise to treat and cure the mentally ill. They argued that mental illness was a disease of the brain and could only be treated by doctors who specialised in the study of brain disease, in other words, by psychiatrists.\textsuperscript{211}

Ingleby states:

\begin{quote}
Psychiatrists have considerable power over people’s lives, and in order to justify the possession of this power - and to keep it in the hands of a single profession - it is necessary to claim a distinctive authority for their judgements; if it were admitted that these judgements were founded on criteria available to everyone, the basis of psychiatric power would collapse. The notion that psychiatrists alone can authoritatively detect mental illness is thus not simply
\end{quote}

\textsuperscript{209} Cocks and Allen, \textit{op cit}, p 304.
\textsuperscript{210} Garton \textit{op cit}, 1982, p 138.
an error arising from ‘idle or isolated’ reflection, but part of a social and professional ideology. 212

As earlier remarked, at the beginning of the twentieth century eugenist thinking dominated the discourses of psychiatrists. All mental disorders were now believed to be hereditary - caused by ‘bad’ genes. Side by side with the eugenist discourse was the discourse of prevention. It came at a time when asylums were overcrowded with patients whom the doctors were unable to cure and they needed to advance their professional image. Psychiatrists now assumed responsibility for mental hygiene, eugenics, care of the feeble minded, management of abnormal children, treatment of criminals, and prevention of crime and prostitution. With their new expertise in the prevention of mental illness they wielded considerable influence on social policy and initiated a greater shift towards state intervention in social life. 213

The psychiatric professions’ altering the basic foundation of their speciality was also in response to a loss of credibility within the medical profession. In America, psychiatry was not approved as a medical speciality until 1934. 214 Grob states ‘...the rise of “scientific” medicine, symbolised by the specific germ theory of disease, the application of laboratory findings and new technologies to clinical practice accentuated the seeming backwardness of asylum medicine’. 215 This led psychiatrists to seek new careers outside asylums, formulate new theories and therapies and expand their professional boundaries to include all manner of social problems. In assuming a preventive role and diverting their interests elsewhere they distanced themselves from the chronically ill patients in asylums.

These changes were taking place in Australia too. New discourses of mental illness led to the establishment of psychotherapy as an important tool in the hands of the psychiatric profession. Private practice flourished and many psychiatrists escaped the constrictions of the mental hospital system. Psychiatry increasingly invaded the

211 Garton, op cit, 1988, pp 15-16.
212 Ingleby op cit, p 136.
215 Grob op cit, pp 130-131.
domestic sphere. Psychiatry claimed to supply explanations for a variety of social problems. Women became the main target of the profession’s concern with neurosis. Garton states ‘Psychiatry prescribed new norms of masculinity and femininity, and failure to live up to those norms carried the implicit message that mental disturbance lay at the heart of the problem’.216

The development of discourses of mental illness can itself lead to an increase in the number of persons considered ‘ill’ and to the creation of more types of mental illness. Violent male behaviour which in the nineteenth century may have necessitated police intervention, according to changing notions of psychiatric illness would require psychiatric committal. Likewise, psychiatric notions of mental illness in women can mean that women who do not conform to expected behavioural norms will be categorised as mentally ill. Garton’s example of Australian women during the inter-war years illustrates this view.

Garton believes women bore the mental strain of the new discourses that stressed the vulnerability of the female. The image of the ideal woman, created by the professionals, mostly male, was that of an ideal wife, efficient household manager and a good child bearer and rearer. For many women the contrast between the image and the reality of their lives, often of drudgery, was difficult to face up to. Society had set standards that women could not conform to. By the 1930s, women were voluntarily seeking psychiatric help.217

Behaviour which appears ‘abnormal’ or is unintelligible in a particular society tends to be regarded as evidence of mental illness.218 We have seen that such labels are a result of the way in which certain forms of thought are created in societies. To understand why certain types of behaviour is considered ‘insane’ we have to analyse the social processes by which that thought comes to be constructed. When a person is said to act in an illogical or unreasonable manner a critical distinction is made depending on what that particular society sees as ‘normal’. behaviour. In other words, it is a social construction. As Edgar points out, ‘..what is taught as normal to one group may not be

216 Garton, op cit, 1988, p 188.  
normal to another...if deviance is behaviour contrary to what is considered to be normal...it will reflect the structure of dominance relations in society." \(^{219}\)

Thus, behaviour which is rational in one context may be irrational in another. In the interests of maintaining social stability non-conformity is, not infrequently, equated with insanity while ‘normality’ is undoubtedly, sanity. Psychiatric diagnosis has become the tool with which this ideological boundary of ‘madness’ is defined. The psychiatric profession has assumed for itself the important role of maintaining social order. Ingleby confirms this view when he says:

> Groups which have an interest in the maintenance of the status quo will also have an interest in equating normality with sanity, and non-conformity with insanity. The decision about where the boundaries of madness are drawn is thus an ideological one, and it is in this straightforward sense that I believe we may characterise psychiatry as an instrument for maintaining social order.\(^{220}\)

But Coulter says, psychiatric diagnoses are bound to be influenced by the opinions of the society within which they are made, hence, it is unfair to accuse the profession of imposing their ideology on the people.\(^{221}\) Ingleby very correctly counters this point when he says that ‘....we should not overlook the extent to which the psychiatric profession sets up normative and interpretative standards and passes these down to the lay population’. As an example he cites the way in which Freudian concepts have ‘filtered into everyday discourse’.\(^{222}\) With changing discourses of mental illness the defining of ‘normality’ becomes more complex.

The foregoing illustrates how concepts of mental illness serve to maintain behavioural norms in society. The profession lays down the rules and the people apply these to judge their own conduct. It is not surprising then, as mentioned above, that Australian

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\(^{218}\) S Roach \textit{op cit}, 1991, p 150.
\(^{219}\) Edgar \textit{op cit}, p 310.
\(^{220}\) Ingleby \textit{op cit}, p 135.
\(^{222}\) Ingleby \textit{op cit}, p 135.
women in the inter-war years were diagnosing themselves as ‘mentally ill’ and voluntarily seeking psychiatric help. Roach Anleu points to the deleterious effects of labelling. She says:

Secondary deviance emerges when the individual’s own self-conception is in line with the deviant label and his or her actions conform to others’ expectations...The assignment of the label ‘mentally ill’, especially by a psychiatrist, is very difficult to remove.\(^{223}\)

Edgar concurs when he says that the consequences of labelling can be very serious for women whose doctors ‘stereotype them as “neurotic” and prescribe drugs to cure conditions which are socially rather than psychologically caused. The real problems may be for ever ignored in the easy acceptance of the label’.\(^{224}\)

In understanding the social construction of mental illness we must heed Bury’s words of caution. He argues that the value of constructionism lies in its emphasis on the ‘frequently unrecognised and problematic nature of science (particularly medical science) and rationality in modern society’. But, ‘...constructionism too readily conveys the impression that care and welfare are mere facades for the interests of powerful groups. In its preoccupation with medicine’s supposed role in social surveillance and control it frequently exaggerates the processes at work’.\(^{225}\) Indeed, we must guard against such excesses but we cannot overlook ethical and moral considerations in the shaping of theories, practices and treatments when dealing with the most vulnerable and dependent groups in our society.

\(^{223}\) Roach Anleu \textit{op cit.}, p 149.

\(^{224}\) Edgar \textit{op cit.}, p 311.

Part II

Multiculturalism, Migrants and Mental Health
Chapter 3

Mental Health and Migrants - the U.S.A, Britain and Canada

Until the 1980s our notion of health was a medical model - cared for by a doctor in a hospital setting. In the eighties this changed away from the hospital setting to a community setting.

Glenis Lloyd

Early discharge (from hospital) can be very dangerous. But it does happen now due to pressure on beds. We put such patients in charge of community health teams who are themselves over-worked and under pressure.

Sue Karpik

There are some information pamphlets in translation but it is not always that these reach the people who need them. Community health organisations do not necessarily have the needful resources and won’t know which group will find the information most useful. They do not have the know-how that multicultural workers have about ethnic groups. To make sure that health issues are correctly addressed and carried forward you need to have multicultural workers in the community health area.

Franca Facci

This chapter traces the development of mental health policies and community health services in America, Canada and Britain, countries, which like Australia, are home to significant populations of non-English speaking migrants. The following survey shows that in comparison to these countries, Australia has been slow to recognise the special mental health needs of not only its migrant population but of the general population as
well. In fact, these developments overseas had no significant effect on Australian mental health services.

In America, the concept of community care for the mentally ill originated in the 1940s, many years before other western nations considered adopting such health policies. In the 1940s there were significant changes in mental health policy as a consequence of the entry of the federal government into the mental health arena and the lessons learnt from World War Two. Between 1940 and the 1960s, there was a decline in hospitalisation and the care and treatment for the mentally ill shifted to the community. In 1954, the Community Mental Health Act became law.\footnote{Gro\textsuperscript{b} op.\textit{cit}, pp 223-310.} In the 1960s America saw community mental health care as a means of delivering services according to the needs of the community, targeting high risk populations through crisis intervention and thus, preventing the need for hospitalisation. Community care would not only help to re-establish discharged patients in the community but would play an educational role in the prevention of mental illness and its recurrence.\footnote{Lewis \textit{op.\textit{cit}}, p 88.} Although community care was not free of problems, expansion of federal aid programs made it possible for many mentally ill persons to live a fairly satisfactory life in the community.

Following World War Two, a strong opinion emerged throughout America that environmental factors were prominent contributors to mental illness and that the mentally ill should receive community care rather than be isolated in mental hospitals.\footnote{D.Mechanic \textit{Mental health and Social Policy}, 1989, p 81.} Wartime experiences helped to further strengthen this belief. The greatest successes in treating psychiatrically ill soldiers occurred in the battle zone which provided the correct atmosphere for recovery. Those casualties who were evacuated to distant facilities for psychiatric treatment did not show the same rate of successful recovery. The conclusion that followed was that civilian patients, as the military, had to be treated in a family and community setting rather than in remote, isolated institutions if they were to recover.\footnote{Gro\textsuperscript{b} \textit{op.\textit{cit}}, pp 194-221.} These lessons learnt from wartime experiences laid the foundations for new mental health policies. America was entering an era that would end or reduce custodial care for the mentally ill. American society believed in the

\footnotesize{\textsuperscript{226} Grob \textit{op.\textit{cit}}, pp 223-310. \hfil \textsuperscript{227} Lewis \textit{op.\textit{cit}}, p 88. \hfil \textsuperscript{228} D.Mechanic \textit{Mental health and Social Policy}, 1989, p 81. \hfil \textsuperscript{229} Grob \textit{op.\textit{cit}}, pp 194-221.}
superiority of community based care over hospital care and it welcomed the change in policy.

In 1946 Congress passed the Mental Health Act by which the National Institute of Mental Health was established.\textsuperscript{230} In 1954 when the Community Mental Health Act became law in the State of New York, any city or county with fifty thousand or more residents was empowered to create a mental health board with a psychiatrist as director. This board received financial support from state and federal governments. During this period the introduction of psychotropic drugs in addition to electric shock treatment and psychosurgery meant that more patients could be released from institutions to live in the community. There was an abundance of federal funds to finance community mental health centres.\textsuperscript{231}

In the early 1960s the Kennedy administration increased mental health expenditure significantly. During the 1960s there was rapid deinstitutionalisation of mentally ill patients. By the mid 60s, federally sponsored community mental health centres began to appear.\textsuperscript{232} Indigenous paraprofessionals were employed in community mental health centres in areas where the population was culturally different from the professional staff providing services. They were untrained but were entitled ‘mental health workers’. They were usually employed in low socio-economic areas, where unemployment was high. They were helpful to the professional staff as they were both culturally and linguistically allied to the local ‘ethnic’ population. A side benefit was that these appointments provided meaningful jobs for the some of the unemployed. The National Institute of Mental Health ran special training programs for these mental health workers and by 1978, there were 10,000 students qualifying per year. Once trained, these workers ‘..carried out mental health counselling, liaised with local schools, trade unions, parents’ associations and gangs, undertook mental health education, and, because they lived in the area and their professional colleagues did not, often worked more nights and weekends than the predominantly white Anglo-Saxon staff’.\textsuperscript{233} For the first time, a significant number of African Americans, Hispanic and Asian students of

\textsuperscript{230} Mechanic \textit{op cit}, p 87.
\textsuperscript{231} Grob \textit{op cit}, pp 223-235.
\textsuperscript{232} W.Vega and J.Murphy \textit{Culture and the Restructuring of Community Mental Health}, 1990, p 3.
\textsuperscript{233} K.Jones \textit{Experience in Mental Health}, 1988, pp 15-16.
low-income background were graduating from universities. Their unique social experiences made them especially suited for community service.\footnote{Vega and Murphy \textit{op cit}, p 6.}

In 1969 federal assistance to mental health funding became minimal as the Nixon administration focused attention on the Vietnam war. Mentally ill persons living in the community were sorely neglected without access to services. In 1974 after Nixon’s resignation there was a reawakening of interest in mental health issues. A grant program was established which provided extra services for community centres including screening, follow up care and therapy for released patients. As new centres received resources the older ones declined and by the mid 70s destitute, mentally ill persons were becoming more visible in the community.\footnote{Grob \textit{op cit}. pp 281-284.}

After 1974, with Jimmy Carter as president, interest in mental health issues for cultural minorities escalated. There was a rapid rise in minority mental health research. Community mental health centres were explicitly required to develop services responsive to linguistically and culturally different individuals. Bilingual staff were required to provide guidance to such individuals and to brief other staff members on methods of bridging linguistic and cultural gaps.\footnote{Vega and Murphy \textit{op cit}, p 7-15.} In 1980 the Mental health systems Act was passed which emphasised federal support for the most high-risk groups and services for the poor and ethnic and racial minorities.\footnote{Ibid, p 8.} The Reagan administration that followed repealed most of the above Act. The Federal Government reduced funding, shifting responsibility back to the states and local governments.\footnote{Grob \textit{op cit}, pp 284-287.}

Whatever the shortcomings, America was ahead of other western nations in establishing policies of community health care for the mentally ill. In America mental health policy, as early as the 1960s was focused on primary prevention. Primary prevention was based on, first, the community mental health movement, and second, psychiatric and social epidemiology. Community mental health centres not only provided care for patients living in the community but were active in the promotion of mental health and the
prevention of mental illness. This philosophy of prevention was based on the view that mental health problems were rooted in social problems. Thus, the staff were not only mental health professionals but social activists as well.\textsuperscript{239}

But these prevention strategies were not very successful. First, the epidemiology did not explain clearly the relationship between social deprivation and the incidence of mental illness. Studies carried out in the 1950s and 1960s showed that the rate of mental illness was significantly higher in the lower social strata due to unemployment, poverty and racism, but the link between cause and effect was not sufficiently identified in order to instal interventionist procedures. The studies were also criticised for focusing only on social factors while ignoring the genetic. The second cause of failure can be attributed to that section of society which believed that social activism was neglecting the patients’ real need for treatment.\textsuperscript{240}

In the 1970s, under the Carter administration, prevention strategies improved and became more effective. Social epidemiology clearly showed the effect that changes in life events and the social status of individuals had on the onset of mental illness. Prevention of mental illness now focused on the elimination of social stressors or the reducing of their harmful effects. In order to achieve this outcome, social networks were strengthened and counselling offered at times of crisis. It was recognised that such services lay outside the ambit of mental health professionals, with other health care personnel. Another aspect of primary prevention was that the older population became the target of intervention. This involved the maintenance of the physical health of the aged in order to ward off the onset of psychological symptoms and improved living conditions for the widowed who suffered a higher risk of psychiatric illness due to social isolation.\textsuperscript{241} And most importantly, community services were to be made flexible so as to be accessible to all social and racial groups.\textsuperscript{242}

In the early 1980s the Reagan Administration undid most of the good work of the seventies. It introduced drastic cuts to federal funding for mental health services but

\textsuperscript{239} A.Rogers and D.Pilgrim \textit{Mental Health Policy in Britain}, 2001, pp 130-131.
\textsuperscript{240} Ibid, p 131.
\textsuperscript{241} Ibid, pp 132-133.
\textsuperscript{242} Mechanic \textit{op cit}, pp 93-94.
retained research responsibilities and a minor role in policy formulation. The reduction of the federal role gave greater authority to the individual states to direct their own mental health services. Although there were funding difficulties there was some merit in this new system as states could decide their own priorities while in earlier decades, federal officials tended to bypass state concerns. When federal involvement diminished, the states were left to devise ways of using more efficiently whatever resources they possessed. They turned their attention to obtaining for the mentally ill, benefits to which they were legally entitled.  

The emergence of the ‘anti-psychiatry’ movement in America in the 1960s took place around the time of deinstitutionalisation of the mentally ill. At the same time there arose a section of psychiatry with an interest in social epidemiology. These factors combined to persuade mental health workers to look for a different approach to solving mental health problems. The result was that community mental health care developed in America earlier than in other western societies. Jones writes:

> Only the United States made a major effort to replace the old system by a new one, in the form of Community Mental Health Centres. In most other countries, it seems to have been taken for granted that no special provision would be necessary. It was assumed that the existing structures of society - the family, community networks, the general health and welfare system - would be capable of shouldering the extra load.  

In Britain, unlike in America, primary and preventative services were not given priority of place in health policy until the 1980s. Hospital services received the major portion of public funds resulting in great inequality of services. After 1980, the National Health Service (NHS) included promotion and prevention in its policy goals but they were predominantly in the area of physical health. Mental health was a neglected entity until later years.  

In Britain, as in America, there were immediate changes in mental health policy at the end of the second world war. Therapeutic communities and psychological treatments

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243 Ibid, p 95.
244 Jones, op cit, p 81.
were introduced. Civil Resettlement Units were provided for the rehabilitation of prisoners of war; to help them to re-establish themselves in the civilian community and prevent relapses of psychological conditions. This was the first instance when mental health policy considered any form of preventative service. Although this was a beginning, prevention and promotion policies remained piecemeal until the 1990s when the incoming Labour Government became more receptive to policies designed to deal with inequalities in health. One of the reasons for the neglect of this aspect of policy was because clinicians have a vested interest in the diagnosis and treatment of mental disorders rather than in their prevention.246

Prior to 1980, primary mental health care in Britain was little more than a means of referring patients to psychiatric professionals. After 1980 the role of primary care changed with a change in mental health policy whereby mental health problems were treated and managed to a great extent, in the community. Community mental health staff provided a wide range of services including counselling, management of depression, preventative and promotional services. In the 1970s and early 1980s, mental health policy had focused more on secondary prevention rather than on primary. The main target was on general practitioners who usually had first contact with mentally ill persons because they were more readily accessible than mental health professionals. GPs were expected to detect psychiatric symptoms early and thus prevent the progress of the disease. In the past two decades GPs have been expected to play a role in secondary prevention as well as one of tertiary prevention, that is, to prevent relapse of the illness by providing after care to the patient. Policy changes have enabled GPs to employ primary health care staff such as counsellors directly when the need arises. GP education courses have resulted in many GPs adopting a holistic approach to view their patients against their social background and lifestyle. Such methods have gone a long way in merging general practice with primary care and improving health promotion and illness prevention.247

During the period of Conservative government, from 1979 to the early 1990s, community mental health care schemes stagnated. This was due to lack of funds and

245 Rogers and Pilgrim, op cit, pp124-125.
246 Ibid, pp 126-129.
poor co-ordination of services. Money was not forthcoming for the transition from institutions to community care or for staff training. Accommodation and rehabilitation services were unsatisfactory as the housing system, the employment system and benefit system worked in isolation from each other and this was not conducive to community care. In 1997 when the Labour Government came into power, it claimed that community care had failed and announced a reform of mental health services. In 1999, the Labour government revised the Care Programme Approach (CPA) which had already been introduced in 1991.\textsuperscript{248}

The CPA required that all patients at risk be identified through a supervision register. Through this approach it was possible to identify which patients needed greater supervision and treatment. Although this was considered a satisfactory way of managing community services, mental health professionals found it “over bureaucratic” and “confusing” due to “lack of consistency” among service managers and patients. It focused on the administrative aspect of mental health care and did not lay down rules for clinical care. Although the CPA has at times been a bureaucratic burden for clinicians, it has remained the central plan around which mental health care reform developed in Britain. When compared with American community treatment, Britain falls short in both staffing levels and service procedures.\textsuperscript{249}

In the 1970s, Canada, along with Australia, became one of the countries to admit the largest number of migrants, refugees or otherwise. Between 1979 and 1981, Canada gave permanent asylum to 60,000 ‘second wave’ South East Asian refugees. Unlike the ‘first wave’ group that preceded them, these were less well educated and primarily of lower socio-economic status. Ninety percent of them spoke neither English nor French. These refugees were settled widely across the country in both cities and rural areas. The very nature of the refugee experience gave rise to grave concern about the mental health status of these refugees. Hence, the Canadian government created a federal task force to

\textsuperscript{247} Ibid, pp 143-149.
\textsuperscript{248} Ibid, pp 83-84.
\textsuperscript{249} Ibid, pp 171-172.
investigate the situation of both refugees and other migrants and to make recommendations. Research in immigrant mental health rose to unprecedented levels.\textsuperscript{250}

The Canadian task force found that while migrant mental health services focused mainly on mainstream facilities such as hospitals, psychiatrists and psychologists, the primary health care system was also receiving increasing attention because 26% of all medical care contacts were, in reality, for mental health problems. The prevention of mental illness was also receiving greater attention. And, most importantly, traditional and folk healing systems were being promoted as mental health resources.\textsuperscript{251}

Canadian mental health workers place great value on traditional healing practices. Mainstream practitioners encourage healers from cultural communities to act as consultants and trainers and would not hesitate to refer patients to them. Many successful outpatient and inpatient programs have been based on traditional treatment methods. Migrants and refugees use traditional healers, rituals and remedies in conjunction with western medical treatment. The community mental health system’s outreach and preventive programs have derived enormous benefits from the involvement of mediators from the cultures of the population they served. Although there has been some opposition from western mental health practitioners to the use of traditional healing methods, which they label as unscientific, the general trend has been one of acceptance. Recent biomedical research had helped in understanding traditional healing processes and the final verdict rested on the obvious benefits which believing patients received from them.\textsuperscript{252}

Canadian community mental health programs are ‘..structurally and philosophically predisposed’ to addressing the following three issues:

1. How to ensure that migrants who need the services access them;
2. How to assess or diagnose clients/patients cross-culturally;
3. How to adapt treatment approaches and therapies for persons from different cultural backgrounds.

\textsuperscript{251} Canadian Task Force on Mental Health Issues Affecting Migrants and Refugees, 1988, p 18.
\textsuperscript{252} Ibid, pp 19-20.
Not only community mental health services but individual mental health practitioners and hospital facilities as well have responded to the challenges posed by multicultural service users. In short, the ideology of culturally appropriate services has been recognised as ethically essential.\textsuperscript{253}

In Canada, mental health policies which favour minority groups, such as the training of ethnic and native therapists and the use of traditional treatment have led the way to progress. The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), a volume greatly revered by western psychiatry, has ‘also paid attention to culture-specific syndromes, religious or spiritual problems and problems related to acculturation’.\textsuperscript{254} Tousignant has found that the influence of folk medicine is such that:

...some Vietnamese herbal clinics in Montreal have a larger non-Asian than Asian clientele.......Another fascinating issue is the proportion of French Canadian patients who consult voodoo practitioners. With the crisis of identity afflicting Western civilization and the frustrations about the soulless high-tech medicine not attending to the more daily complaints, medical systems brought by the immigrants are now attracting some attention outside their group.\textsuperscript{255}

Canada has gone a long way in formulating mental health policies which benefit migrants. Yet, even in that society with free access to mental health consultation and a significant number of immigrant psychiatrists, the barrier to care is high. Language is a notable handicap.\textsuperscript{256} However, the Canadian government has encouraged research in migrant mental health and, to a great extent, the outcome of these findings has influenced policy making. The vast body of research undertaken becomes visible in the Canadian Task Force review on the literature published in 1988. The research continues to the present day in a manner, unfortunately, not matched in Australia where the problems are similar, if not more urgent.

\textsuperscript{253} Ibid, p 20.
\textsuperscript{254} I.Al Issa “General Issues and Research Problems” in I.Al Issa and M.Tousignant (Eds) \textit{op cit}, pp 286-287.
\textsuperscript{256} Tousignant \textit{op cit}, p 68.
In contrast, in Australia there was no research done in the mental health status of soldiers returned from World War Two, although they did receive attention to other needs such as employment and education. Although there were thousands of refugees recruited from IRO camps their psychiatric status was not a matter of concern to the Australian government. Clause 13, paragraph (c), of the Migration Act of 1958 made provision for the Minister for Immigration to deport an immigrant from Australia if, ‘within five years after any entry by him into Australia, he becomes an inmate of a mental hospital or public charitable institution’. It was an easy solution to dealing with the problem of mentally ill migrants, a policy neither compassionate nor humane. Research in the mental health of migrants was not a government priority and such studies as were carried out by private individuals received scant attention.

In Australia, the first mental health community centres started functioning in the early 1960s. Prior to this was mainly custodial care. In New South Wales, community care was little more than out patient clinics; in South Australia, a day hospital was opened and some after-care hostels were established; and in Western Australia, besides a day hospital and after-care hostels, mental health officers were appointed to work in the community with patients and their families. Community mental health got its first real boost in the early seventies when the Whitlam Government made funds available for that specific service. It was in this decade that Interpreter services were started. It was the end of the seventies before Health Care Interpreters were made available, though it was not an adequate service.

Commonwealth interest in mental health policy has been very recent. In 1992, the Health Ministers of the Commonwealth, State and Territory governments released a National Mental Health Policy which was the result of a number of years of work by individuals, community groups and the Australian governments. It states among other things:

It is recognised that some groups in the community have special needs. It is important that mental health services be planned and delivered in a manner which is sensitive to their needs and expectations. In this regard, the

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258 M.Lewis op cit, 1988, p 87.
recommendations of national policies which have been developed for a number of special needs groups, clearly need to be acknowledged in the planning and operation of services.\textsuperscript{259}

It was as late as the 1990s when Commonwealth policy recognised the need for mental health policies for migrants. But, as Minas points out ‘the allocation of necessary educational and clinical resources, the establishment of specific clinical programs and the development of adequate professional knowledge and skills all lag considerably behind these policy developments’.\textsuperscript{260} In short, policies do not always translate into funds; they remain rhetorical and NESB communities gain little or nothing from them.

In 1991, the NSW Department of Health published its framework for NSW mental health services, 1991-2001, a document entitled \textit{Leading the Way}. This strategic plan admitted that NESB persons were under represented in the in-patient population and were poor users of the early detection or prevention services. It accepted that language barriers were the main obstacle to NESB communities gaining access to mental health services and receiving optimum treatment. It outlined the following model of services to overcome these difficulties:

- Mental health professionals must be prepared to utilise interpreter services more readily, more proficiently and more frequently.
- Professionals must gain greater sensitivity and awareness of cultural and mental health issues in migrant communities.
- Where possible, professionally trained staff with a second language should be recruited in areas of high proportions of non-English speaking residents.
- These mental health professionals should relate directly to the Area Director of Mental Health and be deployed when necessary to act as co-therapists or case planners, trainers of mental health and migrant health workers and to participate in case work reviews of NESB clients.\textsuperscript{261}

\textsuperscript{259} National Mental Health Policy, 1992, p 3.


\textsuperscript{261} \textit{Leading the Way}, NSW Health Department State Health Publications, 1993, pp 32-33.
The above are excellent goals and strategies and after a lapse of over a decade, remain as such. In the Illawarra where there is a high proportion of NESB residents, these goals have not been a priority as shown elsewhere in this thesis. The health care interpreter service is inadequate to be utilised ‘more readily, more proficiently and more frequently’. GP education in mental health issues has had a very late start and has not been well received. There is still a significant shortage of bilingual mental health professionals. And, for professionals to ‘gain greater sensitivity and awareness of cultural and mental health issues in migrant communities’ there is a need for more research in the subject.

The World Health Organisation (WHO) research has found that the indirect economic costs attributable to mental illness outweigh the direct treatment costs by two to six times in developed countries. In short, the costs of not treating mental disorders outweigh the costs of treating them. Apart from economic costs are extensive social costs incurred by family members of the mentally ill who often have to bear the emotional burden of caring for them. Further social costs are the deteriorating quality of life for carers, social exclusion and stigmatization of both carers and disabled persons and loss of opportunities for self-improvement. Migrants, refugees and displaced persons, women and persons living in abject poverty were identified among those most vulnerable to mental illness.262

This WHO Report also points out that less than 1% of total health budgets is spent on mental health by 16% of developed countries. As a result only a minority of people in need receive care and treatment for mental disorders. It calls for ‘equity and fairness in the distribution of resources within the mental health sector’. In many countries the above mentioned vulnerable groups are neglected.263 Perhaps, the Australian government should pay heed to this.

Australia, as a whole, has been slow to adopt policies favourable to its mentally ill population. In 1991, the NSW Health Department introduced the CLIPP program (Consultation and Liaison in Primary-care Psychiatry), based on the British CPA

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The development of mental health policies for migrants has been even slower. This indifferent attitude to migrant health could be interpreted more as a reaction to everything ‘different’ or ‘alien’ rather than a pure resentment of outsiders. The Australian medical profession is testimony to this. While other developed countries have adopted alternative therapies and therapists as part of their health scheme, most Australian doctors and psychiatrists are wary of such practices. Puckett, citing the World Health Organisation Chronicle, writes ‘...the verdict on traditional healing has been quite favourable and the World Health Organisation has established a traditional medicine section, which in particular is researching the chemical effects of herbs that are yet unknown in contemporary pharmacopoeias.’

Until the Australian mental health system acknowledges the fact that there are other explanations of mental illness besides the widely accepted Western ones which are rooted in biology and psychosocial maladjustment, services for culturally different persons will not make headway. In 1983, the NSW government adopted a policy of mainstreaming of services to ensure that all individuals obtained equal access to services regardless of ethnicity or religion. In the field of mental health this has not achieved the required results. Almost two decades later NESB persons continue to be poor users of mental health services and are over represented in crisis situations. The emphasis is on ‘culturally sensitive and appropriate services’ but service providers themselves are often confused as to what this means. There is a need for more government funded research into ethnic communities in order to help service providers understand their work. Also, when Australian mental health professionals learn to work side by side with traditional healers and incorporate more bilingual professionals into the system, it may provide some meaning to the phrase.

263 Ibid, p 16.
Chapter 4

Mental Health and Migrants – Australia, 1961 - 1972

When I collapsed at work and briefly lost consciousness, I was admitted to Callan Park hospital. I was treated very badly there by the nurses because I wanted to know what medication they were giving me. I only asked because I was allergic to many drugs including aspirin. I was forcibly given an injection, made submissive and sent to bed. In the course of the night, I had to seek the help of the night nurse in order to find a toilet. She was annoyed at being disturbed and with the help of a male nurse, physically restrained me, dragged me to a cubicle which contained only a bare mattress on the floor, pinned me down on it, gave me another injection and locked me in for the night. After a while, I woke up feeling extremely thirsty. I called out but nobody answered. I banged hard on the door. The male nurse looked in, pushed me back onto the mattress and locked the door.

I spent four unhappy weeks at Callan Park. I was given 48 tablets daily in addition to Largactil injections. After the first day I never protested because I would have got the belt. Those nurses were sadists. They treated me like an animal.

Anica

This chapter examines Australian Commonwealth governments’ policies on mental health and the relationship with state governments, particularly with that of NSW. The Commonwealth government’s policies on mental health were largely influenced by financial considerations. Costs were a major factor in shaping policy. Milton Lewis, the prominent historian of Australian medical practice and policy, has argued that historically the Commonwealth government had no direct responsibility for the provision of psychiatric care except in its own territories. Mental health was the responsibility of the States with limited financial assistance from, often parsimonious, Commonwealth governments. The emphasis by Canberra was on capital expenditure. For example, up to 1964 Commonwealth aid was limited to £10 million, for all the states collectively, and this was in the form of a tied grant for capital expenditure only,

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266 Lewis op cit, p 77.
which in turn was to be divided on a per capita basis. The government believed that provision of increased accommodation through government assistance would mean ‘....a significant contribution by the Commonwealth government towards the improvement in the treatment and care of mentally ill people in Australia...’.

Not surprisingly, throughout the 1960s there was a continuing battle for funds between State and Commonwealth governments. Each blamed the other for the plight of the mentally ill. NSW, dominated by Labor governments, took particular issue over the meagre allotment of funds. For the Commonwealth government, it was not merely a question of the availability of finance but a question of the judiciousness of funding this particular cause above other more important ones. The Commonwealth government had apportioned the health dollar in the way it considered fit and, in its eyes, mental health had received its due. Mental health services and policies for migrants was no concern of the Commonwealth government. The States complained of having to bear an unfair burden. They had no voice in the screening and selection of migrants, which was carried out by the Commonwealth government. Yet, the States had to assume responsibility for them when they became mentally ill. The Commonwealth made no contribution towards their upkeep which was costing State governments more than £500,000 a year.

The Commonwealth government justified its funding policies in the following manner. Under tax reimbursement arrangements, the Commonwealth government paid equal amounts of per capita payments to each State government in respect of migrants as of non-migrants. Thus, migrants ‘earned’ a part of the tax reimbursement for the States. They also contributed to State taxation. The States had enjoyed high levels of prosperity and development as a result of the stimulation given by immigration; hence, it was nothing but right that they should assume the responsibilities as well.

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267 Australian Archives, Series no A1851/1, item no 63/1629, States Grants (Mental Institutions) Act, 1955.
269 Australia Archives, Series No. A 446/T31, Item No. 75/78356.
270 Ibid.
In 1964, the Commonwealth government repealed the *State Grants (Mental Institutions) Act*, 1955, partly in response to growing criticism from the States and partly as the Liberal government’s electioneering tactics. The legislation which replaced the former Act, 1964 *State Grants (Mental Health Institutions) Act* provided that

The Commonwealth government would grant £1 for every £2 expended by the States on the building or equipping of mental health services, without an overall limit for the next three financial years.  

Once again, the emphasis was on capital expenditure.

In 1970, the Commonwealth government extended the Act of 1964 for a further three years. The States and the Federal opposition were vociferous in their criticism of this Act which they saw as extremely inadequate. It only provided for extra beds and buildings and completely ignored the need for training and employment of staff and the development of community facilities.  

Gillespie shows that the Liberal-Country Party Government was heavily influenced by the British Medical Association (BMA), as the Australian Medical Association was then called. The BMA was a powerful body which played a part in government policymaking. The government, anxious not to antagonise the BMA, opted for health policies that were beneficial mainly to middle-income groups, and thereby, to the medical profession. Thus, the government was assured of the ongoing support of the BMA. In many fields, responsibility for health care shifted from the Commonwealth Department of Health to the States or to private organisations. Commonwealth control over the direction of expenditure was increased. The government gave up much ground in order to please the BMA.

New South Wales mental health services had made very few changes since the nineteenth century when the only available option for the majority of mentally ill persons was custodial care. The early twentieth century brought with it new theories of

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271 *Australian Archives*, Series No. A 1851/1, Item No. 63/1629.  
272 Lewis *op cit*, pp 77-78.
psychotherapy, hypnosis and the Freudian practice of psychoanalysis. Psychiatrists in private practice carried out these disciplines but few Australian families could afford to pay for mental health care. In NSW, the trend towards community care for the mentally ill began in the 1960s. In 1961 there was a major scandal associated with one of its leading mental hospitals—Callan Park Psychiatric Hospital. The Royal Commission of Inquiry into Callan Park found not only this hospital but psychiatric services throughout NSW were in a deplorable condition. Lewis observes that NSW mental health services were very slow to change although there was a change in attitude of society towards the mentally ill. He writes that the system did not change significantly until after the 1961 Royal Commission inquiry into conditions at Callan Park Hospital.

In 1961 a Royal Commission, headed by Justice McClemens, was appointed to look into conditions at Callan Park Hospital. This was the third major inquiry into psychiatric services in New South Wales in the twentieth century - the previous ones having been in 1923 and 1948. Lewis says that the 1948 inquiry... was very much an exercise in public relations to allay public and parliamentary concern, and little real benefit resulted from its efforts. The 1961 Royal Commission originated as a response to a report published in 1960 by the then Superintendent of the Callan Park hospital, Dr. Bailey, in which he made serious allegations of corrupt practices at the hospital. Dr Bailey’s revealing report caused a stir in the community and led to demands by the media and hospital employees unions for a government inquiry. The McClemens Royal Commission was instituted by the Minister for Health to look into these allegations.

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274 Garton op cit, 1988, pp 65-68.
275 Crichton op cit, p 49.
276 Lewis op cit, p 75.
277 Royal Commission on Lunacy Law and Administration, 1923.
278 Public Service Board Inquiry into Conditions at Callan Park, 1948.
279 Ibid, p 83.
280 Ibid, p 75.
The Royal Commission inquired specifically into the state of affairs at Callan Park hospital but it also considered matters affecting psychiatric services as a whole. Justice McClemens recognised that Callan Park was in serious need of reform. He stated:

...reform is basically a problem of Medical, Community and Governmental attitudes; the defects of accommodation, medical and nursing care, food and clothing are but symptomatic of something more fundamental.\textsuperscript{281}

The principal findings of the Commission were that Callan Park Hospital was too big, too overcrowded, and short of staff and amenities. This meant poor patient care and treatment and a lack of rehabilitation programs. The Commission found that the most serious shortcoming was overcrowding which in turn led to most of the problems that existed at Callan Park. The Commission found that standards of treatment were not as high as they should be. It stated:

This is not a matter for individual blame; it stems from lack of prestige in the treatment of the mentally ill and from the difficulty in obtaining adequate personnel due to the shortage of applicants with the necessary qualifications.\textsuperscript{282}

Callan Park was built before the discovery of modern drugs, when the accepted procedure was custodial care for the mentally ill. Its accommodation and amenities had to be improved in accordance with the new concept of the mental hospital as being a therapeutic community whose primary function was to rehabilitate all those capable of being rehabilitated. The hospital could not function in isolation from the community. It needed to integrate its early treatment, out-patient and domiciliary care, and required sheltered workshops and more occupation to prevent institutionalisation and to encourage rehabilitation of patients. This required a greater involvement of public responsibility towards the re-employment of the mentally ill and a higher degree of public education regarding their re-socialisation.\textsuperscript{283}

\textsuperscript{281} Report of Mr Justice McClemens into matters affecting Callan Park Mental Hospital, \textit{NSW Parliamentary Papers}, 1961, vol 4, no 32.
\textsuperscript{282} Ibid.
\textsuperscript{283} Ibid, p 669.
The Commissioner was scathing in his criticism of both government policy and public indifference towards the mentally ill. His closing remarks were a comment on contemporary society. He stated:

This community requires a radically new approach to the employment of ex-mental patients. This is a matter of justice and of the rights of human beings. This community denies to mental hospitals the marks of respectability it gives to other hospitals. Mental nursing lacks the prestige of other branches of nursing, though it may involve tasks more onerous, including both the physically and the mentally ill. 284

Among the Commission’s principal recommendations were:

1. The establishment of regional units or hostels which could provide care for suitable patients. These units would bring patients closer to their homes and friends.
2. Renovation of the accommodation available at Callan Park to be brought up to standard for a reduced patient population. A policy should be rigidly enforced to keep the patient population at least 25 percent less than it is at present.
3. An active treatment program should be carried out so that no person capable of being trained to live outside Callan Park remains there.
4. Provision of additional money to meet these expenses as well as for mental health research.
5. Callan Park should be a smaller and different type of hospital geared to therapy and not to custody. 285

Giving evidence before the Royal Commission, the New South Wales Minister for Health said that he realised there was a great deal of work to be done to overcome overcrowding. But his ability to improve conditions at Callan Park was limited due to restrictions of funds. He had no access to finance; this was strictly controlled by the

Treasury. Hence, it was not possible for him to plan future projects. If he had access to available money it could be more economically spent. He had never been consulted about priorities. As a result he could never undertake an effective program to update any hospital. 286

The Health Minister’s evidence lacks credibility. As an important member of the Cabinet, he had a right to contribute to decisions on the budget. The Treasury was guided by government ministers and budget decisions were the collective responsibility of the entire Cabinet. As such, the minister was not entirely free of blame for conditions at the Callan Park Hospital. It was more a case of his ‘passing the buck’.

The Royal Commission report revealed every unsavoury aspect of Callan Park hospital and in so doing passed judgement on the state of mental health care as a whole, as it then existed in New South Wales. The Commissioner painstakingly detailed the numerous problems related to unsatisfactory diet, clothing and accommodation for patients. He emphasised that these shortcomings should not be seen in isolation but against a background of overcrowding. He urged that the community, government and professionals should work together if the problems of the mentally ill were to be solved. He urged the provision of additional money and deplored the community’s indifference to the mentally ill. Unless the community was better educated and informed regarding the plight of the mentally ill, progress would be slow. 287

This report was a turning point in the history of mental health care in New South Wales. In the years that followed there was a reorganisation of mental health services in NSW. A Division of Establishments was formed within the Department of Health. The new division was characterised by its professionalism. By the end of the sixties the central administration contained a number of capable members of the medical profession. One of the first tasks of this division was to upgrade all the psychiatric hospitals in the State. By the end of the decade not only Callan Park but all the State mental hospitals had undergone important changes. There was a reduction in ward sizes, renovation of wards, completion of new wards and improvements in dress and diet. Overall hospital

286 Ibid, p 678.
sizes were reduced, staff numbers, especially professionals, increased, and training programs vastly improved.  

These changes increased the morale of hospital staff and provided incentive for work efficiency. This was reflected in the decrease of in-patient numbers. For example, at one of the State’s largest psychiatric centres in Paramatta, the number of staff increased from 366 in 1961 to 665 in 1969. Patient numbers fell from 1500 in 1961 to approximately 1000 in 1969. During this period, the average length of stay of a patient changed from nine months to three weeks. By 1979, patient numbers decreased to approximately 700.  

The general upgrading of psychiatric hospitals was of great significance and served to improve the mental health services of NSW which had hitherto been an area of sad neglect. Equally important during this period was the availability of psychotropic drugs - tranquilisers and later, antidepressants, meant that psychiatric disorders could be controlled to some extent, giving patients a better quality of life. This also meant that patients could be better cared for in the community.  

Another major change which occurred during this period was the development of the ‘therapeutic community’ approach in psychiatric care. The rigid discipline traditionally maintained in custodial care was replaced by one less restrictive and there was more communication between patients and staff. Psychiatrists and other professional carers held regular group meetings with patients involving them in determining their treatment schedules. Patients benefited greatly from such interactions. The relaxation of the former hierarchical structure was an aid to recovery.  

As important as the upgrading of mental hospitals in the sixties was the introduction of a plan for community psychiatric services. This was a departure from the traditional psychiatric services. By 1964, services were regionalised. This meant that each

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288 G. Edwards “Mental Health in Chaos?” in The Mental Health Status of the Nation, (Address to the Australian National Association for Mental Health), Sydney, 1988, p 7.
289 Edwards op cit, pp 7-8.
291 Ibid.
psychiatric hospital had responsibility for providing a psychiatric service to a geographically defined region. The second stage was sub-regionalisation which involved the division of hospitals into several professional units to service a specific part of the region. By 1968 outpatient clinics were established in centres serviced from a particular hospital. The next phase was the creation of community mental health centres which would help to maintain mentally ill individuals in the community. Stage four involved the establishment of inpatient beds at regional general hospitals and stage five was the specialisation of services within the psychiatric hospital.\textsuperscript{292}

This five point plan was developed by Bill Barclay, then Director of State psychiatric services. The plan was designed to give expression to the various principles of community psychiatry and provide a rational administrative framework in which they could develop in New South Wales. This plan was expected to improve the delivery of mental health services through the provision of continuity of patient care at different stages of a patient’s illness. It would also make treatment more readily accessible to patients and their relatives and render the services community based and community oriented. It was a plan relevant to both the hospital and community development of psychiatry. thus, by the early 1970s, the Commonwealth government involved itself in community mental health\textsuperscript{293}

It is notable that there was no provision made for, or even a mention of, the mental health needs of the migrant community. Yet, NSW had a large number of Australia’s post-World War Two migrants. After 1966 Sydney began to attract more migrants than any other capital city due to its post-war economic and manufacturing boom. Migrant workers clustered around specific industries in NSW in locations such as Wollongong and Newcastle.\textsuperscript{294} Most of these migrants were displaced persons from the post-war refugee camps of Europe. Some of them suffered mental disorders due to their traumatic wartime experiences. Many immigrants were from Yugoslavia, Turkey, Lebanon and other non-English speaking countries. Research carried out both in Australia and overseas has established a link between mental illness and the migration

\textsuperscript{292} Lewis, \textit{op cit}, p 85.
\textsuperscript{293} Edwards, \textit{op cit}, p 8.
\textsuperscript{294} Jupp \textit{opcit}, 1966, pp 64-65.
experience. It is significant that as late as the 1970s both Commonwealth and State governments had failed to recognise the special needs of this group of people.

Perhaps this complacency on the part of the governments was based on the report by a committee of the Commonwealth Immigration Advisory Council (CIAC) which was released in 1961. This report was commissioned by the Commonwealth government to assess the incidence of mental illness among migrants who had arrived in Australia since 1945. This survey which was undertaken by the Department of Immigration, served a dual purpose; that of determining the adequacy of current selection techniques and of determining the financial impact on the States of the post-war immigration program. Some States claimed that migration was adding more to their expenditure than to their revenue, hence, it was important to know whether migrants made up a bigger or smaller percentage of the population of the mental hospitals, than their percentage in the State populations.

The terms of reference for the Commonwealth Immigration Advisory Council’s committee of investigation included the following:

The relative incidence of mental illness among migrants and the Australian born;

The influence on admission rates of such factors as age, sex and period in Australia prior to illness;

Any patterns emerging from investigations, in relation to different years of arrival in Australia.

The committee’s report was based on a survey of first admissions to State mental institutions. It defined a migrant as a person who has resided in Australia for less than five years.

This survey was the first Australia-wide study of the incidence of mental illness among migrants ever to have been undertaken. Its principal findings included the following:

1. Best authoritative opinion places the first annual admission rate in a typical

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295 Vide Literature Review, this thesis.
296 Australian Archives, Series no A 1658/1, Item no556/1/5.
Western community at 0.7 per 1000. The migrant average annual first admission rate for arrivals between 1948 and 1952, including displaced persons was also 0.7 per 1000. If displaced persons are excluded, the migrant figure would be 0.46 per 1000.

2. There is a connection between the higher rates found among migrants who arrived during 1949 and 1950 and the very large intake of displaced persons in those years.

3. Displaced persons with their unhappy background of war experience, have a tendency to suffer from mental illness.

4. Persons aged from 20 to 49 years had the highest rates.

5. Among displaced persons, females had double the rate of all other female migrants.

6. Australia’s procedures for the screening of migrants generally succeed in excluding mentally ill and potentially mentally ill applicants for immigration. The findings of the survey vindicate these procedures.\textsuperscript{298}

The committee’s definition of an immigrant as a person who had been in the country for not more than five years, was questionable. It was based on the assumption that mental illness occurring five years or more after arrival could not indicate any failure in the selection procedure. The Australian Medical Association was altogether sceptical about the effectiveness of the screening procedures. They maintained that while it might be possible to detect the chronically psychotic individuals who applied, it would be difficult, even impossible, to detect episodic illnesses such as depression and schizophrenia. They considered the expense and trouble incurred in such an unreliable procedure was not warranted. The funds could be better spent on further development of mental health services and ‘management-in-depth’ for mentally ill migrants after immigration.\textsuperscript{299}

The report’s definition of a migrant was criticised by Stoller and Krupinski. They observed the following methodological shortcomings in the survey:

1. Since a significant number of migrant breakdowns occur after five years of

\textsuperscript{298} Ibid, Chap 1, paragraph 4.
residence, it is more meaningful to regard a migrant as a person born outside of Australia, rather than limit the study to a person resident for up to 5 years;

2. It is misleading to group all first admissions together, without considering diagnostic groupings;

3. It is unscientific to compare the figure obtained with a “theoretical incidence for a Western community.”

In a subsequent study of mentally ill migrants in Victoria, Krupinski and Stoller further substantiated the second observation stated above. In 1962 they analysed first admissions to all psychiatric units in Victoria in terms of psychiatric diagnoses. They found a high first-admission rate for senile brain disorders and mental retardation among Australian born persons. This emphasises the unreliability of findings obtained by grouping all first admissions together without considering diagnostic categories, as was done in the Immigration Advisory Council’s survey.

The CIAC report was not a useful implement for shaping government health policy. It was based to a great extent on flawed statistics obtained from the States by the Department of Immigration with regard to immigrants who arrived in Australia between 1948 and 1952. Statistics supplied by the States were inappropriate and inconsistent. Their data bore little or no relationship to the migrant populations of the States; there were large and unexplained variations between successive years. Each State used different criteria in classifying migrants. The following comment by the Secretary of the Department of Immigration illustrates the unsatisfactory nature of the available statistics:

Varying figures and percentages have been quoted both by private individuals and representatives of the State governments but, on checking back on them, many glaring inconsistencies were discovered. Attempts were then made to find out the correct figures from official sources and, again, there were so


many inconsistencies that it was not considered wise to rely on them.\textsuperscript{302}

Despite the weakness and unreliability of these statistics, the Commonwealth Immigration Advisory Council committee used this data as a basis for its report. \textsuperscript{303}

The committee’s report was based on hospital admission statistics of mentally ill migrants. This fact itself makes it an inadequate measure of the seriousness of the problem in the migrant community. Both overseas \textsuperscript{304} and Australian research \textsuperscript{305} have shown that some immigrant groups resist hospital admission due to language difficulties or cultural barriers. Furthermore, research has found that some individuals enjoy a prolonged symptom-free period after their arrival.\textsuperscript{306} Krupinski et.al. found that the incidence of schizophrenia in female migrants reached a peak in the group resident for 7 to 15 years and in some male migrants it occurred in the group resident for 7 to 14 years.\textsuperscript{307}

Thus, as a statistical investigation of mental illness in migrants, this committee’s survey was not as successful as it appeared to be. Nevertheless, it provided sufficient satisfaction to the government that its screening procedures were fool-proof. Above all, it furnished evidence that mentally ill migrants did not need special attention since they were no more at risk than the Australian population.

Till the end of the sixties there was general disregard for migrants’ problems. These were alleged to originate within the particular migrants themselves. Migrants’ health problems belonged to this category.\textsuperscript{308} Government apathy was largely responsible for the woeful neglect of migrant health. The government had no migrant health policies and showed no interest in researching migrants’ health problems. The medical

\begin{thebibliography}{99}
\bibitem{302} Australian Archives, Series no A 1658/1, Item no 556/1/5, Letter from Secretary, Department of Health to Commonwealth Director General of Health, 4 June 1958.
\bibitem{303} Australian Archives, Series no A 446 T 31, Item no 75/78356. For details of these surveys, see Appendices A-F.
\bibitem{306} E.Kunz Displaced Persons, 1988, pp 228-229.
\end{thebibliography}
profession was equally to blame. The AMA did not regard migrant health as its concern. The most significant study of migrants’ mental health carried out during the early seventies was by the Australian Council of Social Services (ACOSS). This study was based on information provided by social workers and other non-medical and welfare workers who had first experience of the migrant health situation.  

The situation began to change gradually in the early seventies when ethnic minorities themselves took some control and began to voice their needs. By the late sixties some migrant communities had established their own welfare organisations whose spokespersons were sufficiently confident to express their concerns to government. 

The establishment in 1974 of the Federal Office of Community Relations and the setting up of Ethnic Affairs Commissions led the way to improvements in migrant welfare. Garrett and Lin write:

Ethnic affairs had begun to develop as a more legitimate and substantial policy domain by the early 1970s. There was a growing recognition of the potential influence of the ethnic vote...Furthermore, concern over the large number of immigrants who were leaving Australia again....In the 1970s, ethnic group identity was recognised to be important in the development of policy, programs and services.

308 Bates and Linder-Pelz op cit, p 36.
Chapter 5

Multiculturalism - 1972-1990

5.1 Multiculturalism, Health Services and Migrants

_In 1982 I was admitted to the Wollongong Hospital psychiatric ward. There were no interpreters. I could not understand anything the nurses said. I simply obeyed them. Sometimes my daughter would act as interpreter. Since then, I have been admitted four times to the Shellharbour hospital psychiatric ward. There I was given ECT five times. I was not told anything about it and I did not know what to expect. I was only told that i would have a temporary impairment of memory. But I did not fully recover from it - my memory has been bad from that time onwards. It was altogether a frightening experience._

Desanka

_When I first became sick in 1983, I went to a GP who gave me some tablets. I don’t know if the doctor understood about my illness as there was no interpreter. His medication did not help me. I struggled with my illness for a very long time because I did not know where to go for help. In the late 1980s, I heard about the Macedonian mental health worker and contacted her. She got me referred to a psychiatrist and arranged for me to have an interpreter. I have never come across any literature about mental illness or mental health services in my language._

Dana

_In 1982 I had a gall bladder operation at Shellharbour private hospital. There was no interpreter even for the specialist. My daughter acted as interpreter. At that time I did not even know that interpreters were supposed to be available. I did not know what the doctor said about me. I was very frightened as I knew of a lady who had died after this operation. The nurse only told me that the doctor thinks that I should remain in hospital at least for another two weeks. I started getting very depressed. I suffered from_
depression and anxiety for many years afterwards until a Chinese GP sent me to a psychiatrist in 1991. I am much better now with his medication.

Elica

In 1992 I was admitted to the Wollongong hospital psychiatric ward. I was there for two weeks. There were no interpreters and I could not understand much of what was going on. In 1997, when my illness had become worse, I was admitted to the Shellharbour hospital psychiatric ward where I was treated for schizophrenia and sent home. I don’t think the doctors explained anything to me. Even if they did, I did not know enough English to understand. It is the Macedonian mental health worker who explained everything to me.

Dostana

In 1975 I was admitted to the Wollongong hospital psychiatric ward after I attempted suicide. I was given ECT nearly every day for two weeks. There were no interpreters. A Polish nurse acted as interpreter on some occasions. The doctors who gave me ECT could explain nothing to me. I have never seen literature about mental illness or mental health services in my language. The GPs I saw never enlisted the help of interpreters.

Nada

The following section describes how the Commonwealth and NSW state governments changed the way health care providers responded to patients from NESB who presented at public health facilities for treatment. This section has several objectives. First, it provides a concise history of how and why governments changed the way their health agencies responded to health events of NESB patients. Second, it provides a context for the specific events that dominate the case studies because knowledge of these changes underpins and assists the explanations and arguments which attend the case studies. Finally, it is interesting to note that despite the significant changes detailed below, NESB patients with mental health problems continued to attract little attention.
By 1969 the Federal government’s policy of assimilation for immigrants, especially those from non-English speaking backgrounds, was beginning to unravel. Equal treatment meted out to immigrants from widely different backgrounds had not produced satisfactory results. Whatever attracted immigrants to Australia’s shores, not all new arrivals liked what they saw and many decided to leave rather than make a new life in Australia. For the period 1959 to 1965 total settler loss was over 16 percent of settler arrivals and this figure was rising. By the year 1971-72 settler departures rose to 24.3 percent over settler intake. In other words, almost one quarter of all immigrants decided to leave Australia. This was a significant blow to the nation’s post-war migration policy. Commonwealth governments had approached their post-war migration programs and the relocation of thousands of displaced persons from war-torn Europe with such acritical and unbounded optimism that they had never considered the very opposite of an immigration program. Put briefly, migrants leaving their new home for another was not an eventuality which had occurred to either immigration officials or politicians. Yet, in the late 1950s and throughout the 1960s, settler departures was a defining feature in the nation’s immigration program; settler departures outnumbered settler arrivals. The government soon realised that if migrants were to be recruited and retained, policy changes were necessary.

In the 1970s official policy changed from assimilation to multiculturalism. The outline for change is contained in two important documents - AI Grassby’s statement of 1973 in which he presents his concept of a multicultural society and the Galbally Report of 1978, which reviews post-arrival programs and services for migrants. Also of particular importance for New South Wales is the report of the Ethnic Affairs Commission in 1978, Participation, which investigated ethnic issues, and the Henderson Report of Inquiry into Poverty, 1975. These reports and documents led the way to improved services for migrants and influenced change in the area of mental health services as well. It was also the beginning of greater participation of ethnic groups in the Australian political scene.

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Each of these reports challenged the myth of Australia having an egalitarian society. For example, the Henderson report found significant evidence of financial hardship, few life chances and social circumstances which did not sit easily with the oft repeated phrase of the ‘Lucky Country’. Henderson’s evidence however, did not cover all Australians. It paid scant attention to the social, financial and economic aspects of migrants whose first language was not English.

It would not be long however, until other government reports - one by a Federal government, the other by a State government - also highlighted the social life of migrants. The Federal government’s Galbally Report showed that while post-war migration had clearly benefited the nation’s economy, this contribution had come at a price. Similarly, the EAC’s research showed that like the Henderson Report, not all immigrants had benefited from the Long Boom of Australia’s post-war economy. Ironically, some of the significant contributors - migrant workers - were not at the receiving end of the benefits of their own work.

Change in government policy arose also from change in public consciousness. The end of the sixties brought a new consciousness of the migrant presence. Australians were no longer seeing migrants as a threat and the climate was changing to one of tolerance, if not acceptance. Those responsible for changing Australian attitudes came mainly from established organisations - social workers, clergy and academics - who portrayed migrants as a disadvantaged group rather than a threat to the existing social order.314 Many people began to realise that certain groups were disadvantaged not through their own fault but as a result of the structures of power in society itself. Thus, a greater proportion of the Australian population began to develop a new perspective.315

Increasing social contact with migrants and improved standards of education also influenced Australian attitudes towards migrants. There were some members of society who, on serious thought, began to doubt the efficacy of the ideology of assimilation. They realised that migrants had cultural differences in values, beliefs, customs and habits which could not be disregarded. Charitable groups drew attention to migrant

problems. Together with the increasing awareness of the importance of migrants to Australia came a consciousness that they deserved a better deal. The Liberal-Country Party Government could no longer ignore the fact that it had a problem to deal with and a change of policy was called for.

The earliest evidence of migrant disadvantage came from the education system. Schools with high migrant enrolments reported low academic performance and persistent language difficulties of NESB children. Alongside this were complaints from staff of other organisations, hospitals and government offices that NESB migrants were a hindrance to the efficient performance of their jobs. Conditions such as these led migrants themselves to seek changes at government level. 316

Migrants’ experiences of discrimination and their often poor material circumstances gave many migrants negative feelings about Australian society. A great deal of migrant dissatisfaction came from unsatisfactory dealings between trade unions and migrant workers. NESB migrant workers were the most disadvantaged groups within Australian unions. There was a lack of awareness among union officials about migrants’ needs. Union officials considered the provision of English classes and child care centres as outside their ambit. The tendency was to treat all workers alike in an assimilationist policy. Lack of awareness and lack of power made NESB workers the most exploited group. Many migrant workers who felt discriminated against were unaware of the existence of Anti-Discrimination Boards where they could take their complaints. 317 Bertone and Griffin confirm the above and add that a majority of union officials observed racism and ethnic tensions in the workplace and some times, within the union office. 318

Changing public consciousness and claims by the ethnic groups themselves forced the government to review its policy of assimilation and seek a new approach to the problem of migrant settlement. By the end of the sixties some migrants had become civic leaders.

See also, L. Nicolaou Australian Unions and Immigrant Workers, 1991.
and a number of ethnic organisations had been formed. Not only were they forming their own clubs and leagues but increasingly joining trade unions, churches and other social institutions. Ethnic communities were becoming increasingly vocal and demanding not only the right to maintain their cultural traditions but resources to overcome their educational and other disadvantages. They were slowly but surely making their presence felt.

Adding to this climate of public dissatisfaction was the problem of migrant departure. Large numbers of departing migrants prompted Commonwealth governments to try to understand this process. The Commonwealth government commissioned reports in an attempt to find answers and in turn to develop policies in order to stem the flow of departing migrants. Two reports in particular provided the Commonwealth government with detailed answers. These reports also had unintended consequences for the delivery of health care services to the nation’s immigrant populations. In 1968, at the request of the Federal Minister for Immigration, B.M. Snedden, the Immigration Planning Council produced report on Australia’s immigration program. Three years later, in 1971, following a similar request, the Immigration Advisory Council carried out an inquiry into the departure of settlers.

The first report showed that settler departures had been steadily increasing since 1960. Recorded figures showed that settler loss had grown from 6,303 in 1959/60 to 20,438 in 1966/67. The Committee of Inquiry recommended that every effort be made to reduce population loss arising from unsatisfactory conditions in Australia and required a ‘re-examination of a number of government policies’, and ‘special measures implemented of an economic and social character to attract migrants and to hold them once they arrived in Australia’. In the economic field, the Committee recommended that:

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319 Ibid.
320 Vide Table 1, Rate of Departure, Australia’s Immigration Programme for the Period 1968 to 1973, Report to the Minister of State for Immigration by the Immigration Planning Council, 1968, p 24.
321 Ibid, p 80.
322 Ibid, pp 80-81.
Opportunities for skilled migrants to obtain additional training should be made more widely available in order that they may be recognised as tradesmen of Australian standards. Early action should be taken to give full recognition to equivalent overseas professional qualifications on a basis of uniformity in all States.....\textsuperscript{323}

The Committee recommended that social factors such as reception arrangements, housing and social service benefits, should be re-appraised and geared to the needs of migrants. There should be an increase in the availability of low rental or low deposit houses within the financial capacity of migrants. While the Committee did not make any specific recommendations regarding migrant health services, it expressed strong doubt whether the Australian social service system would prove a positive attraction to migrants.\textsuperscript{324} In September 1968 the Minister tabled this report in the House of Representatives for serious consideration, commending it to policy makers and administrators as a document which ‘opens up some new lines of thought’.\textsuperscript{325}

In 1971 the Federal Minister for Immigration requested an inquiry into the departure of settlers by the Immigration Advisory Council. This inquiry found, among others, the following reasons which prompted migrant departure:

- negative attitudes of the Australian community towards migrants; their inadequate understanding and reluctance to help;
- mental breakdown due to loneliness, employment and housing difficulties, language problems and inability to adjust to the Australian way of life;
- a health care system with inadequate provision for the special needs of migrants, and thereby, lack of faith in the Australian medical system;
- lack of special provision in the school system for migrant education.

The Committee found the risk of mental illness was highest in low income, NESB migrant groups.\textsuperscript{326}

\textsuperscript{323} Ibid, p 83.
\textsuperscript{324} Ibid, pp 83-85.
\textsuperscript{325} Ibid, Statement by the Minister for Immigration in the House of Representatives, September 1968, p 6.
This second report highlighted the provision of health services of both Commonwealth and State agencies as an important explanation as to why newly arrived immigrants were choosing to leave Australia. While Australia claimed a high standard of health and medical services, this report indicated that this commitment did not extend to the care for NESB patients. The Committee made the following recommendations with regard to migrant health care:

- Qualified interpreters and translators should be provided, particularly in hospitals.
- and in general medical practices;
- Students of medicine and allied health and welfare services should study the cultural backgrounds of migrants;
- Written literature should be available in principal foreign languages;
- More multi-lingual welfare officers were needed;
- More emphasis should be placed on counselling.\(^{327}\)

The report and its recommendations did not, however, bring significant changes to the delivery of health services to NESB patients. Bilingual health workers such as ethnic health workers and health care interpreters did not emerge from this report; translated material for patients did not emerge from this report; neither did the notion that people from different linguistic and cultural backgrounds require specialist service providers with similar skills. Moreover, the report made no special recommendations for the care of migrants with mental health problems. While this report was an important beginning, it would take a change of government in Canberra to bring widespread changes to the way an Anglo-Celtic health care system addressed the needs of NESB patients.

In 1972, Australia voted into office a Labor government after twenty three years of Liberal/Country Party rule. This event led to significant changes and innovations, most importantly, in immigration policy.\(^{328}\) The first conscious attempt to define Australia as a multicultural nation was made in 1973 by Al Grassby, Minister for Immigration in the Whitlam government. In a statement entitled *A Multicultural Society for the Future*, he outlined his concept of a plural society. Grassby believed that without such a

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\(^{327}\) Ibid, pp 13-14, pp 46-47.

multicultural society, NESB migrants would become “non-people”.329 He advocated equality for all Australians in every sphere of life, including education and employment; the recognition of the indispensable economic and cultural contribution made by migrants and providing them with the opportunity of participating in Australian politics. Grassby’s ideal was that migrants should participate in the decision making processes that affected their lives and be free to function in their own cultural spheres while being committed to the common good of the nation.330

Motivation for change came also from academics - social scientists such as Jean Martin, James Jupp and Jerzy Zubrzycki, - who identified the lack of equal opportunity in Australia as a key reason for migrant departures. By the mid-seventies both the Liberal and Labor parties supported the policy of multiculturalism. Whether this change of policy was due to a genuine change of heart or merely a ploy to court the migrant vote, is debatable. Castles et. al. see it from another angle. The economic downturn of the early 1970s led to economic and social segmentation linked to race and ethnicity, destroying the concept of the ‘Australian way of life’. Multiculturalism was a distraction deliberately manipulated in order to divert attention from the more pressing issues of inequality in a class-or-gender based society. Governments promoted the ideology of multiculturalism as a response to this new situation which had arisen. 331 Perhaps there was an element of both, in deciding government policy.

In 1972 the Labor Government committed itself to provide support services for migrants and to reducing inequality in Australian society. It funded telephone interpreter services and community development schemes; appointed multi-lingual staff members to community health centres and made ethnic representation on all bodies that served migrants a requirement. With the abandonment of the White Australia Policy in the seventies and the arrival of Indo-Chinese refugees, various migrant groups became more visible and more vocal. 332

329 J.Collins op cit, p 115.
332 Bates and Linder-Pelz, op cit, p 33.
The New South Wales Association of Mental Health was the body that publicised migrant health problems. In 1971 the NSW Department of Health commenced a program of health education for NESB migrants by employing twenty persons with the necessary language and cultural background to be trained as health educators. In 1972 baby health centres, appropriately staffed, were opened in Sydney suburbs with large migrant populations. By 1977, there were twenty seven trained health care interpreters to serve seventeen Sydney hospitals.333

By the mid-seventies the Australian governments, both Labor and Liberal, began to accept some responsibility for migrant disadvantage. These changes were partly due to the publishing of the Henderson Report. This inquiry which was held at both NSW state level and federally, found that many NESB migrants were disadvantaged in the mainstream health care system.334 Since then government policy has had to consider the migrant population. These changes have been reflected in many areas including health services for ethnic minorities. The attitude that problems of migrant health were located within migrants themselves changed and the practices of health care institutions, medical and other professionals came under scrutiny. But major changes were yet to come. These would follow the recommendations of the Galbally Report in 1978.

When Australia embraced an extensive immigration program after World War Two it not only gained cultural and racial diversity but inherited the inevitable problems that go hand in hand with the changed circumstances. The problems were far more deep seated than administrators or the general population realised. A society composed of multicultural groups will inevitably encounter friction and tensions or some other form of divisiveness. Apart from these difficulties, immigrant groups, especially NESB immigrants suffer setbacks in almost every field, the major handicaps being in the areas of health care and employment. In 1972 although the Labor Government made the first move towards a policy of multiculturalism it did little to bring about significant change in the lives of the immigrants.

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In 1975 the Liberal/Country Party Government came into office with a policy commitment to multiculturalism - a culturally diverse but socially cohesive society with equality of opportunity for all. The government was committed to develop a consistent set of policies and programs to help immigrants to settle successfully in Australia. In 1977 the Fraser government, in a first earnest attempt to institute the ideology of multiculturalism, commissioned the Galbally Report. In 1978 the Report of the Review of Post-Arrival Programs and Services for Migrants, known as the Galbally Report after its chairperson, Frank Galbally, was published. The Federal and State governments and ethnic community groups began their serious awareness of ethnic welfare issues with the publication of this report. 335

The Galbally report initiated change for migrants by highlighting facts which neither the Australian governments nor the nation had considered seriously ever before. It defined multiculturalism in a way which transcended the superficiality of the concept which had hitherto prevailed - the colourful differences of “ethnic” food, dress and dance. The Galbally Report emphasised the fact that in a true multicultural society:

...migrants have the right to maintain their cultural and racial identity and that in the best interests of our nation that they should be encouraged and assisted to do so if they wish. Provided that ethnic identity is not stressed at the expense of society at large, but is interwoven into the fabric of our nationhood by the process of multicultural interaction, then the community as a whole will benefit substantially and its democratic nature will be reinforced. 336

The Report stressed the important role the nation should take in accepting the ethnicity of migrants. It is only when people are identified with their cultural background and ethnic group that they take their place in the new society ‘with confidence and a sense of purpose’. It is in the interests of the nation that migrants should be helped to achieve their full potential as soon as possible. The attitude that migrants have everything to

gain must change to the understanding that all Australians will be enriched by the benefits arising from a multicultural society.\textsuperscript{337}

The Galbally Committee set out a three year timetable for the implementation of its 57 recommendations which were based on the following four principles:

1. Equality of opportunity and equal access to programs and services for all members of Australian society so that they may realise their full potential;
2. The right of all Australians to maintain their own culture without prejudice or disadvantage;
3. Migrants should have access to programs and services available to the whole community but at present, special services and programs are necessary to ensure equality of access and provision;
4. Programs and services should be designed and operated in full consultation with migrants in order to encourage self-help with a view to expediting self-reliance.\textsuperscript{338}

The Galbally Report also recommended the allocation of an additional fifty million dollars for expenditure on post-arrival programs and services over a three year period.\textsuperscript{339}

The Galbally Commission identified NESB migrants and refugees as the groups whose needs were most inadequately met by the government’s current programs and services. Other groups which were particularly disadvantaged were those isolated at home (especially women), elderly migrants, migrant women at work, migrants from smaller ethnic groups whose own support services were limited and the children of migrants. These groups were not effectively reached and sometimes not reached at all by current programs and services.\textsuperscript{340}

The Report devoted six paragraphs to health. The main conclusions were as follows:
1. Migrants have difficulty in understanding the complexity of the Australian medical and health services. They need special assistance to make use of services such as

\textsuperscript{337} Galbally Report, 1978.
\textsuperscript{338} Ibid, paragraph 1.7.
\textsuperscript{339} Ibid, p 14.
\textsuperscript{340} Ibid, paragraphs 1.8-1.11.
infant health care, domiciliary care and counselling.

2. Health administrators and professionals have not taken sufficient specific action to devise treatment and rehabilitation for migrants with problems of mental illness and alcoholism. The greatest need is for bilingual professionals and interpreters in medical services and hospitals; also, ethnic health workers trained to work in their own communities.

3. Members should be appointed from migrant groups so that they could help and encourage their communities to use available health care services.

4. While recommending the appointment of bilingual sub-professional health workers it is important that they be carefully selected and trained and be under the supervision of a relevant authority or professional body. 341

In May 1978 the Fraser Government announced its acceptance of the recommendations of the Galbally Report. These recommendations played an important role in the designing of Federal government health policies for migrants. The Galbally Committee recommended that the Federal government, in the first year, should contribute 100 percent of the funds needed to provide ethnic health workers, thereafter sharing costs with the States. 342 Under the new arrangement the Federal Government accepted greater responsibility for resourcing a variety of programs and services for migrants which were previously provided by welfare organisations and private individuals. Federal grants to the States enabled the States to increase funding for ethnic community organisations and direct more expenditure towards services urgently needed in areas such as education and translating and interpreting services for NESB migrants. Despite all these developments migrants were still disadvantaged in health, English language teaching and the labour market.

Another important development which followed as a result of the Galbally recommendations was the creation of the Australian Institute of Multicultural Affairs (AIMA), which was duly established in 1979 by the Fraser Government. Four years later the AIMA found that the government had successfully implemented the Galbally proposals with expenditure matching the provisions of the Report. By 1981 ethnic

341 Ibid, paragraphs 7.47-7.52.
342 Ibid, p 93.
agencies had received grants, migrant resource centres had been set up and the ethnic media was improved with the establishment of the Special Broadcasting Service. Alongside these developments in federal government policies there emerged those of state governments designed in the interest of migrants. The NSW Labor Government established the first state Ethnic Affairs Commission (EAC) in 1977. This was followed by the South Australian EAC, set up by a Liberal Government in 1979. The Victorian EAC was established in 1983 by the then Labor Government. The Burke Labor Government set up the first EAC in Western Australia and Queensland established a Department of Ethnic Affairs in 1982. \(^{343}\)

In 1978 another report was published in New South Wales in the interests of migrant communities. By the Ethnic Affairs Commission Act of 1976 the Commission was required to furnish to the then Premier of NSW, Neville Wran, a report of its investigations of ethnic affairs. This report, Participation, which was published in June 1978 looks at, among other things, the fundamental right of minority groups such as NESB migrants ‘to achieve total participation in the Australian and NSW political and social systems’. This report attempts to implement the philosophy of equity of access and ‘aims at rectifying imbalances and removing underprivilege, not at creating special advantages’. The report maintains that ethnic affairs initiatives cost very little relative to levels of government spending and serve not only the ethnic community but the community as a whole in that it helps to avoid social conflict. \(^{344}\)

In reviewing health care services, the Commission examined the accessibility of such services to migrants taking into account migrants’ own perception of their health service requirements and their ability to communicate these requirements to service providers. A research report sponsored by the Commission, on the provision of health care services to migrants revealed the complex issues involved. The Commission found many problem areas; among them, the following:

1. Health care services need to be more co-ordinated with welfare and counselling services and with interpreters and other multi-lingual professionals in order to make the most efficient use of available resources;

\(^{343}\) J.Collins \textit{op cit}, pp 118-120.

2. Employment and training of interpreters and of immigrant health educators need to be improved and extended to other areas of NSW besides metropolitan Sydney; the Federal government should provide for such expenses;

3. The whole community, including professional organisations, training institutions, individual health professionals, social workers, the unions and the media must be made aware of the issues involved in the access of ethnic communities to health services; it is not a problem to be solved by the Health Commission alone;

4. Ethnic communities themselves must make a general effort to raise the awareness of migrant health issues and take an active role in educating new migrants about health care measures.  

The Commission did not particularly investigate issues involving the mental health of migrants but noted that it was an area of major concern especially for certain groups which they identified as at greater risk. These groups, according to the Commission, included refugees, middle aged women, men without families, the elderly, adolescent boys and girls belonging to families whose culture differs significantly from that of Australian society and those migrants who were under-employed because their qualifications were not recognised. The Commission could see no quick solutions to these problems which were linked to social attitudes. It recommended better access to preventive services, better communication with psychiatrists and more government sponsorship for research in the field of migrant mental health which they considered an area of priority for the future. The Commission expressed concern about problems which arise due to “lack of psychiatrists with direct knowledge of specific immigrant cultures and languages” and suggested that some health care professionals with appropriate registration requirements be allowed to emigrate to Australia. 

The publishing of this Report and the Galbally Report, in 1978, influenced the development of health policies and services for migrants in all States and Territories except in Tasmania and Queensland. Tasmania’s health authorities did not believe that language and cultural differences have a bearing on the delivery or receipt of health

345 Ibid, pp 237-239.
services. The commitment was to integration which made the modification of services unnecessary. Likewise, Queensland opted for the development of “mainstream” health services which ignore the special needs of NESB consumers. Queensland health authorities did not see the recruitment of special migrant health professionals such as interpreters, ethnic health workers, health education officers and policy advisors as a priority. 347 Such was the situation in these States even in the late 1980s.

In 1983-84, guidelines issued by the NSW Minister for health and the NSW Health Department stated:

Improvement in the quality of health available to ethnic groups within our community is a matter of great concern to this Government.348

Also,

The aim is to provide acceptable as well as clinically appropriate services for people of different linguistic and cultural backgrounds.349

These sentiments were echoed by Neal Blewett, Federal Minister for Community Services and Health when he said:

The fulfillment of the health needs of people of migrant descent is a vital step.....We now accept that it should not be up to ethnic health consumers to struggle to overcome often awesome barriers to their access to mainstream services....Now we expect that the system itself must change if we are to guarantee equality of access to all Australians.350

Thus, both Commonwealth and State governments were beginning to accept the reality that there were serious inequalities in the established health care services and that discrepancies did exist in the health status of different groups within the community. Governments were made aware of these problems by the constant complaints brought forward by ethnic group leaders and health workers of ethnic background. Bates and Linder-Pelz write:

...ethnic groups have now become an important political constituency. They

347 G.Mitchell, op cit, p 43.
have forced governments to adapt the delivery of services to the wishes of their clientele, rather than expecting the clients to accept without complaint what was offered.\footnote{Bates and Linder-Pelz op cit, p 37.}

In NSW, Victoria, ACT, South Australia and Western Australia migrant health policies and services are based on:

- the recognised equality of access to and use of services, regardless of languageskill, country of birth or any other aspect of disadvantage ascribed to NESB consumers;
- the acceptance that the responsibility of a response appropriate to the consumer rested with the public health service itself.\footnote{Ibid, p 46.}

This recognises the fact that health services in Australia have been developed by English speaking authorities for English speaking consumers and as such, they are not relevant to many consumers of migrant background. It is an acceptance of the fact that the definition of health and illness can vary according to the consumer’s cultural beliefs and it would be advantageous to include the consumer in the determination of policies and services. In short, health procedures should not be isolated from the language, culture and definitions of consumer groups; the ability to speak English should not be a pre-requisite for receiving satisfactory health services. To be successful, policies need to change with the changing population patterns within the country.

In 1987 the Labor Government established the Department of Community Services and Health (DCSH) which enabled health and human services to be administered at Commonwealth level. An Ethnic Health Unit based in Canberra, was formed, which employed two full-time staff, an ethnic health liaison officer and an ethnic health officer. This Unit’s main functions were:

1. To provide a focus for health policy which addresses the needs of ethnic communities;
2. To provide advice and support to other Departmental areas to ensure that programs and services are delivered to migrants in a culturally and linguistically appropriate manner;
3. To ensure that the above goals are achieved in accordance with the government's access and equity guidelines.\footnote{Ibid, p 41.}

By the eighties, one Australian voter in every seven was a migrant.\footnote{V.Callan \textit{Australian Minority Groups}, 1986, p 79.} It is arguable that change in government policies towards migrants did not take place entirely due to genuine concern about the status of the migrant population. Nor was it due to the intensity with which ethnic groups lobbied for their rights; although they may have played a minor role in changing government thinking. It was imperative for parties to gain the ethnic vote.\footnote{P.Garrett and V.Lin “Ethnic Health Policy and Service Development” in J.Reid and P.Trompf (eds) \textit{The Health of Immigrant Australia}, 1990, p 356.} Migrant groups tended to concentrate in certain geographical regions such as Cabramatta and Fairfield in NSW and politicians targeted these as areas of special interest in order to secure the ethnic vote.

In the eighties both leading political parties had ethnic branches as part of the formal party structure. The support of these ethnic groups was essential in a candidate’s pre-selection at both state and federal levels. By the eighties there were overseas-born members of parliament at both state and federal levels. Callan states that these seats have been gained ‘....either because of the power individual migrants have within political parties or as political parties realise several advantages to them in having members of migrant backgrounds’.\footnote{Callan, \textit{op cit}, p 81.} With the increased representation of ethnics in local, state and federal politics, reforms and changes which favour the migrant population should follow.

Active, informed migrant voters and trade union members have been instrumental in obtaining greater rights for migrant groups. As second and later generation migrants become educated they become more knowledgeable about Australian politics and their own rights. They are no longer willing to stand by while governments determine policy.
which affect them. They insist on being consulted on migrant issues and force
governments to take into consideration their differences and special needs. Migrant
community leaders often use the ethnic vote to bargain for specific migrant needs or
even to dissuade governments from carrying out actions that are not appropriate to
them or are detrimental to their interests. \(^{357}\)

Change of style in the delivery of health services to migrants has been slow but it is
important that there has been change. In the area of mental health there is still much
room for improvement as mainstream services continue to remain geared towards the
English speaking consumer. Governments have made some attempts to make health
services suitable to all Australians, including migrants. But, without proper planning
these efforts can be ineffective. Planning of services must be supported by relevant
research. Minas et al. stress the importance of more and intensive research in the mental
health of NESB communities, the better training of mental health professionals and
increased availability of community mental health information to NESB migrants. They
add:

Such systematic change does not occur easily or quickly and requires strong
support at government, health department, service agency and community
levels. \(^{358}\)

In the nineties the Transcultural Mental Health Units of Victoria and New South Wales
are fulfilling the needs of NESB migrant communities not only by aiming at improving
their mental health status and service delivery but by focusing on areas such as training
and research. Transcultural psychiatry which denotes a viewpoint that goes beyond the
scope of any one cultural unit on to others, though predominantly a field of research,
has practical applications as well. \(^{359}\) Hence, the work done by the Transcultural Mental
Health Units and Centres greatly benefit both the migrant community and the
government.

The practice of multiculturalism may not match its rhetoric but for migrant groups it
has been a definite step forward. The better educated migrants have been elected to

\(^{357}\) Callan, op cit, pp 81-82.

\(^{358}\) H.Minas et al Mental Health Services for NESB Immigrants, 1996, Executive Summary, p 16.
represent specific ethnic groups and some of these ethnic community leaders are members of both the Australian Ethnic Affairs Council and the Australian Institute of Multicultural Affairs. These representatives are in a position to advise the government on the special needs of migrant communities and obtain greater ethnic rights for them. While the larger ethnic communities such as Italians, Greeks and Semites have benefited from this, smaller and less educated NESB groups remain neglected. Since 1979 this situation has been remedied to a certain extent by the establishment of Ethnic Communities Councils (EEC) in each State, which allow for a representative from each migrant community.

In developing multicultural policies, the government has overlooked the importance of language instruction. The recent cuts in funding English classes for migrants is short sighted. Bereft of communication skills migrants are unable to benefit from such services as are available to them. As Browne points out ‘Public health and information campaigns are meaningless if they miss migrant audiences for want of communication’. 

Even though multiculturalism has brought some benefits for migrant groups the policy is yet one that denies them equal status in major institutions. Power and decision making have been largely kept out of their hands. In theory, migrants have equal power to resources such as high government positions and political office but the reality is that the majority population is not overly eager to share equal power and decision making with ethnic communities.

360 Callan op cit, pp 81-82.
361 Bates and Linder-Pelz op cit, p 29.
5.2 Transcultural Psychiatry.

*Over the years there has been much talk about cross-cultural counselling but nothing much has been done in this area. Sometimes cultural issues are overlooked. Professionals are not always sensitive. To learn about another person’s culture needs time but the effort has to be made. In the long run it saves a lot of time and money and a great deal of unhappiness. The Transcultural Mental Health Centre in Sydney is a great help but it is not enough to cover the needs of the entire Illawarra region.*

Angela Mitic

There are millions of refugees in the world today - many of them survivors of wars and political persecution. They are displaced persons suffering not only the trauma of personal torture but the anguish of separation from their homes, families and friends. Added to these are the thousands of voluntary migrants who, for some reason of their own, choose to make their homes in new countries. Large-scale immigration poses many challenges and the health of migrants is one of the most pressing problems in countries sustaining them. Treating mental illness, in particular, is a complex issue when dealing with vulnerable groups of people from such vastly different linguistic and cultural backgrounds. Jablenski writes that transcultural psychiatry developed as the result of social, political, demographic and cultural changes brought about by such world-wide waves of migration on an unprecedented scale.364

Transcultural psychiatry starts from a Western viewpoint - since psychiatry itself is a part of Western culture - but seeks to include other cultural insights. It is synonymous with cross-cultural psychiatry.365 Psychiatry is a scientific discipline which was developed in the West by ‘white’ people for a ‘white’ culture. Transcultural psychiatry recognises the need for a different perspective when dealing with psychiatrically ill individuals who do not conform to this culture. Jayasuriya argues that transcultural psychiatry ‘..questions the view that signs and symptoms of behaviour are logically of

365 Fernando op cit, Introduction pp xiii-xiv.
the same order in different cultures.' and ‘...the taken-for-granted assumptions of psychiatric theorising such as those relating to the normal/abnormal, validity of diagnostic categories, assumptions about modes of treatment....’ Transcultural psychiatry does not advocate a separate or parallel system of diagnostic practice for NESB groups but rather the incorporation of cultural and social dimensions into the traditional psychiatric approach. A practice which incorporates the social and cultural experiences of all sections of the community will enhance mainstream services.

Interest in transcultural psychiatry developed in Canada as early as the 1950s and in Britain, in the seventies. In Australia one of the earliest proponents of transcultural psychiatry was Professor John Cawte, a leading psychiatric specialist of Sydney and member of the WHO Expert Advisory Panel on Mental Health. In 1978 Professor Cawte championed the cause of ‘multicultural medicine’ in an address to medical students at Royal Perth Hospital. The Galbally Report recognised the special health needs of migrants, albeit of European origin. Cawte criticised Galbally for omitting South East Asians and Aborigines. Cawte argued that Aborigines should be regarded as refugees because they had fled their lands and lifestyles in settling elsewhere. He said that health problems of most ethnic minorities resulted from social and psychological difficulties rather than biological. He advocated the establishment of a Department of Transcultural Psychiatry to deal with these problems. He said that there were psychiatrists ready to adopt a transcultural perspective in their practice and blamed government apathy for the lack of services for ethnic minorities.

Cawte recommended three measures to be taken in order to meet the pressing needs of psychiatric services for migrants. First, the establishment of a Department of Transcultural Psychiatry and the inclusion of the subject in the syllabuses of Australian medical schools. Second, the training and appointment of ethnic health para-professionals. And finally he made the unusual suggestion of “xenophiliac health appointments”, as opposed to “xenophobic”. Selection committees should interest

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366 L.Jayasuriya Multicultural Australia: Towards the Twenty-First Century, paper to the Twelfth Annual Conference of the Federation of Ethnic Communities Councils, August 1991.
themselves in candidates’ racial attitudes - a positive interest in foreigners and ethnics would lead to some healthy appointments.\textsuperscript{368}

In the seventies bodies such as the National Health and Medical Research Council and the Royal Australian and New Zealand College of Psychiatrists had also made recommendations for the establishment of a Department of Transcultural Psychiatry.\textsuperscript{369} Community groups, voluntary agencies and others had, over a long time, expressed the view that mainstream psychiatric services were inappropriate for cultural and linguistic minority groups. However, for the government to acknowledge this fact took well over a decade, which in itself is evidence of its apathy and incorrect priorities.

In 1993, the National Inquiry into Human Rights and Mental Illness, chaired by Brian Burdekin, published its findings and recommendations. This was the first Commission to take an in-depth look at the problems of mental illness in migrants. The Inquiry considered the oral evidence of 456 witnesses and the written submissions of over eight hundred individuals, including mental health professionals, consumers, carers, church groups, government and non-government groups. This Report not only highlights the problem of psychiatric illness in migrant communities but also reveals the inadequacy of existing services.

The Inquiry found that:

- Mainstream services are not meeting the needs of large numbers of NESB people - particularly women and the elderly.
- NESB people often come into contact with the health system only when their illness has reached the acute stage.
- There is a clear need for transcultural mental health services and specialist programs for individuals with particular needs, such as survivors of torture and trauma.
- Interpreters are both under-used and used inappropriately.
- There is a dearth of information about the rates of mental illness among different ethnic communities.\textsuperscript{370}

\textsuperscript{368} Ibid, p 495.
\textsuperscript{369} Ibid.
The Inquiry recommended that:

• State and Territory governments should establish transcultural mental health services and, as appropriate, specialist programs in each capital city.

• Governments should take cultural issues into account in their mental health policies, program planning and service delivery. The employment of multilingual staff and staff with training in cross cultural issues should be encouraged.

• General practitioners, psychiatrists, nurses and mental health workers should receive appropriate training in cross cultural issues (especially in terms of symptomatology, diagnosis and assessment). The special problems facing women and the elderly should be emphasised.

• The composition of mental health review and guardianship bodies should reflect the multicultural nature of our society.

• Appropriate use of interpreters should be standard procedure in hospitals and community mental health centres.

• Interpreters working in the health system need to receive training in mental health issues and terminology.

• Health departments should prepare information on mental illness and mental health services in consultation with ethnic communities and ensure that it is disseminated appropriately.

• Non-government organisations supporting NESB people affected by mental illness should receive adequate funding. Government and non-government services should collect usage data and observe regular review and reporting procedures.\(^{371}\)

Expert evidence tendered to the Burdekin Inquiry by several witnesses including individuals such as Dr Minas of Victoria and Professor Silove of New South Wales, emphasised two major problems in the dispensing of mental health services to NESB groups, which would be best solved by establishing a Transcultural Psychiatric Service:

1. The monocultural nature of the Australian medical system is culturally incompatible with NESB migrant groups;

2. The inadequacy and the incorrect use of the interpreter service.\(^{372}\)

\(^{371}\) Ibid, pp 939-940.

\(^{372}\) Ibid, pp 939-940.
At the time of the Burdekin Inquiry the only existing centres with specialist facilities for NESB migrants were the Multicultural Psychiatric Centre in Perth, Western Australia which was established in 1983 and the Transcultural Psychiatric Unit in Melbourne, established in 1988. The former provided specific clinical psychiatric services as well as community psychiatric services for NESB people. It was concerned with better understanding the relationship between culture and mental illness. It also provided supplementary services which ranged from client education in therapeutic activities and living skills to advice and assistance in relation to housing, employment, financial and legal issues. The Centre was involved in providing psychiatrists and other mental health workers with education in cross-cultural issues.\textsuperscript{373} This centre was closed down in 1994 and reopened later in the same year as a Transcultural Psychiatric Unit.

The Victorian Transcultural Psychiatric Unit provides all of the above services and many more in addition. Its four main work areas are: research, education, clinical services and policy development. The Burdekin Inquiry saw the dearth of research as a major obstacle to improving mental health services for NESB people. The Victorian Unit undertakes research in assessing the prevalence of psychiatric illness in ethnic communities, the utilisation of services and cross-cultural issues involved in the diagnosis and treatment of mental disorders. This research program provides information necessary for the development and implementation of services for migrants.\textsuperscript{374}

The Burdekin Inquiry supported the view of several witnesses that there was a critical need for professional education of psychiatrists and other mental health professionals in cross-cultural issues.\textsuperscript{375} The Victorian Unit has an active education program for undergraduate and postgraduate students in medical, psychiatric, nursing and other disciplines. It offers, through Melbourne University, a Graduate Diploma in

\begin{footnotesize}
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\item \textsuperscript{372} Ibid, pp 733-734.
\item \textsuperscript{373} Ibid, p 744.
\item \textsuperscript{374} Ibid, p 745.
\item \textsuperscript{375} Ibid, p 746.
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Transcultural Mental Health. It is also actively involved in educational programs run by non-government organisations and ethnospecific community groups and agencies.\textsuperscript{376}

The NSW Transcultural Mental Health Centre was established in 1993. Its aims are to improve the mental health status of NESB people and ensure the delivery of comprehensive psychiatric services to these communities. This pioneering Centre has a statewide focus which includes clinical work, research, training, community liaison and policy development. It adopts a multi-disciplinary approach and offers direct services to NESB people from a wide array of backgrounds, helping to reduce crisis presentations, involuntary admissions and court orders.\textsuperscript{377} The research carried out by the above three Units greatly benefits the mental health system.

The 1983, Ethnic Affairs Commission of NSW submission to the Richmond Commission drew the attention of the Inquiry to problems of access to, and responsiveness of mental health services experienced by some ethnic groups. Some of the important issues raised were the need for better co-ordination and liaison of health services (particularly psychiatric hospitals) with government and voluntary ethnic services. It also expressed concerns about the ignorance of some NESB groups about the availability of services and the resulting poor utilisation of mental health services by these groups.\textsuperscript{378} Although the Richmond Inquiry acknowledged the representations made by the Ethnic Affairs Commission and recommended the improvement of services for groups with special needs, after almost two decades these concerns continue to be inadequately addressed. Overall, NESB issues are not satisfactorily incorporated into the planning of mainstream service delivery. The NSW Transcultural Mental Health Centre seeks to amend these shortcomings.

The NSW Centre is funded by the State Health department but the mainstreaming of mental health services for NESB communities requires more funds than the government provides. As Morrissey wrote ‘...without adequate resourcing, equitable treatment is impossible and access activities become simple exercises in reordering a growing

\textsuperscript{376} Minas et al, op cit, 1996, p 127.
\textsuperscript{377} “Non-English Speaking Background People and Mental Health Policy in NSW”, \textit{NSW Transcultural Mental Health Centre, Report no 94/2}, 1994, p i.
queue’. The NSW Centre is a ‘...change agent for mainstream mental health service provision to NESB clients, acting as a clearing house for current research and resources and offering clinical expertise and training to mainstream mental health workers’. Indeed, a very commendable role in the face of great odds.

In 1993 the Commonwealth Department of Human Services and Health commissioned a report from Minas, Silove and Kunst on NESB mental health issues. These consultants recommended the establishment of a National Institute of Migration and Mental Health. Based on this report the Commonwealth funded the establishment of a National Network on NESB Mental Health Issues. This Network is working towards the creation of a national agenda in research, education and service development. Two of its primary functions will be to provide a national information service on NESB mental health issues and to promote collaboration across disciplines and geographic regions.

In the first year of the Network’s operation it funded two projects:

1. Development of methods for involving NESB communities in partnership in mental health service development and evaluation.

2. Development of methods for estimating the needs of NESB communities for mental health services.

The major benefits deriving from transcultural psychiatry programs for NESB consumers are:

Direct clinical and referral services by staff with cross-cultural, administrative, teaching and research skills. These include rehabilitation programs, social services, support accommodation and employment preparation and training programs.

Support services for NESB women run by ethnospecific welfare agencies.

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380 NSW Transcultural Mental Health Centre Report no 94/2, op cit, p 24.
383 Ibid, p 129.
Services for survivors of torture and trauma.

Programs that provide support to mainstream psychiatric professionals who assess and treat NESB people.

Programs that provide support to families and carers of people with mental illness and to the community to which the patient belongs. This includes giving information and education in a culturally appropriate manner to help families to make informed judgements and acquire a working knowledge of mental health services. Such programs protect the rights of people with mental illness and enhance their quality of life.

Programs that provide support to policy makers in government health departments, service planners and agency managers. This support lies mainly in the fields of research, education of professionals and policy advice on issues concerning NESB communities.

The establishment of a central transcultural psychiatry unit in each State and Territory to act as a resource for the mental health system.

The establishment of a National Network on NESB Mental Health Issues to work towards a national agenda in research, education and service development.\(^{384}\)

Modern Australian society is composed of a large number of ethnic groups whose cultural and linguistic diversity poses a challenge to the delivery of essential services. This challenge, as experienced in the delivery of mental health services, is far more serious and complex than in any other field. Coping with mental health requirements and service delivery under ordinary circumstances can, in itself, be very demanding. When the situation is further complicated by issues of language and culture, the amplitude of the problem can be daunting to both service providers and users.

Many decades after the first post-war migrant arrived the Australian government has recognised the importance of improving the quality and the accessibility of mental health services for ethnic minorities, especially the NESB communities. It has taken the resolve and dedication of spokespersons of ethnic groups themselves to persuade the government of the urgent need for models of service appropriate to the circumstances of NESB communities. Professionals, consultants and academics - themselves of migrant

\(^{384}\) Ibid, pp 131-133.
antecedents - have been instrumental in the quest for equality of services for all Australians. Services for ethnic consumers should not be separate from mainstream mental health services but must complement and improve them. This is one of the goals of Transcultural psychiatry.

Government health policies have been far from equitable. The monocultural nature of services has resulted in some NESB communities becoming a social “underclass”. Commonwealth and State governments emphasise access, equity and social justice in their health policy statements. Only when these objectives become reality will Australia be a truly egalitarian society.
5.3 Politics and Policies of Health Care.

*The CEO of the Illawarra Area Health Service and its Board of Citizens are all political appointments. Whichever political party is in power puts its own appointees on the Board. So it is all a political issue where the money is spent. It is well known that the mental health budget has often been spent in other areas according to what the Board sees as a priority.*

Peter Brown

*The employment of foreign qualified doctors is a political issue. The AMA, the Department of Health and the government seem to be doing all they can to block foreign doctors. I don’t think the government has anything necessarily against foreigners, it is because they are towing the line with the AMA to control the number of doctors in Australia in terms of controlling their salaries. It is, I repeat, a political issue. Policies are not always made in the interests of the nation.*

Irwin Pakula

The prime objective of an ideal health policy should be to achieve equality in health status within the population. This goal cannot be attained so long as health service procedures remain discriminatory towards some groups in society. In Australia, migrants, women, Aboriginal people and the mentally ill are prominent among the disadvantaged groups. In order to counteract discrimination and ensure equality, health policy should be disposed towards a better understanding of the requirements of the individuals it serves. A humane health policy should provide health care which all categories of users find easy to access and understand.

Between the years 1947 and 1951 the Australian government recruited 168,199 NESB immigrants from the I.R.O. camps under the Displaced Persons scheme.385 During this

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same period refugees made up some 40 percent of Australia’s settler intake. Yet, government health policies made no special effort to accommodate the needs of the migrant population. It was only after the seventies, with the advent of the policy of multiculturalism, that changes - albeit inadequate - were made to the health care system in order to meet the needs of NESB immigrants. One reason why ethnic health policy was slow to develop was the dominance of the medical profession in the health care system. Another was the lack of input from ethnic communities themselves in the formation of health policy.

Policies are a product of politics and are therefore affected by the distribution of power in society. They are also influenced by economic insight regarding the best allocation of scarce commodities such as health care. In Australia, as in most other countries, policy development is closely linked to the political system. The government in power establishes policies which are derived from its political philosophies and values. Government policy sets the terms of reference of a government’s actions and determines a government’s actions in any given field. Policy facilitates the planning and development of government services.

Policy has been defined in various ways. It is a set of actions and decisions made by government. It explains a government’s past actions and sets the framework for its plans and developments for the future. It includes not only what a government will do but what it will not do. Thus, health policy decides the way in which both government and private health organisations operate. Policy has also been defined as that which validates government procedures and spells out its ideology. Policies are not always developed for the public good. They can be a response to an existing or perceived threat of public unrest. Policy can dictate government action or inaction regarding its values and beliefs about how society should be ordered. Thus, policy brings about social

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change.\textsuperscript{390} In Australia, the medical professions’ ascendancy in the health care system has hindered the growth of ethnic health policy.

A government’s policies have a profound impact on peoples’ lives. Australian health care policies do not guarantee equal access to health for all. In 1981 the Commonwealth government adopted the World Health Organisation’s ‘Health for All’ strategy in which the principle of equity is a major component. The main aim of ‘Health for All’ is equal accessibility to health care services for the whole population.\textsuperscript{391} Yet all evidence points to the fact that inequalities do exist within the present health care system. The explanation for this inequality lies in the unsatisfactory nature of government policy formation and on the factors affecting health policy. ‘..policies should not be considered purely and uncritically as if they were dreamed up and implemented with only the welfare of the public in mind’.\textsuperscript{392} A brief look at the way policies are shaped by governments will shed some light on why policies take the forms they do.

In countries where there is a federal system of government, as in Australia, policy formation becomes a complex task. In Australia the responsibility for health care is divided between the Commonwealth, state and territory governments. When responsibility is shared by different levels of government, accountability is diminished and this affects decision making. When Federal and State governments are of different political ideologies it complicates the issue even further. Health policy then becomes the result of political philosophies and power.\textsuperscript{393} At a more tangible level this manifests itself as a continuing debate over the allocation of funds and the assumption of control over various aspects of the health care system. Financial considerations tend to dominate policy recommendations and implementations as Federal and State governments grapple over cost-sharing agreements.

While the Liberal-National Party coalition’s ideology is to reduce the public sector in favour of the private sector and the market, the Labor Party’s interests lie in increasing

\textsuperscript{390} Masterson, \textit{op cit}, p 12.
\textsuperscript{391} Palmer and Short, \textit{op cit}, p 216.
\textsuperscript{392} Masterson \textit{op cit}, p 11.
the public sector while keeping a firm hold on policy direction.\textsuperscript{394} In 1948 the Labor Government declared its policy for taking control over the organisation and management of health services, at the same time, announcing an increase in funding. But this intention was never realised as Labor was defeated in the 1949 elections and the new Liberal government reinforced the existing philanthropic-entrepreneurial approach to health services with the total support of the British Medical Association (BMA) of Australia, which later became the Australian Medical Association.\textsuperscript{395}

Health policy is affected by professional influence and to a lesser extent by commercial interests. Pressure groups and government interact for their mutual benefit. Pressure groups desire to influence political philosophies and government needs the support of these groups in implementing policies.\textsuperscript{396} In Australia, pressure groups attempt to influence policy making at both federal and state levels. A number of pressure groups lobby politicians and senior government officials; amongst them, the medical profession. Between 1900 and 1970, the medical profession became the dominating force in the organisation of health care in Australia.\textsuperscript{397}

From 1949 to 1972, the Liberal Government’s health policy was greatly influenced by the dictates of the BMA. The BMA was a powerful body with clear links to the conservative Liberal party and the government adopted health policies which were favourable to it. This is an example of the role that pressure groups play in government policy making. The Liberal Government did away with Labor policies for a national health service funded from general revenue and introduced contributory health insurance (MBF and HCF), in effect, for the middle classes who could afford to prepay health care costs. This scheme left the poor, the unemployed and pensioners unprovided for - the section of society which, of necessity, included most migrants, the mentally ill and developmentally disabled.\textsuperscript{398} But, it was a scheme which suited the medical profession.

\textsuperscript{394} Ibid, p 5.
\textsuperscript{395} Crichton \textit{op cit}, pp 27-42.
\textsuperscript{396} A.Masterson “Making and Implementing Social Policy”, in Gough \textit{et al.}, 1944, pp 42-55.
\textsuperscript{397} Crichton \textit{op cit}, p 2-7.
\textsuperscript{398} Ibid, pp 42-45.
In 1951 a second-class, non-contributory system was introduced, the Pensioner Medical System, for those receiving social security benefits. Doctors participating in this scheme were to be paid a fee agreed between the government and the BMA. In 1955 a means test was applied to pensioners before they could qualify for this service. This means test was relaxed only in 1966. The BMA at all times kept a strict control over pensioner entitlements and safeguarded its members’ rights to private practice.\textsuperscript{399} These policies undoubtedly caused immense hardship to a large number of Australians.

Just as the BMA desired to influence policy decisions, the government needed its co-operation for the successful implementation of policy. Liberal-Country Party Government policy was to maintain health services at a level that would allow the medical profession to operate without interference, which was not necessarily in the public interest. The medical profession still plays an important part in determining Australian health policy.

Willis explains the inadequacy of Australian health policy as a product of medical dominance. He argues that medical dominance is sustained at three different levels. First, medicine is an autonomous profession in that it is not subject to outside evaluation. Second, medicine has created for itself a position of ascendancy and control over other health occupations. Medicine asserts its authority over other health occupations through direct or indirect control in the organisation of their work. Finally, doctors have instituted themselves as experts on all matters relating to health thus shaping society’s perceptions of health problems and their management.\textsuperscript{400}

Not only does the medical profession have access to such authority but it has also created a very influential position for itself through the role of doctors as direct providers of services.\textsuperscript{401} Doctors enjoy a great deal of freedom in organising their work and determining the way services should be provided because they are not subject to outside control. Medicine is a profession governed by self-regulatory bodies and doctors are usually administered and disciplined by their peers. Yet, Palmer and Short argue that peer review within the medical profession is inadequate on its own as it does

\textsuperscript{399} Ibid.
\textsuperscript{400} E. Willis \textit{Medical Dominance}, 1983, pp 2-3.
not sufficiently protect the health consumer’s interests. Doctors determine what investigations are appropriate for their patients, where they should be carried out and for what length of time. Thus, doctors are the major resource consumers and controllers in health care and the community’s attitude to health care is to a great extent fashioned by the values of the medical profession.

Martin’s study of migrant health care finds that as late as the 1970s, the AMA had not proclaimed a position or a policy on migrant health care. The AMA’s Policy on Medical Services, 1971, which was approved by federal parliament, made no reference to NESB migrants or to interpreters. The medical profession’s definition of migrant health was consistent with its authority over health services in general.

Scotton accounts for the dominance of the medical profession as follows:

The economic power of the profession is based on a monopoly of skills for which no close substitutes are recognised....However, its dominant influence on the structure of the health service system rests not only on this economic base but also on its cohesiveness as a formal and informal interest group and the prestige and authority accorded to it by politicians, administrators and the community as a whole.

To understand health policy as a product of politics, one should examine the roles of parliamentarians, bureaucrats, pressure groups and the electorate. Each group pursues its own interests; politicians seek re-election, bureaucrats wish to further their career prospects, health service providers in the guise of pressure groups (eg: AMA, nurses’ unions) may seek to stabilise their status and power while increasing their incomes. Consumers’ interests lie in improving their health status by obtaining an efficient health service with no added costs to themselves. With these objectives in view each of these

401 Masterson op cit, p 43.
402 Palmer and Short op cit, p 46.
403 Masterson op cit, p 43.
404 Martin op cit, 1978, p 179.
405 R.B.Scotton, Medical Care in Australia, 1974, p 10 cited in Ibid.
groups demands policies which will strengthen their own position in the community. Governments tend to implement policies which are in highest demand since these will ensure more votes and greater political support.\textsuperscript{406} The Fraser Government lost no time in adopting the recommendations of the Galbally Review into Migrant Needs and Services, 1978, at a cost of fifty million dollars over a period of three years. This is an example of a government’s strategy to capture the ethnic vote before it moved back to its traditional base, the Labor party.\textsuperscript{407}

The experience of overseas qualified refugee doctors of non-English speaking background who arrived in Australia after World War Two is an example of the lack of co-operation between Commonwealth and State governments in policy development. Garrett and Lin write that this led to:

\begin{quote}
...varying recognition criteria between states; an inappropriate emphasis on “paper qualifications” and a neglect of demonstrated skills, experience and competency; the poor provision of accurate information and advice; a lack of appropriate orientation, bridging, refresher and upgrading courses; and the long delays and processes involved in gaining recognition.\textsuperscript{408}
\end{quote}

Kunz writes that over a third of these doctors were unable to obtain registration due to strong opposition from the AMA and the apathy of the Commonwealth government. Those who did, had to spend a number of their working years attending ‘..unnecessary university courses and in menial jobs’. Non-recognition of their qualifications was not just a personal tragedy to the foreign doctors but a great loss to Australia which during this period was short of medical practitioners.\textsuperscript{409} Moreover, the medical profession used its political power and influence to arouse public suspicion and fear of the foreign doctors. They were labelled ‘incompetent, unethical and dangerous’.\textsuperscript{410}

If the government had recognised the skills of these overseas trained doctors NESB migrants would have benefited greatly by receiving health care from practitioners who

\begin{footnotesize}
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\item[406] Palmer and Short \textit{op cit}, p 42.
\item[407] Callan \textit{op cit}, p 79.
\item[408] Garrett and Lin, \textit{op cit}, p 364.
\item[409] E.Kunz \textit{The Intruders}, 1975, pp 112-115.
\end{enumerate}
\end{footnotesize}
shared their language and culture. In the absence of this service ‘there grew up a submerged system of illicit medical practice which allowed unqualified imposters to exploit fellow-countrymen desperate for medical advice they could understand’.\footnote{Martin \textit{op cit}, 1978, p 173.}

Between the mid-fifties and seventies the Australian government had no specific health policies for migrants. Migrants were held responsible for their own illnesses, whether physical or mental; they were considered problems within the migrants themselves and not as inadequacies within the health care system.\footnote{Ibid, p 170.} Migrants were blamed for not ‘assimilating’ and adapting to the ‘Australian way of life’ as soon as possible. They were expected to utilise all mainstream services including health services.\footnote{Garrett and Lin \textit{op cit}, p 341.} The Liberal-Country Party government’s health policies were such that they were designed not to disrupt the \textit{status quo} and to maintain expenditure on health services at a minimum.

Since the seventies governments have implemented policy changes favourable to the ethnic population. The political mobilisation of ethnic minority groups has to some extent been responsible for bringing about these changes.\footnote{Ibid.} Politicians value the support of these groups which is important in a candidate’s success at both state and federal levels.\footnote{Callan \textit{op cit}, p 80.} A further factor which influenced change was the increasing awareness among sections of society of the importance of migrants to the cultural and economic development of the country. Increased social interaction with migrants and improved standards of education changed Australian attitudes towards the migrant community. It was in such a political climate that the Fraser government announced its acceptance of the recommendations of the Galbally Report \footnote{416} which led to important changes in ethnic welfare issues.

In NSW community care policies for the mentally ill began in the sixties. Since then the common policy in all Australia has been to discharge the mentally ill from psychiatric institutions into the community. In NSW, serious reform of mental health policy began
as a result of the Richmond Inquiry into Health Services for the Psychiatrically Ill and the Developmentally Disabled, commissioned in 1982 by the NSW Minister for Health. One of the most important changes which ensued from this report is the development of separate policies and services for the mentally ill and the developmentally disabled. Also of great significance is the government’s acceptance of the Inquiry’s recommendation that, except in special circumstances, the mentally ill and the developmentally disabled were to be cared for in the community. The Richmond Committee’s principal objectives were:

1. The funding and/or provision of services which maintain clients in their normal community environment;
2. Progressively reducing the size and number of existing psychiatric hospitals by decentralising the services they provide.417

The Committee’s recommendations were aimed at reducing the size of existing psychiatric hospitals by providing adequate community-based support for the mentally ill. It also recommended, among other things, the allocation of funds for non-government, non-profit organisations for the provision of accommodation for the mentally ill and the implementation of subsidies to private boarding houses to provide housing for the long-term psychologically ill. 418

The Richmond Committee’s recommendations were directed towards the rationalisation and reduction of existing psychiatric hospitals so that the savings thus achieved could be committed to the development of community services. In reality, the allocated sum - 9 million dollars per year for the next three years 419 - was grossly insufficient for the purpose. Even though the government accepted the recommendations the average citizen had misgivings about the workability of such policies. As the number of chronically mentally ill and behaviourally disturbed individuals increased in the community the general population objected to their intrusion into society. A large number of homeless mentally ill persons became unwanted individuals. As mental hospitals declined to take responsibility for patients they once accommodated the

418 Ibid.
419 Ibid, part 1.
community social agencies, such as the Salvation Army, found it increasingly difficult to assist them. In its haste to empty the mental hospitals the government turned into the community many severely mentally ill individuals who became a problem to their families and neighbours. Various media reports testified to this. The major stumbling block was that deinstitutionalisation took place without an adequate shift of resources to community health.

By the end of the eighties not much had resulted from the Richmond Report except for some minor increases in community staffing, some hostels and the closure of, or parts of, some psychiatric hospitals. As non-profit organisations found it impossible to cope with demands for accommodation from inmates discharged from institutions they had no alternative but to refer them to private boarding houses whose services and conditions of care were questionable. In the long run it was the substitution of one kind of institution for another, not necessarily in the best interests of the patients. Clearly, to the State government, it was a cost-cutting venture. Palmer and Short state the transfer of mental patients from the public sector to the private meant that they now became the financial responsibility of the Commonwealth government and not the State government as the private sector depends on the Commonwealth government for most of its funding.

The NSW government’s policy of adopting the Richmond recommendations with the major objective of reducing government expenditure, with little consideration for the effects such changes would have on the mentally ill and their families is an example of how political parties and governments formulate policies. The human factor of providing appropriate care and facilities for the most disadvantaged section of society fades into insignificance in the light of political ambition and power. Philia Polites sums up:

> We hear far too often of mentally ill persons being taken to casualty departments of hospitals by the police, where they are allowed to remain for a while before returning to the homelessness on the streets - we are reminded that there are no votes in mental health. It is certainly the case within the ethnic

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community sector that the shift to a community oriented model has occurred prematurely.422

As Gardner points out ‘...health policy is not the result of rational analysis, but is the outcome of political compromise’.423 The prevailing political philosophy of the period characterises government policy. Interaction between government and interest groups and debate between consumers and producers or providers also play a part in policy formation. In the development of health policy, health care professionals bargain for what is best for them. Consumers are less able to influence policy makers as their cooperation is not as important to the policy-making process as that of providers. Consumers are generally not so well organised as producers and providers.424 In 1987, the Consumers’ Health Forum of Australia was formed to represent the interests of consumer groups. This organisation received a nominal amount of government funding for research purposes though only for the short period of five years.425

Not all groups are able to have access to governments in this way. Most consumer groups publicize their views through the media or resort to lobbying politicians in order to gain their ends. NESB communities are disadvantaged consumers. They lack involvement in formulation of health policies. Although they are occasionally invited to contribute their views and ideas at community group consultations, they rarely do so. The format of such consultations itself often prevents them from participation. For instance, the requirement of written submissions would be a deterrent. Policies formulated without adequate input from NESB groups will necessarily be inappropriate for them.426

Another notable deficiency in Australian health policy is the inadequacy of research into its ethnic communities. Insufficient data about the health needs of different groups and their patterns of service utilisation means that available policies cannot be properly

421 Palmer and Short op cit, pp 241-242.
423 Gardner op cit, p 5.
424 Masterson op cit, p 45.
425 Gardner op cit, p 75.
implemented, thus, making the most well intended policies irrelevant to them.\textsuperscript{427} Further to this, the ‘...dominance of the health care system by the world of medicine has meant that the achievements in ethnic health care have been marginal’.\textsuperscript{428}

\textsuperscript{426} I.Minas et al Mental Health for a Multicultural Australia, 1993, p 17.
\textsuperscript{427} Ibid.
\textsuperscript{428} Garrett and Lin \textit{op cit}, p 377.
Chapter 6

NSW Department of Health - 1960-1990

6.1 Administrative arrangements

*The Wollongong Regional office did not have much scope to introduce policy as we were directly under the Health Commission of NSW until 1984. When the Area Health Service was formed, in theory, the Department of Health formulated policy and the Area Health Boards implemented it. In reality, how much policy they implement depends on how much money is made available to them.*

Pat Mowbray

*The IAHS has far more control over its own destiny and how it utilises its budget although it has to be in line with Department of health guidelines. Under the Regional Offices, the Regions were told what to do and how the money was spent. With the IAHS there is much more flexibility; where it gets tied up is the amount of money allocated to it. The IAHS has the prerogative to move funds around from other projects into mental health and vice versa. Vice versa was the more prevalent!*

Irwin Pakula

From the time of colonial settlement in January 1788 to the 1970s, the New South Wales health care system was structured around the health administration system of Great Britain. This scheme derived from the mother country was inadequate for NSW’s needs which, as politicians and administrators began to realise, were not identical to those of Britain. Yet, the system survived for almost two centuries before it was subjected to scrutiny. In April 1973, in NSW, the administrative structure changed from a Ministry of Health under the State’s Minister for Health, to a NSW Health
Commission, responsible to the Minister yet with a greater degree of autonomy in policy formation and implementation. Migrant health issues did not feature in the Health Commission’s policies although it did recognise that NESB communities suffered scarcity of health services. In 1982, a Department of Health with Health Regions replaced the Health Commission which in turn changed again in 1983 to a Department of Health with Areas. During the period 1982-83, migrant health became an objective of the department’s policies.

Up to 1972 NSW health agencies, directly under the Minister for Health, were divided into several categories; the Department of Health, the Hospitals Commission, the Ambulance Service Board and the Statutory Registration Body. The Department of Health was headed by an Under Secretary, a bureaucrat not medically qualified. Under him were the medically qualified Director General of Public Health, the Director of the Division of Establishments who was also a medical professional and the Secretary of Management Services. There was little or no co-ordination between these divisions and they functioned independently to a great extent.

Below the Director General of Public Health was the Director of State Health Services who was also a medical practitioner. Together, they were responsible for the operation of the State’s environmental health services such as sanitation and food and drug supervision. They were also responsible for scientific services including pathology services, occupational health and forensic medicine and for personal health services comprising of divisions such as maternal and child health, dental health and supervision of private hospitals. The Director of the Division of Establishments had under him the State's Psychiatric services, Geriatric services and services for the developmentally disabled.

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434 Ibid.
In the early 1960s the NSW government began to be concerned about the efficiency of public hospital services. Resources were unequally divided with the bigger Sydney hospitals receiving more than their due for developments which were often unrelated to the needs of their clientele. Also, competition between Hospital Boards led to unnecessary duplication of services. In 1963 the Minister for Health appointed a committee to investigate the rationalization of hospitals with a view to re-organising the hospital system. 435

The report of this committee recommended that hospitals be linked together into regions and services decentralised and shared. It also recommended that psychiatric and geriatric services, public health and services for the developmentally disabled be integrated with the public hospital system in these regions. In 1965 the government fell and the new government commissioned the same committee to investigate the amalgamation of the state’s health services. In 1969 this report (Same as above - Starr Report 2) recommended the amalgamation of the Hospitals Commission, the Dept. of Public Health and Ambulance services under one administrative agency, the NSW Health Commission. 436

In 1973 the Health Commission of NSW was established, comprising of five Commissioners. Regionalisation was the essential feature of the Commission’s organisation and whole system of operation. By the end of 1973, 13 Regional Offices were established, each under a Regional Director. Health services were decentralized and individual Regions assumed responsibility for their areas. Each Regional Director was delegated considerable authority, consistent with overall Commission and ministerial responsibility. The ability to deal with a majority of matters at a local level facilitated decision making. 437

The creation of the NSW Health Commission had a major impact on mental health services. The office of the Director of State Psychiatric Services was abolished and the Regional Directors were made responsible for mental health services within their own

435 A.Crichton op cit, p 50.
regions. These bureaucrats had little or no expertise in mental health which created difficulties for those involved in psychiatric care. Moreover, Regional offices had little executive authority and all proposals needing decisions had to be forwarded to the Health Commission, causing unnecessary delays.438

Thus far, whatever community mental health services that existed were provided by the mental hospitals. In 1975, the Regional Directors took control of community services. This change created a rift between community centre staff and the staff of the hospitals. This disadvantaged the patients as it interfered in the continuity of care between hospital and community.439

The main functions of the Commission were the setting of policies, allotting budgets and monitoring the performances of the Regional offices.440 The Commission was administered from Sydney through a central office responsible for developing health policies and implementing them through the Regional offices.441

New South Wales public health services were divided into four categories:
1. Public Hospitals in over 270 locations throughout NSW, which provided the public with services for chronic and acute illnesses.
2. State and Psychiatric hospitals, 21 in number, which provided services for people with mental illness, developmental disabilities, and to the aged. These hospitals were funded by the NSW government.
3. Community health services, federally funded, which employed over 3000 workers to provide care for people suffering disabilities or temporary illness.
4. The Ambulance service which provided emergency transport, paramedic care and transport for the chronically ill.442

439 Ibid.
442 Ibid.
The Commission was further involved in the School Dental scheme, Health Services Research and Hospital Development scheme, all federally funded. It was the Commission’s responsibility to see that funds were properly spent in areas of greatest need.\textsuperscript{443} By 1976 the Commission was experiencing difficulties in properly planning and co-ordinating health services due to the uncertainty of funds from both CW and State governments.\textsuperscript{444} By 1977 the Commission was facing continuing escalation of costs and it undertook a number of research projects on maintenance expenditure and budgeting in public hospitals for the purpose of curtailing costs.\textsuperscript{445}

In the financial year 1981-82, the CW made significant cuts to the funds it provided to the State - from an estimated $509.5 million to $483.5 million - causing the NSW government to raise revenue by increasing hospital charges. All public health services experienced budgetary difficulties. The Minister for Health appointed a Task Force to investigate the disastrous condition of the Commission’s finances and its operations.\textsuperscript{446}

The Task Force found that the Health Commission had fulfilled the obligation to create a single health administration from three former independent bureaucracies - health, hospital and ambulance services. The corporate structure of the Commission consisting of five Commissioners led to a diffusion of power and lack of accountability. It also led to delays in policy formation and implementation. A departmental structure with a Secretary at the head would be a more appropriate form of administration at a time of financial restraint requiring tight budgetary control.\textsuperscript{447}

In December 1982 this change was effected when the government passed the \textit{Health Administration Act 1982} which abolished the Health Commission and replaced it with a Department of Health with Regional Offices. Staff numbers were cut and Regional offices reduced from thirteen to eleven. The Task Force recommended that Central Office should concern itself with policy making, co-ordination of relations with the


Treasury and other government departments and monitoring Departmental activities rather than duplicating functions carried out by the Regional offices.448

Since the decentralisation of health care services was already in process, the government saw the next logical step to be the formation of health care services management Boards representative of local communities, organisations and institutions. Such Boards would have statutory responsibility for ensuring the development, quality and delivery of health services within their defined geographic area according to the needs of the population they serve. In December 1983, four Area Health Services Boards were piloted. By June 1984, 15 Area Boards had been proclaimed.449

Subsequently, a total of 23 Area Health Services were established. In 1988 there was a major reorganisation of services and the 23 former services were re-constituted into 10 Areas and 10 Chief Executive Officers were appointed to manage them. The Regional Offices were closed, removing an unnecessary layer of administration.450 Each Area Health Service is responsible for planning and the day to day management of services, including public hospitals and community health services within its geographic area. Each Area Health Service is now managed by a Board of Directors which is directly accountable to the Minister. In rural NSW, health care services are organised into 6 Regions, each administered by a Regional Office of the Health Department.451

Although a major expansion of community services occurred from 1973 to 1974, migrant health received scant attention. In 1977 the Health Commission, for the first time, acknowledging migrants’ needs, established a health care service employing twelve interpreters. They were based in Sydney and provided a telephone interpreter service to hospitals in and around the inner city area. Small groups of interpreters were also attached to major metropolitan hospitals.452 Regional areas such as the Illawarra

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448 Ibid.
where there was an urgent need for interpreters due to its NESB population were neglected.

During the period 1982-83, health administrators developed some policies to meet the needs of NESB population groups. Ethnic Services Co-ordinators were appointed at hospitals serving large ethnic communities. The health care interpreter service expanded. Three ethnic health workers were appointed, one of them based in the Illawarra. In 1984, the Illawarra secured further funding for the appointment of more ethnic health workers and migrant health project workers.\textsuperscript{453}

The fact that migrant health policies were further developed in the eighties can be attributed to the EAC’s introduction of Ethnic Affairs Policy Statements in 1988, whereby all government departments were required by law to submit annual ethnic affairs policy statements to parliament. This ensured that all departments developed and implemented policies to make services accessible and appropriate for all residents, regardless of ethnic, religious or cultural background. When the Health Department submitted its first Ethnic Affairs Policy Statement it included a range of improvements for migrant communities such as health education programs for NESB people, translation of Departmental publications into community languages, enhancement of the Health Care interpreter service and the establishment of area migrant health committees to ensure that Area Health Services were responsive to the needs of local migrant communities.\textsuperscript{454}

\textsuperscript{453} Annual Report of the NSW Health Department 1984, \textit{NSW Parliamentary Papers}, vol 11,

6.2 NSW Psychiatric Services, 1955-75.

_In 1968 I was admitted to Callan Park psychiatric hospital. I was placed in a small ward with twenty beds. It was over crowded. I later learnt that Callan Park was a notorious hospital. It was full of migrant patients and they were treated like rubbish. Maybe that is why I was sent there. During my four weeks in the hospital I was never seen by a doctor. There were only nurses and they were never kind. When I was discharged I was requested to return after three months for a check up. I never returned to Callan Park hospital._

_Anica_

_In the mid 1960s my mother suffered a nervous breakdown and was admitted to Parramatta hospital. She was very frightened to stay in hospital as she understood nothing that was being done to her. The staff did not understand the type of care which a NESB person who had undergone so much trauma as a refugee, needed. Once she was given ECT and something went wrong. As a result, she was unconscious for hours - maybe days - we were not told. Not long afterwards she was discharged saying she was well enough to go home. I took her home and looked after her as best as I could, for the rest of her life. She never really recovered._

_Ruth Mataitis_

_In the 1950s and 60s, the need and demand for mental health services for immigrants were well documented. The research carried out by some members of the medical profession in the fifties followed by the work of Krupinski and Stoller had received national and international attention._

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which both State and Commonwealth governments’ health policy should respond to these problems. It also drew attention to the clinical services which that policy would require.

Although the need was patent, the Annual Reports of the Inspector General of Mental Hospitals give a contrary impression. From the 1950s to the 1970s, psychiatric services consisted of hospitalisation and a small number of out patient clinics attached to the major mental hospitals. These reports also show that if there were psychological services for migrants from NESB, they were such that they did not merit a mention. Put simply, mental health services for migrants were limited to the psychiatric.

Towards the end of the sixties some community services were commenced in the form of out patient clinics in regional areas. Migrants had to access these mainstream services in whatever way they could. The provision of specialist health care interpreters, trained not only in language skills but also in cultural aspects of health service provision, was still more than a decade away as were ethnic health workers. For specialist trained bilingual mental health workers, the wait would be even longer. In this situation, it was left to charitable organisations to provide migrant patients with personal support as ethnic community agencies were rarely active during this time.

In the Annual Reports of the Inspector-General, later the Director of Psychiatric Services, there is only one mention of migrants besides some statistics relating to immigrant patients. Moreover, these statistics seem unreliable because each report carries two contradictory sets of figures. This demonstrates the scant attention given to migrants, especially those in unsound health. There is no mention whatever of any kind of special help for them. Yet, by the fifties, NSW had absorbed a large number of migrants. In 1956 the population of NSW increased by 20,771 due to migration, in 1957 there was an increase of 26,014 and in 1958, the figure was 17,494.

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456 J.Krupinski Social Science 7 Medicine, 1967, vol 1.
458 Year Book of the Commonwealth of Australia, 1955 and 1959, Nos 41 and 45.
After World War Two there was a dramatic increase in immigration. Rapid expansion and structural change in the Australian economy after the war demanded an increase in labour. Among those admitted to strengthen the labour force were hundreds of thousands of non-English speaking migrants from southern Europe and refugees from the IRO camps, (DPs). Australia was second only to the United States of America in the number of DPs it admitted, but it took more DPs per head of population than any other nation.\(^{459}\) DPs were NESB migrants, mainly of Yugoslav background. During the peak years of 1949 and 1950 net migration exceeded 150,000 a year.\(^{460}\) New South Wales absorbed a large number of migrant workers who were given jobs in the Newcastle and Port Kembla steel industry. By 1952, 22.6% of all steelworkers at BHP in Port Kembla were migrants.\(^{461}\) The Snowy Mountains construction scheme, road building, logging and farming also employed migrant labour. Many displaced persons suffered mental disorders due to war time trauma. Yet, whatever mental health services were available were for the host population which migrants could neither understand nor access satisfactorily.

Murphy observed that DPs had a history of mental suffering. They easily slid into depressive states with the exacerbation of past neuroses brought about by isolation and social deprivation. He writes:

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\text{...the displacement neurosis with which many DPs are afflicted at the time of resettlement shows no sign of disappearing automatically upon their acquisition of a new homeland, and for this reason it is regrettable that Australian psychiatry is backward in its recognition of this condition, for the treatment of mentally ill DPs cannot be regarded as satisfactory. While improvements in this service are matters of general Australian concern....it seems not unreasonable to ask that such mentally afflicted patients should be examined and treated by people to whom they can make themselves understood, which is by no means the case at the moment.}^{462}
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\(^{459}\) Kunz op cit, 1988, pp 40-41.
In the report for the year ended 30 June 1955, the NSW Inspector-General of Mental Hospitals, D. Fraser, states that psychiatric services were seriously hampered throughout the year by the heavy shortage of medical and nursing staff. Of a total of 64 medical positions advertised only 32 were filled. Despite these serious shortages and the difficulties in filling vacant positions which in turn exacerbated the existing shortages, the Inspector-General boldly asserted that no patient admitted to a NSW Mental hospital jeopardised his or her prospect of recovery. In order to reduce the work load of the medical staff he appointed medical clerks who attended to the routine work of writing up case papers, medical reports and official documents. This enabled the doctors to concentrate more on the treatment of patients.  

These medical clerks were all ‘New Australians’ who possessed medical degrees from European universities. Doctors with foreign qualifications were not allowed to practise in NSW until they completed the last three years of the medical course at the University of Sydney and passed the final examination. Those who were unable to do so due to financial or other difficulties were permitted to work as medical clerks. At a time when there was a serious shortage of medical staff, this seems an unusual and unhelpful solution to such a pressing problem. Clerical work could successfully be performed by persons less qualified than those who hold a medical degree, be it from a foreign university.

The comments of the Inspector-General show that the current staff shortages in psychiatric services are not new, nor is the government’s attitude to the employment of foreign doctors. A recurring theme in all the Reports from the early 1950s to the seventies is the shortage of psychiatrists. Yet, over a third of foreign qualified doctors were unable to obtain registration. Those who did, spent a number of years working in unskilled jobs due to non-recognition of their qualifications.

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464 Ibid.
In 1961, the Health Advisory Council of NSW was formed with the Director General of Public Health as its chairman. In March of the same year he was further appointed Director General of State Psychiatric services. The Council’s principal recommendation was the prevention and early treatment of mental illness through better training of doctors, medical students, nurses and all others employed in the field of psychiatry. It also gave priority to the establishment of community psychiatric services which, if properly established and well located could relieve the over-crowding in psychiatric hospitals and permit eighty percent of patients to recieve appropriate treatment without the need for hospital admission. The Council also listed as an ‘immediate project’, the recruitment of psychiatrists, if necessary, from overseas, ‘under specific guarantees of employment’.\textsuperscript{466}

That this important recommendation went unheeded becomes apparent today, over four decades later, when the shortage of psychiatric staff continues to persist. Psychiatric staff interviewed in 2000 and 2001 strongly disapproved the government’s reluctance to admit foreign professionals with medical and psychiatric training which would be an important way of improving health services for NESB communities.\textsuperscript{467}

The Inspectors generals’ reports show that overcrowding in mental hospitals had been a serious problem in the fifties. The accommodation of mentally ill patients was becoming worse each year. The 1956 Report states:

Ten years ago there were 1667 more patients in the mental hospitals than they were built to accommodate. Last year there were 2369. From that overcrowding all manner of difficulties arise........staff are hampered in their work, treatment suffers, auxilliary services are overtaxed and administration of the hospital is made more difficult.\textsuperscript{468}

Overcrowding was of such a serious nature that some patients had their beds moved to the verandahs, lounge rooms were converted into dormitories and some patients even

\textsuperscript{466} NSW Parliamentary Papers, Joint Session vol 1, 1962, Report of the Director General of Psychiatric Services.

\textsuperscript{467} Interview with Dr Pakula, October 2001, and A.Mitic, May 2000.

slept on beds made up on the floor in passageways when there was no room for a fixed bedstead. Adding new wards to existing hospitals and building more hospitals did not seem to be the answer to the problem of overcrowding. The state now began to view mental health and mental illness as a community problem. The community had to take its share of responsibility for the care and welfare of the mentally ill.469 This could not have been an easy task. The community’s sense of responsibility in this matter has yet a long way to go before a discharged mental patient is accepted back into their circle without mistrust and before all traces of stigma traditionally attached to mental illness have disappeared.

Apart from statistical Tables, the Report for the year ending 1961 is the first report to devote a few lines to migrant patients, if only to acknowledge their presence. The Director, Dr Donald Fraser writes:

As would be expected under a vigorous policy to encourage Migrants to the country the numbers of these people admitted to Mental Hospitals has considerably increased......No inference is drawn from these figures which are minimum figures because they are collated with a limit of five years residence, other than to refer to the need to provide for accommodation and maintenance of the patients concerned. 470

The Reports do not give a clear indication of the number of migrants in mental hospitals. The statistics available are confusing and unclear. For example:

Report for the Year ended 30 June 1955,
Immigrants in Mental Hospitals during the year 1954............................634
Immigrants in Mental Hospitals during the year 1955............................537.
Table 9, (Showing the native countries of those under care)
Total patients (other than Australian born) under care during 1954-55...........3056 471

469 Ibid.
471 NSW Parliamentary Papers, 1956-57, vol 1 session 2.
There are similar discrepancies in the reports up to the year 1964, after which the statistics adopt a different form where the patient number is given as a total and not divided into categories.  

In 1955 NSW had fourteen institutions to care for and treat patients under the Lunacy Act. The *1878 Lunacy Act* and the subsequent *Lunacy Amendment Act of 1881* remained unchanged for the following eighty years. Under this Act, drunkenness, criminal or offensive behaviour warranted a lunacy charge and such persons received treatment in mental institutions. In addition, they looked after elderly patients who suffered from mild mental derangement due to old age. In the fifties and sixties the focus was on mental hygiene. Medical staff visited overseas countries regularly in order to keep abreast of the latest developments in mental hygiene.

During these decades psychiatric procedures followed at the hospitals included psychotherapy, electro-convulsive treatment, insulin therapy and the operation known as leucotomy. The advent of new drugs such as chlorpromazine and reserpine was of great benefit in the treatment of chronically disturbed patients. However, the Report notes that the drugs were an expensive alternative to existing psychiatric techniques. In 1958, the Cerebral Surgery and Research Unit was opened attached to the Callan Park psychiatric hospital. It had facilities for psychiatry, psychology, neurology, biochemistry, neurosurgery and electroencephalography. Its specialised equipment was imported from the United States and Europe. Brain investigations and brain surgery were carried out in this specialised Unit as well as research in drugs and the treatment of epilepsy and illnesses such as schizophrenia. Patients from other psychiatric hospitals were admitted here for investigation, diagnosis and treatment.

The Annual Reports give detailed descriptions of the NSW psychiatric hospitals, treatment, recreation and other facilities available to patients. They include admission and accommodation statistics and deal extensively with staff training, staff...

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474 NSW Parliamentary Papers, 1956-57, vol 1, session 2.
475 Ibid.
duties, building activities, food, laundry and other auxiliary services. In the 1960s they describe research programs and outline plans for the development of community mental health services.

In his 1969 Report, the Director of NSW Psychiatric services, Dr William Barclay, sounded a note of caution about the continuing care of mentally ill persons in the community. In his far-sighted commentary, he warned society of the possibility of becoming ‘unduly optimistic about its care of the mentally ill and to be deluded by the reduction of patients in mental hospitals into believing that all has been done that needs to be done’. 477

His comments came about as a result of the substantial increase in admissions to NSW psychiatric hospitals during the year 1967-68 compared with previous years, as shown in the Table below:

<table>
<thead>
<tr>
<th>Year</th>
<th>Admissions</th>
<th>Readmissions</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1964-65</td>
<td>6924</td>
<td>8765</td>
<td>15,689</td>
</tr>
<tr>
<td>1965-66</td>
<td>7582</td>
<td>9037</td>
<td>16,619</td>
</tr>
<tr>
<td>1966-67</td>
<td>7945</td>
<td>9374</td>
<td>17,319</td>
</tr>
<tr>
<td>1967-68</td>
<td>8069</td>
<td>10,225</td>
<td>18,294</td>
</tr>
</tbody>
</table>

Dr Barclay believed that this increase in admissions was partly due to the community’s awareness of the problem of mental illness, resulting in patients being admitted at earlier stages of their illness. The greater availability of psychiatric hospital beds and the pursuit of an active ‘open arms’ policy in which readmission was encouraged if there was any suggestion that the patient may relapse, could have been contributing factors for the increase. But, he called for a careful inquiry into the reasons as it would have been hoped that by then some levelling off would have been achieved as a result of the community care programs. 479

478 Ibid.
In the late sixties as the custodial approach was gradually abandoned and patients were provided with a wide range of social and therapeutic activities, they had a freedom of movement unprecedented in earlier years. But due to overcrowding patients could not effectively benefit from the new treatments or services. It was wasteful and expensive to retain patients in hospital whose need was for sheltered accommodation rather than active treatment. Approximately 800 patients were discharged each year from NSW psychiatric hospitals after a stay in hospital of more than one year. Three hundred of these patients had been in hospital for more than ten years. For four hundred of them only a very limited recovery could be expected. The majority of these patients were without family ties due to their prolonged stay in hospital. A meagre pension was their only financial support. This group of patients was accommodated in guest houses and boarding houses. The living conditions and services some of these provided left a great deal to be desired.480

Dr Barclay continues:

The reduction of the resident population of mental hospitals is only one aspect of a community mental health programme. If the care of the mentally ill is to be transferred from the institution to the community a wide variety of support services must be provided within that community. The provision of these supportive services means the employment of professionally trained staff. Approximately 75 per cent of the cost of running a psychiatric hospital goes on staff salaries. This cost will still have to be met to provide services within the community. Not only must we expect an increased expenditure to meet the growth in population of our State, but it is also reasonable to expect an increase in the quality of the service we offer to the citizens of our State. 481

Subsequent events have shown that all such warnings have been disregarded. The rapid deinstitutionalisation which followed the implementation of the Richmond Report threw NSW mental health services into disarray, a condition it has not recovered from, to date. Dr Barclay stressed the importance of decent, sheltered accommodation and

481 Ibid.
where relevant, sheltered employment, and above all, a crisis intervention system which can successfully reduce hospital admissions.\footnote{Ibid.} These were supportive services essential for mentally ill patients transferred from institutions to community care. While some measure of these services have been provided piecemeal, even at the present time there is still a great inadequacy. In the Illawarra, the Crisis Intervention Team was discontinued in the year 2002 and its duties distributed to the Northern Area and Southern Area community mental services.\footnote{Interview with Angela Mitic, Macedonian Mental Health Worker, 9 July 2003.}

The first serious reference to services for consumers of ethnic background appeared in the Director’s Report for 1969, though very briefly. He stated that a very important element in a community mental health program was the provision of readily available outpatient services within the community where people could avail themselves of early treatment. He also pointed out the changing nature of big cities such as Sydney where each locality ‘has a distinct social character and in some cases a characteristic ethnic background of its citizens. One service cannot meet all these needs and it is important that community mental health facilities be established separately in each district with programmes designed to meet the needs of the particular population of that region.’ He also emphasised that decentralization was essential in order to take the service required to those who needed it and for whom transport could be an insuperable barrier.\footnote{\textit{NSW Parliamentary Papers}, 1969-70, vol 4, session 3.} He was one of the earliest advocates of ethno-specific services.

June 1971 statistics showed a decline in admission numbers when compared to the previous year. The number of patients resident in NSW psychiatric hospitals was also in decline. The Director of Psychiatric Services attributed this to the greater availability of Nursing Home beds to accommodate those who were senile due to age. There was also a significant development in boarding houses catering specifically for discharged psychiatric patients, although there was some concern about the standard of care available in such accommodation. The Director believed that legislation should be introduced to control boarding houses, such as had already been introduced in South Australia. \footnote{\textit{NSW Parliamentary Papers}, 1971, Joint Vol, session 1.}
The Director assumed that the decline in admissions meant that community services were functioning well in some regions; mainly those served by Callan Park, Gladesville and Rydalmere hospitals. He believed that mental disorders had their origins in community, social and family problems and as such, persons afflicted needed supportive welfare services. Such services were not within the scope of mental Health services and not their responsibility. Yet, they were essential for the prevention and treatment of mental illness. He added:

It is unfortunate that the present approach to welfare in this country is largely directed towards the provision of financial assistance. As necessary as financial assistance is, for some people, it is not sufficient in itself. An adequate social welfare system depends on personal services by people to people.............a decision must be made whether this is the responsibility of the Mental Health Service, the Health Service or some other agency.  

In the 1960s community mental health services consisted of not much more than the extension of regional services. Psychiatric hospitals ran outpatient clinics in suburbs served by the main hospital. For instance, Gladesville hospital provided outpatient services at Port Kembla and Wollongong. The important element in community mental health programs was that people could avail themselves of early treatment without having to travel great distances.

Some charitable organisations, such as the St Vincent de Paul Society, interested themselves in the welfare of ex-psychiatric patients, especially those with no relatives or other support. They provided hostel accommodation for them until they developed enough confidence to cope on their own, and then moved them into shared apartments. Ex-service organisations and church organisations also took some interest in psychiatric patients. They made social contact with them by organising picnics and outings, dances and other evening recreational activities. Voluntary agencies functioned mainly on charitable donations and a slender capital grant from the government. As such, they

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486 Ibid.
found it increasingly difficult to keep up their good work and sometimes were forced to abandon projects. 488

Until the seventies, when multiculturalism became official government policy, all inpatient and community mental health services were run on a strictly monocultural basis. There was no consideration given to migrants, especially the NESB, in planning of services. In the present day, services have changed, though very slowly and not sufficiently. NGOs still play an important role in the provision of care for the mentally ill and most obtain some amount of government funding. Organisations such as Lifeline South Coast, STARTTS NSW, CRSS and the Migrant Resource Centres provide a great deal of assistance for migrants and refugees with health needs. They survive on small amounts of government funds, charitable donations and depend largely on support groups of voluntary workers.

From the mid-1960s to the present day, the pattern of migration to Australia has changed from mainly European to primarily South East and West Asian and Central and South American. 489 These migrants come from countries where there have been massive social upheavals. A majority of them have suffered severe trauma or torture leaving them physically and mentally scarred. Refugees, unlike other migrants, have been known to suffer high levels of mental disorder. 490 Moreover, migrants are disproportionately represented in the lower socio-economic groups. Social inequality leads to poor health. 491 The wellbeing of a nation is essentially linked to the health of its people. Migrants are now a permanent and established part of Australian society. Early intervention policies which recognise the specific health needs and socio economic inequalities among disadvantaged groups would help migrants to participate fully in Australian life. Some believed the changes proposed by David Richmond would bring better services for mental health patients.

489 J.Krupinski, “Changing Patterns of Migration to Australia and their Influence on the health of migrants” in Social Science and Medicine, vol 18, no 11, pp 297-298.
491 G.Bottomley and M.de Lepervanche “The Social Context of Immigrant Health and Illness” in Reid and Trompf (eds) op cit, pp 30-76.
6.3 The Richmond Report

I remember a public meeting was held in Wollongong about the Richmond report. The government made out as if it was going to be a wonderful thing. I asked ‘What about NESB patients? Where are they going to live?’ It was the worst thing that happened to NESB people.

Ruth Mataitis

The Richmond Report did nothing for NESB clients. I don’t think it did much for anyone as a result of its proposals there are so many neglected mentally ill people around. When they are in-patients or in hostels we manage them quite well. Now when I see them sleeping on benches, I don’t know if deinstitutionalisation is the ideal. I don’t know what the answer is but I don’t think closing institutions and having a unit with a few beds solves the problem.

Peter Brown

In 2001 I was admitted to the Shellharbour hospital psychiatric unit, after a nervous breakdown. It was a horrible place. As there was a shortage of beds, I was put in a ward along with drug addicts and severely disturbed patients. Here, my personal belongings (clothing) were stolen. I was punched in the face by other patients who wanted to get my cigarettes off me. I was petrified.

Anica

The inquiry and report of the Richmond committee commissioned by the New South Wales government in 1983 was a turning point in the formation of that State’s mental health policy. The Inquiry which was headed by David Richmond of the Public Service Board was commissioned by the NSW government to investigate into health services for the psychiatrically ill and developmentally disabled. The NSW government approved the major recommendations of the Report, the implementation of which
commenced in 1984. Although the government readily accepted the Richmond proposals, specialist interest groups and the general public were not so enthusiastic. The NSW Nurses Union, Health Unions and other community organisations strongly criticised the Report’s recommendations, especially the transferring of mentally ill persons into private accommodation and community-based centres. There was a loud public outcry against the Inquiry. This was expressed by both organisations and private individuals via the media.

Among the recommendations accepted by the government were the following basic proposals:

The separate organisation of services for those with psychiatric illness and those with developmental disabilities:
A shift in emphasis from institutional care to community care;
The development of community mental health services in order to reduce admissions to psychiatric hospitals and to provide good alternative services within the community.492

The Richmond Committee advocated the closure of the major parts of thirteen psychiatric hospitals and the complete closure of others. Large areas of public real estate occupied by these hospitals were to be sold and the proceeds from the sales would not necessarily go back into health expenditure. The Report stated that:

When appropriate and suitable sites are actually disposed of and the proceeds realised the issue arises whether or not the funds should be returned to the health budget. The fact that at some point in time the community, through government decision, invested some resources in capital for health services does not enshrine these resources in the health system. The resources should be realised for the best current community use.493

The ‘Defeat the Health Cuts Campaign’ of NSW, were scathing in their attack on the Report. They claimed that Mr Richmond in ‘careful senior public servant’s prose’

492 The Richmond Report, Part 1 - General proposals.
493 Ibid, p 45.
stated that it was the government’s right to do as it pleased with the money; after balancing all the other pressing needs of the community - luxury housing, hotels, or whatever, it would be wise for some of it to go back to health to smooth the whole operation. The Campaigners declared that the demolition of specialised hospitals and equipment was not only a colossal waste of government money but also a needless destruction of socially valuable infrastructure of psychiatric and mental retardation hospital services built up over the years.494

The Report recommended that a sum of approximately 9 million dollars per year be allocated for the succeeding three years to fund community based services.495 Unions estimated that this proposal together with other financial proposals would mean that 30 million dollars per year would be cut from mental health and developmentally-disabled care.496 David Brown of the Committee on Mental Health Activity (COMHA), argued that at first glance the Richmond Report looked progressive; with closer scrutiny, it appeared to be mainly a response to the State government’s fiscal crisis. ‘It’s another case of rationalisation under the cover of progressive rhetoric’.497

A truly progressive aspect of the report, however, was the separation of care for the mentally ill from that of the developmentally disabled. Hitherto, these two categories of patients as well as confused elderly persons were all placed in the same institution. Of the specific sum of 9 million dollars per year allocated in Part 1 of the Report, 5 million dollars were to be utilised for mental health services. This sum would include 1.2 million dollars per year as funding to non-government organisations for the provision of accommodation and care for the mentally ill. All mentally ill persons except acute psychiatric cases were to be found accommodation in private hostels and group homes made available from welfare housing stock.498 This was the greatest flaw in this Report which otherwise contained some sound recommendations.

The new Mental Health Bill of 1983 stated that:

494 University of Wollongong Archives, George Petersen Collection, “Defeat the Health Cuts Campaign” Fact Sheet, May 1983, no 1.
495 Richmond Report, Part 1.
496 Tribune, 1 June 1983, p 16.
497 Ibid.
...only those people who have attempted, or are likely to attempt, to kill themselves, pose a threat of serious bodily harm to themselves or to others, or whose behaviour is so intolerable as may cause a breach of the peace, are eligible for involuntary care and treatment.\textsuperscript{499}

The enactment of this Bill together with the hasty implementation of the Richmond Report would mean that there would be thousands of sick people without proper care. Mental illness manifests itself in many different ways and not all mentally ill people are dangerous; but they still need proper treatment. Fifteen years ago the U.S.A adopted a similar program and the result was that many mentally ill people found their way into prisons, on to the streets or led lives of neglect in low-class boarding houses. As the Deputy Leader of the NSW Opposition pointed out, ‘...as well as a right to freedom, there should also be a right to treatment for potentially reversible mental illness. There is very little liberty in the right to remain mentally ill’\textsuperscript{500}

The strongest criticism of the Report was regarding the haste with which the recommendations were to be implemented. According to the Richmond Plan, by 1988, the community residential program would provide residential places for 1900 patients placed in the community from Fifth Schedule hospitals. The NSW Nurses’ Union pointed out that there were some community placement programs currently operating for the psychiatrically ill where it had taken a considerable number of years for patients to be trained in living skills, in order to equip them for an independent life-style in the community. To rush patients out of hospitals into the community over a period of two and a half to three years as Richmond recommended would mean that there was insufficient time for them to develop the necessary living skills. Inadequate accommodation and support facilities ‘will result in “dumping” of a large number of patients in the community with all the resultant social problems for themselves and the community in which they live’\textsuperscript{501}

\textsuperscript{498} Richmond Report, Part 3.
\textsuperscript{499} Mental Health Bill, 1983, Clause 5, cited in Sydney Morning Herald, 16 May 1983.
\textsuperscript{500} R.Foot “The Right to be Mentally Ill”, in Sydney Morning Herald, 16 May 1983.
\textsuperscript{501} NSW Nurses’ Association Critique of the Richmond Enquiry Report, 1983, pp 1-2, University of Wollongong Archives.
The NSW Nurses’ Association went further to say that privatisation of care for the mentally ill was unsatisfactory as private sector services were run for profit. Such motives did not maintain acceptable standards of patient care, whereas publicly owned and government run institutions and services set standards of excellence, provide educational facilities and most importantly, are open to public scrutiny and accountability. Indeed, persons who have lived for many years in institutions will need a high level of retraining in everyday living skills before they can pursue a community life-style. Some may have lived so long in institutions that they may not be able to learn to live in the community at all. Private boarding houses or hostels were not appropriate accommodation for such people.

Most people accepted the basic philosophy behind the Richmond proposals, that accommodation for the mentally ill should be ‘humane and homelike’. Whether private boardings, poorly funded with untrained staff, would fulfil these requirements was a different question. Dearth of welfare housing was a real problem. The main obstacle was the rapidity with which deinstitutionalisation was to take place without the necessary preparation for such a scheme. Dr Michael Ryan writes;

..there are vast numbers of people on waiting lists for these “terrible institutions” who would accept a bed tomorrow if it was made available. These people will be doubly disadvantaged by the Richmond Report as they will have to wait until the savings occur, if ever they occur, before beds are made available to them. We should insist that the report be not operated on until all those people on waiting lists throughout the state are adequately accommodated (sic) and not vice versa as proposed by Richmond.

Bad as they were for non-immigrants, the implications of the Richmond Report were worse for mentally ill migrants. Legge writes that ‘The Richmond Report appears to assume a monocultural community. Nowhere in the Report does ethnicity feature, either in recommendations about accommodation nor (sic) about criteria for staff selection,

education or allocation.\textsuperscript{504} In fact, the Report did make one reference to migrants and that was in response to representations put forward by the Ethnic Affairs Commission of NSW.\textsuperscript{505} But the ethnicity of patients was not taken into consideration when dealing with the problem of accommodation.

In 1989 Mandicos examined residential facilities established on the recommendations of the Richmond Report. She found that hostels and self-care units in the Illawarra region had a low participation rate by migrants of ethnic background. This was because these places did not address the needs of such persons. Her view is that there should be staff with a greater awareness of cultural differences to allow for residents of ethnic background to communicate in their mother tongue. Also, activities should be appropriate to the various groups. She found that activities available were in a monolingual form which isolated residents of ethnic background within the facility. Unless these issues were addressed, families would be forced into a position of having to care for their ailing members regardless of their ability to do so.\textsuperscript{506}

In Strazzari’s study of the Richmond Report she examined the relevance of the proposals for Polish migrants in the Hunter region of NSW. Poles comprised the largest migrant group in the Hunter and were also over represented among migrant patients in the Hunter region psychiatric hospitals. An analysis of patient files revealed that a large percentage of Polish migrants admitted to psychiatric hospitals were unlikely to have supportive networks in the community. This was because of age, imbalance of sexes, lack of extended family and geographic dispersion.\textsuperscript{507}

Results of this study showed that a majority of Polish migrants encountered communication problems because they were non-English speaking. Only 40% of the psychiatric admissions were married. These two factors alone could lead to social

\begin{footnotes}
\footnotetext{503}{Dr M.Ryan, Regional Advisor in Developmental Disabilities, Wollongong, in a letter to the Federal MP for Illawarra, June 1983, G.Petersen Collection, University of Wollongong Archives.}
\footnotetext{504}{V.Legge, Lecturer in Sociology \textit{Accommodation Needs for Aged Australians from Non-English Speaking Countries}, Cumberland College of Health Sciences, (undated document), University of Wollongong Archives}
\footnotetext{505}{The Richmond Report, 1983, part 3, pp 3-6.}
\footnotetext{506}{C.Mandicos, Community Worker for the Ethnic Aged \textit{Accommodation Issues}, Illawarra Ethnic Council, 1989, University of Wollongong Archives.}
\end{footnotes}
isolation. 31% lived with family, 16% lived alone, 20% lived in hostels and 11% at no fixed abode. The remainder were unaccounted for. With such living arrangements it is obvious that this migrant group was sadly lacking in supportive networks. This group of patients stood to gain nothing from the Richmond recommendations and these circumstances were possibly not uncommon among other ethnic groups.

This study shows once again the need for appropriate accommodation for mentally ill migrants. The author recommends the establishment of group homes where patients can converse with others from a common linguistic and cultural background. These are not requirements which can be fulfilled overnight. Nevertheless, they are important requirements if community care is to be meaningful for non-English speaking migrants. The fact that the Richmond Committee ignored this aspect of community care shows that it was neglectful of the needs of NESB migrants in the NSW population. The effectiveness of welfare services in a multicultural society depends on the sensitivity with which they are dealt out to all members of the community. As Strazzari states, if the reality is to match the rhetoric, ‘...much has to be done to make appropriate community based services accessible to discharged psychiatric patients before Richmond’s recommendations can be implemented successfully’. Otherwise, community care would become synonymous with neglect.

The Richmond Report recognised that the quality of life of the psychiatrically disabled would be enhanced by the movement of these persons from institutions into the community. But it becomes clear that the Commission had not made sufficient evaluative studies before deciding on its proposals. The specific needs of minority communities need to be determined and identified prior to planning. The NSW Nurses’ Association pointed out that the finance allotted for group homes and hostels was unrealistic and would not allow for the achievement of the objectives of the Report. There was a lack of available and appropriate staff. When patients who have been institutionalised for long periods are suddenly placed in the community, the disruption to their pattern of life would not be in their best interests. No clear mechanism of

508 Ibid.
509 Ibid, p 27.
community consultation and involvement had been suggested which would result in the mentally disabled being in the community but not of the community. Also, the closure of hospitals and the ensuing loss of jobs by trained staff would mean that the community would lose the services of skilled professionals.\textsuperscript{510}

R. Jackson, NSW Minister for Corrective Services and Roads, writes in a letter regarding the closure of hospitals:

\begin{quote}
I have already strongly protested against the Richmond recommendations in general and in particular the proposals in regard to Garrawarra hospital....... I might also advise you that the Richmond Committee visited Garrawarra on one occasion for less than three hours and besides inspecting the wards, interviewed very few people.\textsuperscript{511}
\end{quote}

The members of the Interagency Meetings on Homelessness, in a submission to the Committee stated, among other things:

\begin{quote}
The number of mentally disabled persons in the community had increased in the last ten years. They already lacked accommodation and care and wandered the streets of Sydney in absolute poverty. The few services they did have were inadequate and were provided by untrained, insufficient and unsupervised staff. Community health centres were run down, morale within these services was low. Factors that contributed to this situation were the increased cost of inner city accommodation and the impossibility of obtaining and maintaining low cost housing. Until appropriate long term accommodation is provided, voluntary admission to psychiatric hospitals should be made easier. Long term institutionalisation is not desirable but it at least provided the
\end{quote}

\textsuperscript{510} Letter from Jenny Haines, General Secretary, NSW Nurses’ Association to G. Petersen, MP for Illawarra, 18 April 1983, Geo Petersen Collection, University of Wollongong Archives.
mentally disabled with the basic rights of food, clothing and shelter for which most of them now have to depend on charity.\textsuperscript{512}

It is evident that the NSW government, in implementing the Richmond proposals had not paid much attention to public opinion. While there were many benefits in the Richmond proposals, some needed modification. A number of mentally ill persons would benefit from community living while an equal number, or more, would become homeless. It had happened before, in England, in Italy and in the United States of America. In the sixties de-institutionalisation of psychiatric patients in New York resulted in a 70\% drop in hospitalised patient numbers. But the State government’s failure to commit adequate funds for community services increased the number of deranged, homeless persons wandering the city.\textsuperscript{513}

Not all discharged psychiatric patients were fortunate enough to obtain community support. The Richmond Inquiry’s recommendations were based on the model of a community which enjoys residential stability and therefore has supportive networks composed of extended families and friends. For many ex-patients, especially for recently arrived migrants, this is not so. Some have no family and not much contact with neighbours, probably due to language and cultural differences, and hence have not developed support networks. Government health and welfare services are non-existent for such people -. they have little or no knowledge of the services they are entitled to. There is a danger that such persons are likely to be more isolated and exploited in a hostel or boarding house than in a hospital setting.

It may be the Richmond Committee had good intentions when they recommended group homes, 24 hour crisis teams and “Living Skills” centres but as the National Times pointed out:

What guarantee is there that funding will continue for the houses and hostels, the crisis teams and living centres once the patients are out on the streets? Look

\textsuperscript{511} Ibid Letter from R.Jackson to G.Petersen, 6 June 1983.
\textsuperscript{512} Submission prepared by Members of the Interagency Meetings on Homelessness, 1983, G.Petersen Collection, University of Wollongong Archives.
\textsuperscript{513} Weekend Australian, 2 April 1983.
what happened to community health centres. They started with a fanfare under the Whitlam government and gradually the Commonwealth withdrew all funding so that the centres now operate with reduced staff and services, including psychological services. Psychiatric hospitals may be under-financed and run-down but at least they provide shelter and asylum.514

Dr Lennane, president of the Public Medical Officers’ Association, had no faith in the NSW government’s motives. She claimed that she was told ‘...long before the Richmond Inquiry was set up that the State government wanted to sell two psychiatric hospitals (Macquarie and Rydalmere) and get its hands on the land. ...It is a completely cynical political exercise’.515 Indeed, many factors seem to support this assumption. Moving patients into the community would attract Commonwealth funds currently denied to State psychiatric hospitals. The use of welfare housing from the Commonwealth funded Housing Commission stock also meant a cut in State government expenditure. At the same time it aggravated problems for workers who had been for years on long waiting lists in order to obtain welfare housing. 516

If the Richmond Committee made a deeper deliberation of the commission in hand perhaps their proposals would have been rather different. Richmond’s supporters claim that his critics are wise with hindsight. But many factors point otherwise. In 1983 there were hundreds of mentally ill persons already in the community, some of them homeless. Nothing was done to improve their quality of life. They had no claim to the accommodation provided by the Richmond scheme. The proposed accommodation was confined to those persons who were being de-institutionalised. This gives rise to the important question why these people deserve lesser care than those turned out of institutions as a result of the Richmond Report.

This Report had far reaching implications for a large number of psychiatrically ill persons. Cuts in public care encouraged greater use of private services which many could not afford, especially mentally ill migrants. Their needs, which were generally

515 Ibid.
poorly met by existing services, gained nothing from the Richmond scheme. If the Richmond Committee made a deeper investigation of the needs of the population to be served, perhaps they would have had a better understanding of the migrant’s predicament. As we will see in the following chapters, changes in the way health was organised in NSW and the promise of improvements though the Richmond Report brought mixed results to migrant patients.
PART III

ILLAWARRA AND THE SVETLANAS IN SLINGBACKS
Chapter 7

History of Migration to Wollongong.

We are from northern Italy. In 1961 we came to Australia. Before we migrated we went for an interview with Australian officials but they did not give us enough information. We did not understand their language and they did not understand our’s. There was a lack of communication with the migrants. We were put up in a hostel in Fairymeadow. It was poor accommodation. We started building our own house because we had brought a little money with us. But other migrants were not so lucky.

The Good Neighbour Council told migrants that they must learn English and become like Australians but it is hard to learn a new language when you have a family to look after and not enough money.

Efrim & Giulia Bonacina

The government provided jobs but in other ways did not look after migrant welfare. In 1949 my father came by himself and was sent to work clearing forests in Queensland. We, the rest of the family, came some months later and were put up at Bonegila hostel for six weeks and given 5 shillings each and that was it.

Ruth Mataitis

I came to Australia in 1971 with my husband and three year old son. We knew nobody here and we had no knowledge of English. We were sent to a hostel in Fairymeadow for six months. I felt very lonely without family or friends. It was an emotionally negative time for me.

Nada

Australia’s post-World War Two immigration policy was based on the need for an increased population for reasons of defence as well as for the fullest expansion of the economy. The Labor government introduced a program which designed to increase the
Australian population by one percent per annum. The aim was mass immigration from Britain in order to preserve Australia’s Anglo-Celtic culture, but when this failed the government admitted a steady flow of migrants from eastern and southern Europe including thousands of refugees and displaced persons from IRO camps. A large number of these migrants settled in and around Wollongong, changing the face of that region for ever.

The backbone of Wollongong’s economy has always been coal mining and the steel industry; these have had the greatest impact on settlement patterns. After World War Two there was a dynamic growth in these industries resulting in a corresponding expansion in population and housing. The high demand for labour could not be met by internal immigration. Wages and working conditions in the steel industry were poor and unattractive to the local labour force. The solution was to seek overseas workers. The national immigration program proved to be the answer.

The Broken Hill Proprietary Company (BHP) which owned the iron and steel plant at Port Kembla, faced with a labour shortage, recruited directly from migrant camps. It gave preference to single men who could be housed in hostels, rather than families which would worsen the housing shortage. The government, recognising the importance of the coal and steel industries for the expansion of manufacturing, directed displaced persons to the region. The Federated Ironworkers’ Association at first resisted migrant labour, fearful of its effects on the Australian workforce. The union later relented and in 1949 agreed to the employment of displaced persons, on condition that they would join the union compulsorily and would not replace those Australians already employed. BHP was eager to employ displaced persons because they were bound by a two year job contract.

Migrant workers were willing to occupy the unattractive and underpaid positions which Australian workers spurned. By 1952 the Port Kembla steel works employed 1,700 NESB migrants; they made up almost 50% of those employed in the dirty and

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dangerous jobs attached to coke ovens, open hearth and blast furnaces and foundries. By 1966, the number had risen to 60%.\textsuperscript{520} By the end of the fifties the supply of displaced persons was exhausted and the steel industry turned to unskilled workers from southern Europe. The focus then shifted to the Yugoslav republics and the Mediterranean countries.

In an interview with Peter Hilton, a former BHP executive, and member of the Good Neighbour Council, he recalled:

\begin{quote}
In the late 50s and 60s BHP recruited literally thousands of migrants for work in the steel works. I remember when the first Spaniards, the first Italians and the Polish came. Soon there were at least seventy different nationalities. On arrival they were sent to Bonegilla migrant camp near Albury. I went there frequently and recruited migrants for BHP. Once employed they were given hostel accommodation in Wollongong, initially for six months, but an extension was sometimes considered.\textsuperscript{521}
\end{quote}

By 1981, there were 37,039 NESB people in the Illawarra statistical division. 28,176 of this number were in the Wollongong local government area. This amounted to 16.6% of the Wollongong population.\textsuperscript{522} The Yugoslavs, particularly the Macedonians, formed the largest migrant group. The 1986 census showed a total of 6,959 Yugoslav-born people in Wollongong city alone. The next in number were the Italians, at 5,300, followed by the Greek, German, Dutch, Spanish and Latin American communities. In the seventies there was a flow of migrants from Lebanon and Turkey, victims of war and poor economic conditions.\textsuperscript{523} In the late seventies, with the ending of the White Australia policy, there was an inflow of Indo Chinese refugees.

\begin{footnotes}
\item Hagan and Wells (eds), \textit{op cit}, p 209.
\item Interview with Peter Hilton, former BHP Executive on 8 June 2001.
\end{footnotes}
In 1981, the steel industry which had shaped the pattern of immigration to Wollongong, went into economic recession and started cutting down its workforce. This slowed down the flow of unskilled immigrants to the region. Nevertheless, in 1981, the overseas born still comprised 28% of the city’s population and a further 23% had at least one parent born overseas, proportions higher than any of the ten largest urban areas in Australia, excepting Perth. In 1986, even after severe restructuring, out of a total of 12,170 workers at BHP, 5,670 were migrants - almost half the workforce. In the late eighties and the nineties there were migrants from India, China, Philippines, Indonesia, Malaysia and the Pacific Islands. Some of these migrants were different from those of the earlier era in that they were educated and qualified to work as academics, or in tourism and in other growth industries.

Migrants tended to settle in close proximity to their work places. BHP provided hostel accommodation for its migrant workers at Port Kembla. While British migrants were accommodated with their families, European male workers were separated from their dependants who were confined to holding centres at Scheyville and Bathurst. Hostels were also established in Unanderra, Berkeley and Fairymeadow. Many migrants found temporary accommodation in hostels unsatisfactory, and in the mid sixties, the rate of migrant departures became a matter of concern to the government. Soon the government realised that the quality of accommodation had to improve in order to attract and retain migrants.

According to the founders of the Italian Social Welfare Organisation, Ephraim and Guilia Bonacina, who migrated to Wollongong in 1961, hostel accommodation was deplorable. They state:

> We were in Bonegilla hostel for 45 days. It was very poor accommodation. There were no cooking facilities and we had to eat food prepared by hostel staff which is very hard to do in a strange country. There were common

526 Hagan and Wells (eds) op cit, p 210.
528 Illawarra Mercury, 12 October 1966.
showers. When Ephraim got a job with BHP, the family was sent to Scheyville for 2 weeks and then on to Fairymeadow hostel. After another 11 months of hard life in the hostel we started building our own house. We could do this as we had brought a little money with us. Those migrants who had no money had to put up with unsatisfactory accommodation and they suffered a lot.529

Housing became a major problem for Wollongong due to the increased population. In the sixties the NSW Housing Commision commenced the building of multi-storey flats in areas close to the steel works. Large areas of public housing were created to accommodate migrants. During the sixties new house building exceeded the expected level by about 30 percent. A boom in the construction of flats and home units carried through to 1973 causing an upsurge in the housing market.530 New suburbs were developed in Berkeley, Unanderra, Cringila and further south, in Warilla. Cringila being closest to the steel works had low cost housing which attracted migrants. According to the 1971 Census 68% of Cringila’s population comprised migrants, mainly of NESB.531 It was common for migrants from the same country to be concentrated in one area. In the Illawarra, almost half of the Yugoslav born live in Cringila, Warrawong, Port Kembla and Lake Heights. In Cringila the proportion of Yugoslav born to others is two to one.532

The Italian community tended to cluster around the northern lakeside suburbs and Port Kembla; also, in north Corrimal, Tarrawanna, Balgownie and Fairymeadow. As their economic status improved they moved to other suburbs of Wollongong such as Figtree and West Wollongong. In the 50s and 60s, Greeks settled mainly in Cringila but in later years a majority of them moved south to residential areas in Warilla and Barrack Heights. The Germans and Dutch tended to settle in areas removed from other NESB migrants, in Oak Flats, Albion Park Rail and Shellharbour. Dutch communities were also concentrated in the northern suburbs from Corrimal to Bulli. The Indochinese migrants who arrived in the seventies and early eighties were socially and economically

529 Interview with Efrim and Giulia Bonacina, 12 April 2001.
530 R.Cardew op cit, p 103.
531 Hagan and Wells op cit, p 211.
disadvantaged and dependent on government assistance. They tended to settle in tightly
knit groups, most of them in Fairymeadow, near the old migrant hostel. 533

The Vietnamese are one of the more recent migrant communities to settle in Wollongong. Their numbers are small in comparison to such groups as the Yugoslavs, Italians or Greeks. With their reputation for enterprise and resourcefulness some Vietnamese migrants soon involved themselves in commerce, maintaining restaurants, bakeries and grocery shops. Yet, a large number of them are disadvantaged due to their refugee status and linguistic disability and even in 1991, suffered a higher level of unemployment and impoverishment than did other ethnic groups in the region. 534

Early migrants suffered hardship due to lack of government support. There were no health and welfare services for them and living conditions were sub-standard. Worth quoting at length, Ruth Mataitis, former member of the NSW Premier’s Advisory Council and the IECC, one of the earliest migrants to Wollongong, says:

The government provided jobs but in other ways did not look after migrant welfare. In 1949 my father came by himself and was sent to work clearing forests in Queensland. The rest of the family came a few months later, were put up at Bonegilla hostel for 6 weeks, given 5 shillings each and that was it. One morning we were put on a train to Sydney and from there on another to Brisbane. I think all this was done by Immigration officers but we understood nothing because of the language problem and there was no one to help us. We had no food or drink all day and no money. I was very sick with measles at the time.
After one night in a Brisbane hotel where we were given a meal, we were put on yet another train in the morning and sent to a country station - we did not know why or where. After spending half a day at that railway station with no food and only tap water to drink, we were ordered into a truck, by an unknown man whom we looked upon with fear and distrust, and driven into the bush. It turned out that he was taking us to our father’s work site but we were

not to know it. We lived there for one year in a tent.

This is my story - I am sure there are many more like this. Some people were kind. Others were business-like, just sent us on our way with no kind word or attempt to explain. It was indeed very stressful. 535

Some migrants interviewed believed that the Australian government did not supply them with sufficient information before they migrated. As a result they did not know what to expect in the new country or had wrong expectations. There was a lack of communication with the migrants. Once in Australia they were largely left to their own devices. Hilton says that for most migrants a house of their own was a priority. Migrant men often worked at a second job at night while their wives worked long hours as cleaners in order to raise money for a deposit or to get a bank loan to purchase a dwelling. He says ‘The government did not help them. They were not given loans. It was a case of the migrants helping themselves rather than the government helping them. There were some migrants already settled in the area since the 30s. They lent money, gave accommodation and helped the new migrants in many ways. It was not the government that helped them’. 536

Bonacina voices the same opinion. She says some migrants built one room and the family lived in it. Many migrant women worked all day and would then go home and do the housework so they had no time or energy to attend English classes. She says: ‘Rents were very high. When we made an application to the Housing Commission we had to be in a two year waiting list. Everything was in English which made it more difficult. There were no interpreters and the migrants understood nothing’. She maintains that in the 60s Australia had unrealistic expectations of migrants. The tendency was to blame the migrants themselves for all the difficulties they suffered. 537

She adds: ‘They resented us saying we were taking their jobs. But we were not. We were doing the most menial work which they themselves would not do. Teachers were ignorant about migrants and their background so they humiliated migrant children. My

535 Interview with Ruth Mataitis, former member of NSW Premier’s Advisory Council and Life Member of Illawarra Ethnic Council, 14 September 2001.
536 P.Hilton Interview, 8 June 2001.
537 Efrim and Giulia Bonacina Interview, 12 April 2001.
son was caned for not knowing to play cricket. In Italy we had never heard of cricket. Not just teachers, everyone was ignorant about migrants. Italians and Germans were particularly resented as we were seen as the enemy of the British. South Italians were suspected of having Mafia connections! Those who could not speak English got second class treatment in hospital. Now things are much better. Peoples’ attitudes to migrants have changed much - for the better.538

In the post-war years Wollongong changed rapidly. This was mainly due to the expansion of the steel industry and the role BHP played in immigration. Migrant volunteers and the Good Neighbour Council worked for the improvement of the migrants’ lot. This work was carried on by migrant groups who formed their own societies and worked diligently for the betterment of their communities. Most migrants and migrant workers interviewed thought the Wollongong City Council was largely indifferent about migrant issues except for one Lord Mayor, Frank Arkell, who took an active interest in migrant affairs.

538 Ibid.
Chapter 8

Illawarra – Migrants and Mental Health Services, 1960-1990

8.1 Mental Health Services in the Illawarra, 1960 - 1990

My illness began in 1975. It took 22 years for me to get the correct treatment. All those years I did not even know that a mental health service existed. All those years I was not referred to the appropriate services by either the GPs or the hospitals. I suffered pointlessly for so long and my family suffered too. I was sent from one place to another; I never arrived at the correct point until the Macedonian mental health worker stepped in. Something must have been very wrong the way services were run.

Nada

From the 1960s to the 1980s, mental health did not attract much attention. There were no specific mental health services for NESB migrants. In the 1970s and 1980s there was one mental health policy for mentally ill people in NSW. There were no concessions for language, culture or country of birth or origin. The Health Department assumed each patient was the same. In this period, mental health and migrant health services were not priorities for Australian governments and as a result, NESB communities were greatly disadvantaged.\(^{539}\) The Illawarra was the most under-funded and under-serviced health region in the State at this time, and in the view of many health professionals, this situation continues at the time of writing. Interviews carried out by me trace the history and development of mental health services in the Illawarra and emphasise the neglect suffered by NESB communities in particular.

Early immigrants to the Illawarra such as Mataitis and Bonacina who acted as voluntary interpreters in the 60s and 70s encountered many NESB migrants who suffered mental disorders in silence as there was no help for them unless they were severely ill, in which case they would be admitted to a psychiatric hospital. Many migrant women suffered

\(^{539}\) Interview with Dr G.Mitchell, former Director of Migrant Health, Illawarra, 4 April 2000.
minor disorders as a result of isolation and loneliness, conditions which could be helped with counselling or other means but they did not qualify for help. In Mataitis’ opinion, to be considered for treatment one had to be visibly mentally ill. Only those who behaved obviously strangely got any help.540

Mataitis related the story of a NESB migrant woman who kept awake all night doing needlework for fear of dreaming of the concentration camp where she had survived. During the day, she worked and cat-napped. She was ruining her health but Mataitis was unable to get any kind of help for her as she was not ‘really, mentally ill’. Eventually, this woman’s health deteriorated so badly that she ended her days in the Gladesville mental hospital in Parramatta.541

Mataitis knew another NESB migrant woman whose doctor prescribed Valium for her mental problem and was dismissed from her cleaning job at BHP Steel when her employer found out about it. She was not seriously ill as she was still holding a job but because of the language problem, the easiest way out for the doctor was to prescribe a tranquiliser. She was thoroughly confused that she was so severely punished for carrying out the doctor’s orders.542 Both Mataitis and Bonacina spoke of the difficulty and hopelessness of trying to help mentally ill migrants without qualified interpreters. Communication problems always aggravated the patient’s illness.

Dr Pat Mowbray, former Director of Community Health Services in the Illawarra, recalled that in the 60s there were no psychiatric beds in Wollongong hospital. Psychiatric patients seen at the Casualty department were given direct admission to Sydney hospitals, usually, to Gladesville. Wollongong hospital had no psychiatrist and all psychiatric cases were handled by the Medical Superintendent. It was only in the early 70s that Wollongong hospital was allotted funds for a psychiatric ward, which was duly opened in 1972. This, Ward 20, was the first proper psychiatric service in Wollongong. Yet, there was no real provision for NESB patients as there were no interpreters.543

541 Ibid.
542 Ibid.
543 Interview with Dr P.Mowbray, 11 October 2001.
Peter Brown and Sue Lampe, who worked as psychiatric nurses in Ward 20 in the 70s said that there were no specific policies in relation to NESB patients. There were no interpreters so the staff managed the patients to the best of their ability. Sue Karpik, who was also a nurse attached to Ward 20 in the 70s confirmed this, ‘I have no memory of any special services in mental health or even general health for NESB people at that time. We got no education regarding NESB issues. There was no interpreter service and I don’t think we met the basic needs of NESB patients’.

In the 80s the NSW health service changed from a Health Commission to a department with Area Health Service Boards. There was a Director of Migrant Health in Sydney and Migrant Health Advisors in each Area, including the Illawarra. Dr. Glenn Mitchell who formerly held this position in the Illawarra, believes that mental health services for migrants was not a high priority at the monthly meetings of the NSW Migrant Health Advisors. He said:

> It was seldom discussed........our main concern was the admission of migrants to public hospitals; we were concerned about translations, the introduction of interpreter services and community development programs through ethnic health workers, i.e., involving migrant health workers in community and hospital based health matters. We did talk about mental health but the major thrust was the above.

Glenis Lloyd, former Director of Migrant Health, NSW, confirmed this view when she said that in the 80s the mental health of migrants did not get much attention except ‘acute’ cases which had to be admitted to hospital. In migrant health the focus was on hospital admission services, access to interpreters and making existing services accessible for migrants. She added, ‘In those days there were not many existing mental

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544 Interview with P.Brown, Co-ordinator, Community Mental Health Services, Illawarra, 10 December 2001.
545 Interview with S.Lampe, Quality Co-ordinator, Mental Health Service, IAHS, 3 December 2001.
546 Interview with S.Karpik, Nursing Manager, Psychiatric Unit, Shellharbour Hospital, 21 December 2001.
546 Interview with Dr G.Mitchell, 4 April 2000 and 11 April 2000.
health policies anyway - for migrants or for anyone. The EAC and individuals like the then Director of Migrant Health, Illawarra, saw quite clearly the way in which migrant health could be advanced but the Health Department did not always accept their policy direction. There was a lot of political rhetoric around at that time which did not always translate into clear policy'.

Mitchell, said of mental health services in the 70s and 80s:

If their first language was English they got reasonably good care. All services were for them. Mentally ill NESB migrants were very badly off. It was a monolingual, mono-cultural system of mental health care which would occasionally link itself with a NESB worker; sometimes, not always. Until the 90s there was nothing (for NESB communities). In 1993 a Transcultural Mental health centre was established in Sydney. Illawarra has no such facility and has to refer patients to Sydney.

The Illawarra with its high proportion of migrants had a significant number of mentally ill NESB people in the community. Dealing with these patients became an enormous problem. Migrant Health Advisors could not do much as the system was geared to English speaking people; but they tried to sensitize the system to make it more flexible in accommodating NESB patients. The Illawarra became the first Area Health Service to hire a bilingual mental health worker.

This mental health worker of Macedonian background, appointed in 1987, remains to date the only ethnic mental health worker in the region. She said:

In 1987 the Macedonian Welfare Association lobbied the NSW government for an ethnic mental health worker. The Macedonian community, to the present day has the highest incidence of mental illness in the region. I had no previous training in mental health work. I was trained on the job; six months intensive training in the psychiatric field and completion of counselling courses at Level I

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547 Interview with Glenis Lloyd, 23 September 1999.
548 Interview with Dr G. Mitchell, 4 April 2000 and 11 April 2000.
and Level 2, at Illawarra TAFE. I also undertook self-education with the help of books and video tapes. I interviewed families and friends of the mentally ill in order to obtain a greater understanding of mental illness and the problems it creates for the sufferers. ⁵⁵⁰

This is an example of what the government can do for ethnic communities at very little cost to the tax payer but of great benefit to the mentally ill in ethnic communities. Mitic regrets that other ethnic communities in the Illawarra have no specific mental health workers. There are general health workers who sometimes work with the mentally ill but it is not the same as having a full time mental health worker who can communicate with patients in their own language. ⁵⁵¹ The fact that this worker has held this position for over 14 years and has been of immense help to the mentally ill persons in the Macedonian community shows the benefit of appointing such ethnic workers to ease the dearth of bilingual psychiatric professionals.

Mitic provides both individual and group support for her clients and their families. She provides education for families of the mentally ill so that they may have a better understanding of the problem. She establishes better links between clients and psychiatric services and other government departments such as housing. She liaisons between clients and Social Security, Centrelink and other government agencies. Most of her clients do not speak English. Even if they do, they lack confidence due to cultural barriers. Mitic has established a living skills program for the mentally ill persons in the Macedonian community which has been successfully run for the past 12 years. Above all, she keeps a watchful eye over those who need help and assists them by counselling or referring them to the appropriate professionals. This goes a long way in preventing hospital admissions ⁵⁵²

In a situation where there is an urgent need for more bilingual professionals, the appointment of ethnic mental health workers would not only benefit patients but would be a cost cutting measure. In 1984 after the Richmond recommendations were

⁵⁴⁹ Interview with Mitchell op cit.
⁵⁵⁰ Interview with Angela Mitic, Ethnic Mental Health Worker, 25 May 2000.
⁵⁵¹ Ibid.
⁵⁵² Ibid.
implemented there were large numbers of neglected former mental patients in the community. In Mitchell’s opinion:

The Richmond Report was a backward step. There were no back up services for patients in the community. The patients became worse. Any services set up were for English speaking patients. There were none for NESB patients. Previously, patients received in-house care while in hospital. Most patients lost this when they were turned out, especially migrants. After long years in institutions they had lost living skills and could not live in the community without proper care; they needed retraining in living skills.\(^{553}\)

It is in the above circumstances that ethnic mental health workers can be most useful. They can provide a reasonable level of care so that the patient does not deteriorate to such a condition as to need the services of a mental health Crisis Team or hospital admission. If admissions cannot be prevented, at least, they can be reduced, thus reducing expenditure and needless trauma to everybody concerned. To put it in Mitic’s own words:

I can’t speak for other communities but I think the Macedonians are well looked after......most of my clients have families and I look after those who have no one. It needs a lot of time to work with patients without families. As a result of work done by people like me the number of admissions can be reduced.\(^{554}\)

For many decades the IECC has emphasised the need for better migrant health services for the Illawarra. It has claimed that Wollongong has suffered discrimination with regard to such services when compared to Sydney. By the nineties services had improved but only marginally. A Transcultural Mental Health Centre (TMHC) was established in Sydney in 1993 but no similar provision was made for Wollongong. The Sydney TMHC provides services for Illawarra patients but these are inadequate. There is still a shortage of bilingual psychiatric professionals. For instance, there is no Macedonian speaking psychiatrist in Wollongong or Sydney although Macedonians

\(^{553}\) Interview with Mitchell \textit{op cit.}
\(^{554}\) Interview with Mitic \textit{op cit.}
would comprise one of the largest ethnic groups in the region. The Sydney TMHC employs a Macedonian psychiatric nurse and counsellors. Wollongong has no Macedonian counsellor, hence, the Sydney professionals come down to Wollongong to provide services for patients resident in Wollongong. Each patient is provided with three sessions which is helpful but not adequate as there is no long term follow up. Most patients need more than three sessions if they are to benefit. Psychiatric patients often have neither the means nor the motivation to go to Sydney for further treatment.555

Mitic stated unequivocally that Wollongong needed the services of a Macedonian speaking psychiatrist or at least, a counsellor - one cannot perform intensive psychotherapy through an interpreter. She added:

The government is not unaware. The government knows - it should know. I have made it clear about this need and I am sure other ethnic communities have done likewise. The government can advertise in Macedonia and obtain professionals.....it is partly a question of money and partly, indifference.556

Mitchell summed it up as follows:

Government apathy and lethargy can kill initiatives in a health system far more than deliberate obstruction. It was more the system’s unwillingness to change rather than restrictions that hindered progress. The problem with mental health services, then and now, is that it is largely a system set up by English speaking people for English speaking people. A system set up for a majority cannot successfully deal with a minority. That is the problem facing NESB people.557

555 Ibid.
556 Ibid.
557 Interview with Mitchell op cit.
8.2 Mental Health Services in the Illawarra - Changes in the 1980s.

In the early eighties migrant health services received a boost in the form of large sums of money from the Federal government. This funding was the result of the Galbally Report recommendations. It was the beginning of the recruitment of Health Care Interpreters and migrant health workers.

Glenn Mitchell

In the early 1980s there was this concept of multicultural health. I think it was in 1982 that a position was created in the Health Department for a co-ordinator of Migrant Health. A historian, Dr Glenn Mitchell, was first appointed to fill that position. He did a great deal locally to put the needs and aspirations of NESB communities on the health agenda.

Sue Lampe

In the 1980s mental health services in NSW changed and mainstream services improved. The Richmond Inquiry of 1983 and the implementation of its proposals were partly responsible for the change. The EAC emphasised the need for mainstream services to be reorganised to suit the needs of NESB clientele. These changes brought about some improvement in mental health services in NSW but the end result was that disadvantages outnumbered benefits for the mentally ill. The Illawarra, with its large proportion of NESB communities, benefited to the extent that it now could obtain some assistance from the newly established Health Care interpreter service. But community mental health services were still inadequate and mentally ill people suffered neglect. Those from non-English speaking groups were doubly disadvantaged.

Throughout the eighties there was discussion as to what should be done about mental patients in asylums. This led to the Richmond Inquiry of 1983, and the implementation of its proposals. While it was widely accepted that the Richmond Committee’s policy of

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558 Interview with G.Lloyd, former Director of Migrant Health, NSW, 23 September 1999.
deinstitutionalisation of the mentally ill was sound, the general opinion was that the implementation of the policy was hasty and flawed and the allocation of funds for the project was grossly inadequate. Caring for the mentally ill in the community became a serious problem due to insufficient resources. Some neglected sufferers were cared for by charitable organisations while many more became homeless and destitute.⁵⁶⁰

During the eighties mental health services in the Illawarra, for the first time, took into account the presence of NESB communities. This was, to a great extent, due to the following reasons. The newly appointed Director of Migrant Health for the Illawarra region had a good understanding of migrants’ needs and did a great deal to put the aspirations of NESB communities on the health agenda. He developed migrant health policies to change health services for the better. He organised education for general and mental health carers regarding NESB issues and emphasised the use of interpreter services.⁵⁶¹ His most valuable contribution was the establishment of a Multicultural Health Team based in Wollongong, to provide community education and train health professionals. This prompted awareness of diversity in society and made the health system more responsive to the needs of NESB communities.⁵⁶²

NGOs and leaders of ethnic groups also played their part in lobbying for services. The IMRC and the IECC, with the help of the EAC, made representations on behalf of ethnic communities which influenced the development of policies favourable for migrants. In the mid-80s, due to the efforts of the EAC, the Health Department established an Ethnic Health Access Committee which comprised representatives from the EAC, the community and other government departments. The aim was to improve the delivery of health services to the community.⁵⁶³ Along with this came the expansion of the health Care Interpreter service and the translation of information pamphlets into other languages for the benefit of ethnic groups.

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⁵⁵⁹ Interview with G.Mitchell, former Director of Migrant Health, Illawarra, 4 April 2000 and 11 April 2000.
⁵⁶⁰ Ibid.
⁵⁶² Interview with F.Facci, Co-ordinator, Migrant Health Services, Illawarra, 28 February 2001.
The foregoing were changes for the better but the implementation of the Richmond proposals caused radical changes which badly affected the Illawarra area. The decentralisation of services from large psychiatric hospitals into small psychiatric units attached to general hospitals and community care for deinstitutionalised mental patients was a change, strongly felt in the Illawarra with its ethnically diverse community. Mental health carers were aware that policies and services for NESB communities had to be improved but could not do so due to insufficient funds from the government.\footnote{564 Interview Mitchell, \textit{op cit}.}

In the mid-80s, with the meagre funds available, two Day Care Centres were established although there was a need for five. A few Group Homes were set up and some mental health staff employed. A psychotherapy centre and an Adolescent Health Centre were also opened. An Occupational Health centre run by a community mental health worker was established where patients could learn skills and handicrafts. In 1986 Wollongong obtained the services of a psychiatrist to take over the running of mental health services. Towards the end of the 80s, funds were depleted and some aspects of community mental health declined. The Day Care centres gradually disappeared and the Occupational Health centre went unused. Mowbray believes that this was due both to lack of funds and the psychiatrist’s lack of interest in community mental health services.\footnote{565 Interview with Dr P. Mowbray, 11 October 2001.}

The mental health Mobile Treatment Team (Crisis Team) established in 1986, was a direct result of the Richmond Report. It was meant to attend to patients who needed help but could not get admission to a hospital and those recently deinstitutionalised. Peter Brown, the first clinical supervisor of this team in the Illawarra said of this project:

\begin{quote}
We started with 10 staff. The first year we saw 675 people in crisis. We worked singly and could go out to 10 different patients at a time. Soon the service was swamped by patients who needed help. Within 2 or 3 years we were seeing two or three thousand people in crisis. The staff has now increased to 19 but for security reasons they have to go out in pairs so they can still do
\end{quote}
only 10 calls at a time even though they are seeing three or four times the number of patients. There is such pressure on the team - it is not just crisis situations, people have to be given their daily medication in their homes as an alternative to being in-patients. Often, the service is very badly stretched because the Team has to cover a huge area - the whole of the Illawarra, from Helensberg to Gerroa.566

Brown continued:

The Mobile team runs on a slim budget. Our budget may be bigger now than it was a few years ago but it goes mainly on infrastructure such as computers and on drugs. Five or ten years ago drugs cost a minimal $1000 a month - a few cents per tablet. Now there are new drugs, better drugs but very costly. The cost of drugs for the Mobile Team is around $80,000 per year. We are not funded for these drugs so we lose $80,000 of our budget just on that. Most of the remainder goes on support schemes such as occupational safety and quality management. These are important too, but money goes on these rather than on direct patient care. There is no increase in services of people actually going out to see patients. It seems to be more the done thing today to spend on information technology and that sort of thing. Our funding is grossly inadequate for a region this size.567

The Mobile Team is an outcome of the Richmond Report which has not been successful. The idea itself deserves merit but experience has shown that it is not manageable. With closure of hospitals mental health services are short of professional staff and beds resulting in a constant state of crisis. Brown observes that it is difficult to have a crisis service going in the long term. Most of the people in crisis are those who need more permanent care. A larger professional staff and more funds to keep the Team going may be an answer.568

566 Interview with P.Brown, Co-ordinator Mental Health Services, IAHS, 10 December 2001.
567 Ibid.
568 Ibid.
Soon after the publication of the Richmond Report, the NSW Mental Health Act was revised, after several decades. As a result of this Act and the Richmond recommendations Mental Health Review Teams were appointed to deal with the problems of mental patients in the community. Lloyd sees this as a big step forward. She said:

Not many people agree that Richmond was good but Richmond made the problem physically visible.......The Richmond report was good because it was the beginning of some new services for the mentally ill, like Mental Health Review Teams which included people from ethnic backgrounds.569

Mitchell does not agree. He argued that very few of these teams were bilingual. The teams had no special training in how to deal with ethnic minorities and few had interpreters. The teams were poorly funded and poorly resourced. Psychiatric hospitals were closed down and the patients, except the very severely ill, were turned into the community. This certainly made the problem of mental illness more readily identifiable - more visible. But, community health services had to deal with these patients and that was not easy, as they were under resourced. Prior to Richmond, mental health services were for ESB people. After Richmond it was the same. So the focus was on ESB people and not on NESB people.570

Mowbray, who implemented the Richmond proposals in the Illawarra, recalls it as a very difficult task. She said:

Richmond’s vision for the mentally ill was that they would be well off in the community with community health staff to look after them, group homes to live in, facilities to attend (eg. Day hospitals). But unfortunately, nothing happened. There was no money forthcoming for all the support needed. Funds came through in dribs and drabs - a very difficult period overall. Some of our psychiatric staff were against the Richmond proposals. They had worked in Sydney hospitals and saw the extent of the problem. They could not see the

569 Interview with G.Lloyd, former Director of Migrant Health NSW, 23 September 1999.
rationality of closing down hospitals in this disorderly manner. Not only did I have the unenviable job of trying to get funds but I had to face opposition from my own staff.\textsuperscript{571}

It was a very stressful period for staff involved in mental health and community health work and equally traumatic for patients and their families. Mowbray reflected:

There were no hostels set up as yet in Wollongong. Some patients were in Ward 20 - the only psychiatric ward we had. Some had been so long in Sydney hospitals that they were let into the Sydney community. Some, with or without family, were sent back to Wollongong. We asked for group homes and day care centres but these were a long time coming. We could barely cope.\textsuperscript{572}

Mataitis, during her voluntary work with ethnic communities in Wollongong encountered several NESB families which were unable to cope with mentally ill family members returned into their care when deinstitutionalisation took place. She had recorded the following cases:

Case 1. A NESB family had a schizophrenic son who was put out of hospital into a “safe house” in the community. He would visit his parents regularly and demand money from them. He became very violent. According to Mataitis, he destroyed his parents and drove them to an early grave.

Case 2. A young schizophrenic boy was put into his parents’ care. He took all their pension money. They were so distraught as they could not handle him. They wished to return to their native Macedonia but could not do so as there was no help for their son who could not live in the community.

Case 3. A NESB family in Cringila had a 17 year old daughter who was sent out of hospital into her parents’ care. She attempted suicide several times. She was in and out of hospital. The hospital would put her on medication and send her back. This happened a few times and she finally committed suicide.

\textsuperscript{570} Interview with Dr G. Mitchell, former Director of Migrant Health, Illawarra, 4 April 2000 and 11 April 2000.
\textsuperscript{571} Interview with Mowbray \textit{op cit}.
\textsuperscript{572} Ibid.
Case 4. A Polish woman who was mentally ill was sent back to her family. She had some good spells for a while but later started relapsing all the time. Her family did not know how to care for her as they had no understanding of her illness. Her 29 year old son became so desperate that he left home never to return.

Case 5. Yet another NESB woman was sent home from hospital but she was very sick. She was not taking her medication and was pretending to the family that she was well. She became extremely disordered. She too was in and out of hospital; the hospital often told her she was fine and could go home. Her family endured an unbelievable amount of suffering.

Mataitis recalled several other cases where NESB patients were sent to boarding houses which took all their pension money in return for poor quality meals and no care. Another NESB patient was given injections because he did not take his medication regularly. He was too old to look after himself and should have been cared for in a hostel. He was a burden on the community. She remembers a house where five mentally ill people lived unsupervised. One of the inmates was a young woman who was very sick. No hostel was willing to take her so the Multicultural Village took her but only for three weeks. They could not even have her in the common dining room because of her inappropriate behaviour. They had to isolate her.573

Mataitis recounted her own experience with mental health services when her mother suffered from depression after the death of her father in the sixties. She was admitted to Parramatta hospital where she was very unhappy and frightened as the staff did not understand the type of care needed by a NESB person who had undergone so much trauma as a refugee. She said:

Once my mother was given electric shock treatment and something went wrong and she was unconscious for hours - may be days - we were not told how long. After recovering consciousness her condition became worse but later improved slightly. Then the hospital said she was well enough to go home so I looked after her in my own home until she died. I always felt that the hospital should have looked after her differently - not just put her to bed to be locked away and

forgotten. 574

These are only a few of the cases recorded by Mataitis but she said they are typical. They are the sort of patients who should not have been let into the community as they needed to be supervised twenty four hours a day. Life becomes very difficult for families that have to look after a mentally ill member. More so for elderly families. Their lives come to a standstill and there is only fear and tension. Sometimes the sick person is incapable of taking care of his or her personal hygiene. Such people need to be taken care of elsewhere and their conditions controlled by medication. When the responsibility falls on the younger members of the family it is equally bad. They have jobs to go to, to earn their living and sometimes to support their own young families. They cannot cope with the burden of a mentally ill family member, as in the case of the son who left home. Moreover, it is unreasonable to expect NESB people who have barely enough English to conduct their day to day lives, to be able to understand and interpret intricate instructions regarding medication and patient care.

Government apathy to the health problems of migrants is evident in the manner in which it received the policy paper researched and written in 1988 by the then Director of Migrant Health services, Illawarra. This well researched document offered many valuable suggestions for a multicultural health policy which the author expected would ‘hopefully become wide ranging discussion and critical commentary on a significant matter of public policy’. 575 This document emphasised, among other things, the importance of relevant research without which the planning and delivery of health services for migrants would be of limited use. It stressed the need for public debate and comment on migrant health policies and services, in which ethnic health consumers themselves should have an active role. 576

Mitchell regretted that his recommendations were not implemented. He said:

It was not just because of funding. It has more to do with attitude. Australian bureaucracies are inherited from England. They have the heritage of catering

574 Ibid.
only for English speaking people. They are out of kilter with changes happening in the country. After 1945 the complexion of Australia changed. It has a plural society. We need bureaucracies which keep pace with change. There is a big inertia, a big resistance to change. This is partly racist. Agencies do not want to admit that there is a different group of people to work with.  

8.3 Ethnic Community Groups, Migrants and Services

After my husband died there was no one to help me. The children were always sick. When I took them to the doctor he told me that I am a bad mother because I was starving them. We were all undernourished but I could not help it as we were so poor. When I asked the Social Security Department for help they told me 'If you can’t survive here, go back to your country'.....I became very sick. I could not sleep. I felt my stomach bloating with fluid. Yet, for six months I did not see the doctor because I could not speak English and there was no interpreter for the GP.

Dana

I was Assistant Medical Superintendent of Wollongong hospital in the 1960s. We were seeing a large number of NESB patients and it was very, very difficult as there were no interpreters. We had to rely on relatives or friends of patients, hospital staff - anyone at all.

Pat Mowbray

Since the major migrant intake of post-World War Two, migrant health has been a serious concern. The connection between migration and illness, particularly, mental illness has already been examined in this thesis. The literature review amply establishes the connection. Commonwealth and State governments have been neglectful and slow in providing appropriate and sufficient services of any kind for Australian migrants.

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576 Ibid.
577 Interview with Mitchell, op cit.
Migrant health has suffered greatly. This thesis adopts the position that Australian governments have long disregarded the special health needs of migrants. NESB migrants in particular have not received their due. The Illawarra region, especially Wollongong, is one of the best examples of this neglect. Mental health services for migrants cannot be assessed without first examining health and general services for migrants. This chapter examines migrant services in Wollongong.

Wollongong is an industrial city with a large migrant population, a majority of them from a NESB. According to the 1981 Census, there were 37,039 NESB people in the Illawarra Statistical Division which comprised the local government areas of Wollongong, Kiama, Shellharbour, Shoalhaven and Wingecarribee. Of these, 28,176 NESB people were in the Wollongong local government area, which amounts to 16.6% of the Wollongong population. In the 1986 Census, the number was 35,993 or 12.8% of the population. This figure is the same as the average for the state of New South Wales. Further, there were 84 different nationalities in the Wollongong local government area alone.

The Illawarra Area Health Service (IAHS) is responsible for the provision of health services for the above local government areas. Wollongong is a typical example of a city where NESB people have been disadvantaged due to lack of services or have been unable to access the existing services. According to the 1986 census, 20.6% of the NESB population spoke little or no English which would be the reason why they experienced difficulties in accessing health services. In 1988 NESB people made up 13% of all public hospital admissions and 10.2% of all new client registrations in community health in the Illawarra.

The Illawarra is a culturally diverse society. The majority of the NESB population come from southern European countries such as Italy, Greece, Yugoslavia, Spain and

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580 Illawarra Ethnic Communities Council Issues to be Raised at Combined Regional ECC Meeting, February 1989, University of Wollongong Archives.
Portugal. They are mainly from rural backgrounds and of low socio-economic status. Their education levels are generally low. The more recent arrivals are from South East Asia, the Middle East and South and Central America. The NESB communities have a large proportion of elderly people. According to the 1981 census, in New South Wales as a whole, 12% of people over 55 years were of NES background; in the Illawarra region the corresponding figure was 13.9%. Predictions for the year 2000 were that 25-33% of the NESB population of the Wollongong local government area would be over 60 years of age as compared to the national figure of 20%.\

In the 1980s there was a high level of unemployment among NESB communities in the Illawarra. Their low level of education meant that when employed, they tended to be in unskilled and hazardous jobs, principally in the BHP Steel works at Port Kembla. Their lack of English made it more likely they would have industrial accidents. The 1986 and 1988 censuses of the Department of Social Security show that NESB people made up 17.9% of those receiving unemployment benefits in the Illawarra. They were also over represented amongst the recipients of sickness benefits. The NESB communities were, on the whole, financially disadvantaged. As migrants they also confronted cultural and linguistic barriers. All these factors would affect their health and wellbeing and emphasise the pressing need for welfare services which were then negligible.

The Illawarra Ethnic Council (IEC), which later became known as the Illawarra Ethnic Communities Council (IECC), has played a key role in migrant welfare. Established in 1975, it is the organisation responsible for representing and promoting the interests of ethnic communities and individuals in the Illawarra. It is a non-political, non-profit, voluntary organisation working within the established structures, utilising community expertise to improve the wellbeing and general status of ethnic communities. While providing advice and assistance, the IEC emphasises the independence and integrity of every ethnic group to work for the welfare and development of its own community. Stated in the Council’s own words:

...it does not endeavour to provide specific welfare or cultural services, but

rather acts as a facilitator, encouraging, promoting and assisting ethnic communities to develop their own support structures and more effectively participate in the wider community.\footnote{IEC Document Role of the Illawarra Ethnic Council, 1987, University of Wollongong Archives.}

One of the main objectives of the IEC is the monitoring of access to health services by ethnic communities and ensuring that migrant health is an integral part of all community health programs. From the time of inception the IEC has rendered invaluable service to the ethnic community of the Illawarra and it has done so in spite of immense funding difficulties. Apart from voluntary contributions from individuals and non-government organisations (NGOs) it has had to seek funding from government and the Ethnic Affairs Commission (EAC) of NSW. Herein lies the greatest impediment to its progress. Despite having a multicultural society, migrant welfare has not been a great priority with Australian governments. There is abundant archival evidence which points to government apathy in regard to matters of funding.

The 1983/84 Welfare grant from the State government, through the EAC of NSW, to the IEC was a mere $17,000. In 1986 the IEC applied to the EAC of NSW for a grant of $47,000 to support its Community Development program in 1987 but received only $22,000. In a letter to the Chairman of the EAC, the IEC deplores the action as a major inconsideration and lack of support. The President of the IEC writes:

\ldots\text{The latter figure does not even address the full cost of the Community Liaison Officer employed by the IEC. Such serious underestimation for an organisation which provides a major service and support for the Illawarra’s ethnic community must raise in all concerned a questioning of the commitment which the EAC has for the migrants in this area...\ldots}\text{I am sure you are aware of the extent and importance of work being done by the IEC in all areas of migrant health and welfare. Such work and diligence for a voluntary group surely deserves more consideration and support than the present grant indicates.}\footnote{IEC Document Role of the Illawarra Ethnic Council, 1987, University of Wollongong Archives.}
This insufficient grant, nevertheless, was accompanied by a letter from the Premier and Minister for Ethnic Affairs of NSW, expressing ‘...the Government’s appreciation of the valuable contribution your organisation is making to our multicultural society, and I offer my best wishes for its success.’

At the end of 1987, the IEC protested again to the NSW Premier against a repetition of under-funding from the EAC Grants program for 1988. In a letter to the Premier the president of the IEC assured him that his grant application was realistically costed, based on the needs of the IEC and the community it served. He states further,

...organisations such as ours are unable to develop long term and effective strategies because of the precarious nature of our funding. The annual exercise of reapplying for funds does little to enhance continuity of effort or the employment and retention of the best possible staff for the positions that are so essential. Some form of permanent, ongoing funding ....is of course the ideal, however, failing that, experience has shown that block funding for periods of three years greatly enhances program effectiveness and efficiency.

That the above appeal had little effect is obvious when in 1990 the IEC protested to the EAC Commissioner for the Illawarra region that funding for their organisation was not at a realistic level and fell well short of the costs experienced. The president of the IEC complained that the EAC made no contribution towards administration expenses or rental of premises. The $34,000 grant for wages was unrealistic and inadequate and as a result the IEC had lost staff to other institutions where they were better paid for fewer duties. The EAC in turn blamed the Federal government for funding deficiencies.

585 Letter from L.Ihnat, President IEC to P.Totaro, Chairman, EAC of NSW, 12 January 1987, IEC Documents, University of Wollongong Archives.
586 Letter from Premier, NSW to President of the IEC, 31 December 1986, IEC Documents, University of Wollongong Archives.
587 Letter from L.Ihnat, to B.Unsworth, Premier NSW, 27 October 1987, IEC Documents, University of Wollongong Archives.
588 Consultation with J.Gebhardt, Commissioner for EAC: Illawarra Region, 1 July 1990, IEC Documents, University of Wollongong Archives.
The Federal government had not increased funds to the EAC, NSW, hence the EAC could not increase grants.\textsuperscript{589} It was the age old strategy of shifting responsibility.

In 1990 the Greiner Liberal government announced a $1.3 million grant to ethnic communities. This was a cut, rather than a bestowal, and brought widespread criticism from ethnic communities. The Ethnic Communities Council (ECC) of NSW estimated that over 4 million dollars in grant applications were made to the EAC but only $1.3 million was given. This meant that only one in four groups received government aid while others would have to terminate their activities or seek help elsewhere.\textsuperscript{590} These government cuts had their repercussions on migrant welfare statewide. Several ethnic community organisations were no longer sustained by EAC grants and there were no viable alternative sources. The Illawarra Migrant Resource Centre (IMRC) was badly disadvantaged and the quality of assistance given to the migrant community was significantly affected. In 1991 the position of the sole worker at the Womens’ Directorate in Wollongong was cut.\textsuperscript{591}

These cuts in funding came at a most unfortunate time. The IMRC is heavily involved in settlement services for refugees and other migrants. From 1992 onwards there were a number of Croatian and Serbian refugees seeking settlement as a result of war in their homeland. Restriction of funds meant that the IMRC was unable to provide adequate support services for them.\textsuperscript{592}

It is not at Federal and State levels alone that migrant welfare has been neglected. At local government level, Wollongong City Council itself has been lethargic towards migrant issues and neglectful of the LEAPS program. In February 1988 the Minister for Local Government, with the involvement of the EAC of NSW, launched the Local government Ethnic Affairs Policy Statement (LEAPS) scheme. LEAPS is a management plan set up by a Council, in order to ensure that all council services are

\textsuperscript{589} Consultation with Stepan Kerkyasharian, Chairman, EAC at the IEC, 20 September 1990, IEC Document, University of Wollongong Archives.
\textsuperscript{591} Illawarra Migrant Resource Centre Circular, 24 September 1991, University of Wollongong Archives.
\textsuperscript{592} Interview with Bosnian Family Support Worker and Community Development Worker, IMRC, Wollongong, 17 January 2001.
accessible and appropriate to all residents, regardless of their ethnic or linguistic backgrounds.\textsuperscript{593}

A Council which adopts the LEAPS scheme should examine the services it provides and ascertain that NESB communities do not experience any barriers in accessing such services. If any such barriers are identified, the Council should, of necessity, develop strategies to overcome them. The Anglo-Australian nature of the Wollongong City Council’s services caused barriers to develop. As a result, NESB people have been denied equal access to services. Some of the disadvantages they have suffered are as follows:

- Lack of multilingual information and services that are culturally appropriate;
- Discrimination;
- Staff who are not culturally sensitive or speak relevant community languages;
- Failure to involve NESB people in consultative, planning or advisory bodies.\textsuperscript{594}

The LEAPS program is based on the concept of mainstreaming which essentially means that all of Council’s services should be accessible and appropriate to all of its residents, including those from NESB. According to the NSW Reference Group on Local Government and Ethnic Affairs, this process of reconciliation can be hastened through the development of appropriate consultative mechanisms, the identification of a LEAPS Co-ordinator (i.e an Ethnic Communities Worker) and an ongoing review process.\textsuperscript{595}

Two years after the commencement of the Pilot LEAPS project, the IEC pointed out that the Wollongong City Council had not yet produced an Ethnic Affairs Policy statement; neither did it have an Ethnic Communities Worker to monitor it. The Pilot LEAPS program was funded on a two year basis; the Illawarra Area Assistance Scheme funding the first year and the Wollongong City Council, the second. After this period the Wollongong Council was expected to take up the position on a permanent basis. In a city with such an ethnically diverse population, one would expect the Council to be


\textsuperscript{594} IEC Liaison Officer, W. Hamilton, in a Press Release to WIN TV, 22 November 1988, University of Wollongong Archives.

\textsuperscript{595}
committed to multiculturalism in the interest of the community it serves; instead of which the Council showed no sense of responsibility or intention of recruiting an Ethnic Communities Worker to evaluate and implement the Council’s Ethnic Affairs Policy. The Wollongong ethnic communities were let down by the lack of commitment on the part of the Council. The Council needed to adopt proper consultation procedures with a peak ethnic organisation like the IEC in matters such as ethnic policy development.

In many instances persons of non-English speaking background utilize the non-government welfare sector in preference to mainstream services. This often reflects the inadequacies of the latter services. It could be that ethnic communities lack information about that particular service. In order to ensure that ethnic groups have the information necessary to avail themselves of the services the government provides, publicity campaigns should be conducted in the ethnic press as well. Even if ethnic groups receive this information in their own languages, they would still be reluctant to use the service unless there is provision made for languages other than English in the delivery of the service. Cultural insensitivity on the part of the service provider may alienate the client or make the service inappropriate.

The above circumstances emphasise the need for bilingual staff and adequate interpreter services. NESB persons encounter many barriers in the health care setting due to problems of communication; that is, the dearth of bilingual health professionals and interpreters. In the fifties and sixties the government did not consider bi-lingual workers or trained interpreters as a crucial need even in public hospitals. In the early seventies as a result of intensive lobbying by ethnic communities and voluntary organisations some interpreters were appointed to hospitals, most of them untrained. Only in 1973 was a serious attempt made to establish a training course for interpreters. In 1973 the Commonwealth Telephone Interpreter Service (TIS) was started. In 1978 the National Accreditation Authority for Translators and Interpreters (NAATI) was created to set standards within the practice of interpreting.

595 Ibid.
596 Ibid.
597 P. Garrett and V. Lin “Ethnic Health Policy and Service Development” in Reid and Trompf (eds) op cit, p 349.
Although the lack of these services was not an insufficiency exclusive to the NESB communities of the Illawarra, there was an urgent need in that particular area considering that the NESB population of the region outnumbered that of some of the capital cities of Australia and equalled the average for the State of NSW. While organisations such as the Federation of Ethnic Communities Council of Australia (FECCA) and the ECCs accomplished much in the area of migrant issues, the tendency was to give precedence to the needs of capital cities over those of the regions. For many years the Illawarra had experienced such exception and for many years the IEC had stressed the fact that the Illawarra region represented ‘...a special and substantial need which has been consistently ignored’.  

Problems facing the Illawarra in terms of access to interpreters were different from those experienced in large cities such as Sydney where there was a pool of good quality interpreters to access. The Chairman of the IEC states that the Illawarra is unique in that there are 87 different ethnic communities but does not have interpreters with the expertise to cover areas such as medical and legal. These interpreters needed to be booked and may have to come down from Sydney. He writes, ‘In some respects this could be regarded as latent discrimination against those living in regional areas/country areas’. In 1989 the IEC established a committee to combat the acute shortage of trained interpreters in the Illawarra. Its aims were:

- to inform the community of the potential employment prospects for interpreters in the Illawarra;
- to lobby Illawarra region T.A.F.E to broaden the study of community language programs to enable graduates to qualify to NAATI, level 2.

So urgent was the need, that the Illawarra Language Services Forum also took up the cause. This group was formed of workers from community organisation who worked

598 Letter from Chairman, IEC to the Chairman, FECCA, C.Harbaum, 3 May 1989, IEC Documents, University of Wollongong Archives.  
Letter from Chairman, IEC to the Chairman, ECC of NSW, 8 January 1988, IEC Documents, University of Wollongong Archives.  
Letter from Chairman, IEC to the Working Party on the Role and Use of Interpreters, Attorney General’s Department Sydney, 28 September 1989, IEC Documents, University of Wollongong Archives.  
with migrant communities, educators from TAFE and AMES and representatives from
government agencies involved in the provision of interpreter services. The Forum
believed that the employment of trained, competent, accredited interpreters was integral
to the management of access and equity strategies. They argue:

Among migrant communities there will always be people; newly arrived
immigrants, the ethnic aged, whose need for specialised information...
...can, at times, only be met by an interpreter. Such people who are denied
access to an interpreter, are also denied access to a service, and as such are
effectively disenfranchised.601

The Forum found that the provision of effective language services was ‘..made
frustratingly difficult because of the obstacles in the process of accreditation of
interpreters’. There was not a standard marking system used for all languages. The lack
of accredited interpreters significantly affected the daily lives of the migrant community
who had to rely on family or friends to act as interpreter. People who had the potential
to be interpreters were deterred by the lengthy and expensive accreditation procedure.
This was a lamentable loss of resources and skill to the community.602

In spite of all the agitation by ethnic communities the shortage of trained interpreters
remained even in major ethnic groups such as Macedonian. The smaller groups had to
resort to the danger and embarrassment of using untrained personnel at a time of
anxiety and stress. The IEC suggested that the ethnic communities in the Illawarra
‘...could be a good pool of interpreters. TAFE or Wollongong University could develop
courses whereby these untrained bilingual/multilingual people could gain the necessary
skills to become qualified interpreters’. Ongoing training should be made available to
all interpreters. Government employees could also be accessed and encouraged, perhaps
through a small financial incentive to upgrade their language skills.603

601 Letter from the Illawarra Language Services Forum to the National Director, NAATI, 28 May 1991,
IEC Documents, University of Wollongong Archives.
602 Ibid.
603 Letter from the IEC to the Working Party on the Role and Use of Interpreters, Attorney General’s
Department Sydney, 28 September 1989, IEC Documents, University of Wollongong Archives.
The shortage of interpreters has continued into the 1990s and even into the twenty first
century. In an interview with Angela Mitic, Ethnic Mental Health worker, Illawarra,
which took place in the year 2000, she said that psychiatric Crisis Teams were
‘...struggling with a shortage of interpreters. They can’t always get an interpreter at short
notice when they are dealing with a crisis’.\textsuperscript{604} IMRC workers expressed similar views.
Most Serbian and Croatian refugees who settled in Wollongong were unemployed and
did not speak English. Most of them had health problems; mainly dental problems and
mental disorders. In 1992, there were no interpreters who spoke their languages. It was
very difficult to help them because of this. The free English program for refugees ran
for only six months - hardly long enough for them to acquire a working knowledge of
the language. Now, there are some interpreters, but not enough of them.\textsuperscript{605}

That migrant health was not getting the attention it deserved even in the eighties, which
is several decades after the first migrant intake, is the opinion of a number of personnel
employed in that field during the era. Glenis Lloyd believes that migrant health did not
get as much attention as it should have because it was competing directly with a number
of other issues happening in health at that time - Womens’ health, Maternal and Child
health and the slow rise of Aids. These seized the attention of the Health Department. In
the early eighties the Federal Labor Government allocated funds for many migrant
projects. By the end of the eighties the funds dried up, migrant affairs lost direction and
became a lucrative industry with individual vested interests in departmental agencies.\textsuperscript{606}

In the seventies and the eighties ethnic groups lobbyed for the development of ethno-
specific health services, sometimes, successfully, as in the case of interpreters (though
not in sufficient numbers) and a small number of non-professional bilingual staff in
community health centres. But the lack of bilingual professionals left these ethnic
workers without the necessary point of referral. Migrant health services in general were
not of great concern to either Federal or State governments and migrant mental health
was in total neglect.

\textsuperscript{604} Interview with A. Mitic, Ethnic Mental Health worker, Illawarra, 25 May 2000.
\textsuperscript{605} Interview with IMRC workers \textit{op cit}, 17 January 2001.
\textsuperscript{606} Interview with Glenis Lloyd, former Ethnic Community Worker, Wollongong, 23 September 1999.
8.4 Mental Health Services in the Illawarra - Some Views of the Region’s Mental Health Professionals

I am happy with my doctors but I think my present wellbeing is largely due to my constant contact with the Macedonian mental health worker. She is marvellous. She knows how to handle people. It is easy to talk to her and she is, above all, a good listener. You can’t get this from the psychiatrists. It is from her that I learnt about my illness. No doctor ever explained anything to me. They monitor my medication - they don’t seem to have the time for much else. I think psychiatrists are crazy!

Anica

Rada (not her real name) is a Macedonian woman with a long history of mental illness. She has had several admissions to the Shellharbour psychiatric unit. On one occasion she went to the Shellharbour hospital emergency suffering from a gynaecological problem. The admitting officer had forthwith sent her to the psychiatric unit where she was prescribed medication for her mental condition and discharged the following day. She suffered her physical problem a few days longer, and getting no relief, she was persuaded by her husband to see his GP. She was under the impression that nothing could be done for her gynaecological problem. It was left to the GP to sort out her problem with the hospital, by which time her condition had deteriorated considerably.

From the files of Dr W, an Illawarra GP (name withheld at interviewee’s request).

In July 1989, the NSW government transferred the management of state psychiatric hospitals from the Department of Health to Area Health Services. Whether mental health services in the Illawarra improved as a result of this transfer is questionable. The Illawarra continued to be an under funded region and services remained in much the same condition as before according to some of the mental health professionals interviewed. Whatever the benefits, they were outweighed by the disadvantages. The professionals interviewed were those who had worked in the field of mental health from

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the 70s to the present day and were able to trace a comprehensible picture of services during that period. They were divided as to whether mental health services have improved under the IAHS. But the consensus was that mental health services in the Illawarra are inadequate for everyone in general and NESB communities by their very definition, were more disadvantaged than others.

Dr Pakula, Director of Mental Health Services, Illawarra, 1989-2001, said:

Trying to develop ethnic mental health services has never taken off. Dr Bennett, who was Director of Mental Health Services in the Illawarra in 1987, started it and I continued to develop it but it never worked. We started a pilot project and trained an ethnic mental health worker for the Macedonian community. This was meant to be the beginning of a core group of ethnic mental health workers but this plan never eventuated. It was never supported by the Department of Health with funds. The departmental policy was largely to pay lip service to multiculturalism - lots of talk and lots of writing about multiculturalism but very little or nothing was done in dollars for the Illawarra area. It is not the direction the Department of Health is taking - the setting up of different groups within the Area Health Service. 608

Mental health services undergo regular reviews for National Mental Health standards. In this survey there is a component looking at multicultural aspects of psychiatry - the needs of individuals, the provision of an interpreter service and culturally appropriate ways of assisting patients. These surveys have shown that the Illawarra is far behind in serving the needs of a culturally diverse society. Dr Pakula says that compared, for example, to a country like New Zealand, where he worked in 1993, the Illawarra was behind. He found the Auckland hospital mental health unit well organised and the staff reflected the needs of the indigenous Maori population. They were represented among doctors, nurses, psychologists and social workers. The population given the service was well reflected in those giving the service, it makes an enormous difference. There was no such program here. 609

608 Interview with Dr I. Pakula, October 2001.
609 Ibid.
On the question of mental health funding, all four professionals agreed emphatically that the Illawarra was a grossly under funded region. Dr Pakula said:

When I was Director of Mental health services in the Illawarra, from 1989 to 2001, the North Sydney Area was funded three times more per capita than the Illawarra. We were vastly under funded and it was almost impossible to get extra funds. The Shellharbour Hospital Psychiatric Unit which serves the entire Illawarra region has only 54 beds. This unit sees more patients per year admitted through it than any other psychiatric unit attached to a general hospital in New South Wales. Yet, it is probably one of the poorest funded units in New South Wales. We have a high turnover, a high number of admissions here. Look at the profile of the Illawarra. All the socio-demographic data point to poor roads, high number of school leavers prior to age 15, high unemployment, high Aboriginal and NESB population and a large number of households with an income below 20,000 dollars per year. These are major difficulties which affect this area and contribute to high admission rates. Without extra funds our hands are tied.  

Peter Brown agreed that even in the present day there is an unfair distribution of resources across New South Wales. On a per capita basis the Illawarra should do much better than it currently does. Newcastle, an area only slightly bigger than Illawarra, has 45 Mental Health Registrars while Illawarra has only 6. The Illawarra has only 54 beds while Newcastle has the benefit of an institution with many more available beds. In the Illawarra, chronic patients keep coming back to the Shellharbour unit because there is nowhere else to go. Of the 54 beds, 20 are set aside for chronic patients, hence, not everyone can be properly looked after. In Newcastle, patients can stay longer in the wards and get proper attention. Moreover, Newcastle has the advantage of having a medical school; doctors can do their post-graduate studies there. There is nothing in the Illawarra to attract professional staff here. In fact, some of our psychiatric staff have

610 Ibid
gone away to other areas for further study or work and most of them have not returned.  

Karpik maintained that mental health does not get enough funding because it is a very low profile component of the IAHS. The reason is because the community sees it that way, the providers do the same. It boils down to the stigma attached to mental illness. Karpik firmly believes that if a referendum were to be held, all other illnesses would get priority over mental illness. She further emphasised this view when she said:

> There is a tendency in society to blame the sufferers of mental illness for their condition; either their life-style or their faulty upbringing. Not only do they blame the family but the health workers as well, for not being able to control their illness. People don’t seem to understand that there are other components to mental illness such as stress, genetics, environment etc. People are stigmatised for being mentally ill and if you are NESB, you are marginalised to an unbelievable degree. Unfortunately, the IAHS sees mental illness as an area of low priority. To my knowledge it has always been difficult to obtain funds for mental health.  

Brown confirmed this view when he said that mental illness is never ‘the flavour of the month’. Anything else would be more acceptable to the community than mental illness. The community is more sympathetic towards issues like cancer or heart disease rather than schizophrenia or drug abuse. This perception is changing, but very slowly. So, health managers tend to spend the money to please the public.  

Wollongong was never allocated a fifth schedule hospital because it was considered close enough to Sydney for patients to utilise Sydney hospitals. This proved to be a great disadvantage for the area. In the eighties when large psychiatric hospitals were closed down and sold off, the resources were still available for the area. Thus,

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611 Interview with Peter Brown, Co-ordinator, Community Mental Health Services, Illawarra, 10 December 2001.

612 Interview with Sue Karpik, Nursing Manager, Shellharbour Hospital Psychiatric Unit, 21 December 2001.

613 Interview with P.Brown. 
Wollongong missed out on funds. Wollongong had just 23 beds attached to the public hospital and no real infrastructure. Karpik said:

We didn’t have education in mental health or a big body of doctors in mental health, we started from virtually zero and had to build up from that over the years. There didn’t seem to be money for anything. This contributed to the culture within the Illawarra that mental health was just ‘an add on’. Whereas in places like Newcastle where they had big psychiatric institutions, mental health services were better established. They started off on a different basis so mental health services have a better status there.614

There was a difference of opinion among the professionals interviewed as to the efficacy of the work done by the IAHS. One professional believed that the IAHS has more control over its own destiny and as such, more flexibility with the budget. Under the Regional offices, the regions were dictated terms and had little or no say in how the money was spent. The IAHS has the prerogative to move funds around as it pleases so that deserving projects attract more funds.615

But other professionals saw this as a disadvantage. It was a prerogative easily subjected to abuse. They maintained that the mental health budget has often been spent in other areas which IAHS Board members saw as a priority. Professional B stated:

The Department of Health quarantined the mental health budget because the IAHS would spend it on anything but mental health. In spite of this, the budget is not safe - there are always ways of getting around it, of doing the improper thing. I cannot say that there has been a real improvement in services or a genuine enhancement of the budget. So, I can’t say that services are better under the IAHS.616

The IAHS maintained that having psychiatric wards attached to general hospitals would destigmatise mental illness and thus improve services. They would be treated as any

614 Interview with S.Karpik.
615 Interview with professional A, November 2001.
other ward in the hospital, such as the surgical or medical ward. But Professional B says the reality is that it has not been so. He said:

We were told that surgeons and physicians would be readily available to psychiatric patients when necessary - that there will be a free flow between wards. But this is not so. Surgeons and physicians hardly ever come here. Nobody likes coming here to provide a service. The psychiatric ward is stigmatised even within the hospital. 617

For a psychiatric patients to see a surgeon or physician is at times so difficult that they have to go through the Emergency Department before they eventually get any attention. There is no cross-flow of services with the psychiatric ward as there is between other wards. There have been times when it has been difficult even to get a medical or surgical registrar to call on a patient in the psychiatric ward. Moving psychiatric wards into general hospitals has not put them on an equal footing with other wards. Mental illness has not lost its stigma. 618

Professional D was very critical of the IAHS’ nurse training procedures. In the late sixties psychiatric nursing was a three year course followed by another two years training in general nursing. Today, psychiatric nursing is only a small component of the general nursing course. It is no longer a speciality. This has done a great deal of damage to the profile of psychiatric nursing. She said:

there is a great body of knowledge out there to do with psychiatric nursing and multicultural issues. When all this is put into the general nursing course, it just disappears and does not exist any more. This is a great loss. 619

A major reason for the Illawarra being under funded and under resourced is the strong link between policies and politics. The Illawarra is a Labor dominated electorate. It is not a swinging seat. For years Wollongong has voted Labor, so Labor does not have

616 Interview with professional B, December 2001.
617 Ibid.
618 Ibid.
much to do for the electorate - they have got the votes anyway. Liberals do not do much because they know it is not easy to change the political scene. Hence, neither party is interested in providing much for this area and between the two, the area suffers. Conversely, the electorate too remains silent when it has the government of its choice. Perhaps, if it were a Liberal government the electorate would be saying a great deal more about lack of funds and resources for mental health services.

All the professionals interviewed agreed that the Illawarra suffered funding shortages and general neglect of mental health services mainly due to political reasons. They see the IAHS as a ‘very political body’. One of the professionals stated:

At the head of the IAHS is the CEO, below him is a Board of Citizens. These are all political appointments. Whichever party is in power puts its own appointees on the Board. So, it is all a political issue where the money is spent. If the Illawarra were to get more funds it would be at the cost of some other Health Area and that is where politics starts coming into it. Every year, especially at parliamentary election time, a new resource distribution formula comes out - a formula for funding which is set to resolve all our problems. Over the years many such formulas have come and gone but nothing has really changed. I, as a middle manager, am involved in finding policies to suit the currently available budget. We keep making changes, not those best for the service but those that will not stretch the budget. This is not a satisfactory way of forming policy and I am party to it. I am compelled to be.620

Professional C said that the government makes out that it gives more funds for mental health than it actually does. She added:

The government puts a wonderful spin on things - dresses things up for appearance! In March 2001, the Minister for Health announced that he was giving 1.1 million dollars for the Shellharbour psychiatric unit. It made a splash in the media but the truth of the matter is that we did not get 1.1 million. When it came to the giving, he said that 600 or 700 thousand dollars had already been

620 Ibid.
spent on the unit, but that was not correct. So, we did not really get 1.1 million but the public thought it was laudable getting 1.1 million from the minister. It was a publicity stunt. It all depends on who is at the head of the IAHS. If the CEO is concerned about mental health issues he can influence policy and spending provided it does not clash with his political interests.621

Professional B recalled the last term of the NSW Liberal government (the Greiner government) as the only time that something positive was happening to the mental health budget. The Liberal government set targets to increase funds for mental health each year for a period of seven years. But the electorate got only three years of these increases as the Liberals were defeated and Labor coming in, quashed the plan. It was a good plan which should have been continued as we knew for certain that we were getting more money each year and we could employ more staff and plan other improvements.622

It is a repetition of the age old story of one government undoing the work of another. Governments develop policies which are beneficial to them and do not unduly stretch their budgets. Public problems reach their political agenda only when interest groups convert them into political issues. It is unclear whether champions for the Illawarra were lacking or whether they were not effective enough to be heard, but it is an accepted fact that the area has historically suffered discrimination. All the professionals interviewed contributed to this view, as did other health workers interviewed previously.623 The true significance of the results of under funding and under resourcing is not always clearly understood by the public. To most, it manifests itself as shortage of beds, long waiting periods and such inconveniences. But staff who work under these conditions see the dangers and risks that the public may not be aware of, as outlined in the following paragraphs.

The shortage of funds and resources has led not merely to public inconvenience but to more serious outcomes like the deskilling of staff. Professional B explained this thus:

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621 Interview with professional C, December 2001.
622 Interview with professional B.
The new psychiatric Registrars are being trained in a system where there is a chronic shortage of beds and resources. As such, when they are assessing a patient they have to adopt a view, not based on their judgement of what is clinically relevant, but to suit the availability of beds. What, in our day, we were taught to consider as serious signs and symptoms which needed immediate intervention are no longer considered so. At a time when there were adequate beds we made decisions on admissions, based on different criteria. Today, staff are happier to take risks with patients. This can be serious; it has sometimes resulted in suicides. I am not criticising them. They are justified in working like that because of the system they are trained in - a system of chronic shortages. So, their perception has to change. After a while people lose their perspective of why they are doing it and it becomes the norm. Thus, lower clinical standards become the norm.  

He went on to add:

Such strategies have a negative impact on everybody but more so on NESB communities who find it difficult to understand what is happening due to communication problems. If I were to use my learnt perception as to who should or should not be admitted, this unit will not be able to function, there would be too many patients in it all the time. So, you have to change with the times and adopt a different view. This deskilling process in professional staff is, in my eyes, a serious flaw, to say the least.

The shortage of beds leads to other disadvantages and dangers which were amply illustrated in the interviews with the mental health professionals. In an area as vast as the Illawarra when there are only 54 beds available to the whole population, patients cannot get a fair deal. Professional B explained:

On some days there are many admissions - maybe about 10 patients more than the number of beds available. So, patients could be prematurely discharged. 

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623 Vide previous chapters of this thesis.
624 Interview with professional B.
am not saying that they are but it can force you into the situation. You may be compelled to do it. It is more crisis management than planned intervention. This is not a criticism of the clinicians - it is just the system under which we work.626

Anica, an ex-patient of the Shellharbour psychiatric unit described it as a ‘horrible place’. When she was admitted to the unit while suffering from depression, she was warded alongside drug addicts and severely disturbed patients due to a shortage of beds. Here, her personal belongings such as items of clothing were stolen. She was physically attacked (punched in the face), by other patients who got her cigarettes off her. She was petrified and wanted to see a social worker but none ever came to the ward. She was told that the social worker was on holiday.627

Rural doctors and GPs have complained of shortage of beds, nurses and psychiatrists, leading to low morale. Tony Humphrey of the mental health advocacy group, Speranza, writes that in some regions there were nearly 50 percent more patients than beds on some days.628

The greatest danger in early discharge lies in the risk of suicide. Karpik explained this thus:

For example, take a person suffering from depression. We treat him in this unit for 7 days and he gets better. If we discharge him in 7 days, not only is he better but he can also plan suicide better. So, we should keep him not 7 days but for at least 14 days until he passes this crucial point and gets over this hump, this most critical period, which he usually does when his thinking becomes clearer. Then, and only then, is he fit to be discharged. But that does not happen now due to the pressure on beds. We put such patients in charge of community teams who are themselves under pressure.629

625 Ibid.
626 Ibid.
627 Interview with Anica, 28 April 2003.
628 Sydney Morning Herald, 4 June 2001, p 1.
629 Interview with S.Karpik, 21 December 2001.
It is not uncommon for patients to find themselves in a waiting list for an appointment to see a community mental health professional. Community mental health teams are over-worked and under-staffed and cannot see patients as often as they should. The media sometimes highlights incidents where patients have committed suicide in between appointments or have done so due to the inability to get proper care at the proper time. For every reported suicide there would be many which are not considered newsworthy.630

When psychiatric institutions were closed down in the eighties, caring for the mentally ill became largely the responsibility of community mental health services. Patients were often discharged early with little follow up from community based services which were stretched to the limit. The outcome of this was that there were, and still are, a number of distressed and disoriented individuals at large in the community who ultimately become a concern for the police or charities. Such troubled individuals often resort to drugs which in turn can lead to violence, becoming a case for the police to handle. This creates an unfair burden on the police because dealing with mental illness does not come within the scope of their duties. According to leading figures in the judicial and prison systems, nearly a third of people appearing before local courts have an underlying mental illness, and almost 10 percent of jail inmates are seriously mentally ill.631

Karpik believes that mentally ill patients were better looked after in the fifth schedule hospitals before they were closed in the eighties. She said;

> I see homeless people on the streets. Some of them have passed through our service. We cared for them well in a safe environment. Now they do not get their basic meals regularly - let alone medication. They have no shelter. We gave them food, medication, shelter and protection.632

She went on to add:

Hospitals were expensive to run but it is not cheap to run services in the community - if done properly. Cutting costs reduces the quality of services. There were lots of patients who could function well enough in the community. I am speaking of the hundreds of severely ill people who were let out of hospital without proper after care.633

When disturbed and uncared for people in the community become a problem which the police cannot handle, Karpik said that the psychiatric unit becomes the ‘dumping grounds’. She pointed out that:

The community has come to look upon this unit as a crisis management centre for all problems. The police, the ambulance service - even the Housing department send their problems to us, whether they be criminal, drug and alcohol related or even family disputes. The police expect us to ‘hold’ the offenders. We are not a gaol. We don’t play a custodial role. When all and sundry are sent here we have major problems looking after our psychiatric patients who need our full attention. These are on going problems created through inefficient community care.634

Brown confirmed the view that deinstitutionalisation has created innumerable problems not only for the mentally ill but for those working in psychiatric services as well. Homelessness and neglect has been the major outcome for many mentally ill people who should rightly be cared for in hospital. Those living in boarding houses have been exploited. There have been investigations into the running of these boarding houses and owners have been found guilty of misdoings. Most inmates give up their invalid pensions in return for a bed, insufficient food and often, no medication.635

Brown argued that when psychiatric hospitals were closed the money injected into the mental health system was insufficient to develop community mental health services to

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632 Interview with Karpik op cit.
633 Ibid.
634 Ibid.
635 Interview with Brown op cit.
cope with the number of patients discharged. These patients swelled the numbers of the sick people already in the community who were not being cared for. From 1978 up to 1986 there was an increase of only one nursing position in community mental health services in Wollongong. Many resources were lost - hospital beds, doctors and nurses.\(^\text{636}\)

Accommodating patients in small psychiatric units has created special problems in more ways than one. Insufficient bed numbers is a major problem but the lack of space for patients to move around in is as great a difficulty. Old institutions were large and even high security patients were locked up in a wide area where they could move around freely. In today’s psychiatric units there is very little space and a patient cannot get away from others even if he or she wanted some solitude. This close confinement causes the slightest problem to flare up into aggression. Often, the result is violence towards other patients and sometimes, towards staff as well. Security is a major problem in these units and security risks that go with the job is an important reason why it is so difficult to fill staff vacancies.\(^\text{637}\)

The professionals interviewed were of the opinion that inadequacy of services and general neglect were not the only disadvantages that mentally ill people suffered. They suffered discrimination in the general health system as well. Professional D stated:

The mentally ill cannot even access general health services satisfactorily. For example, if a person presents at Emergency with a respiratory problem and the admitting nurse reading his notes finds he has had a mental health problem some time back, he is sent to our (psychiatric) unit straight away. It is as if once mentally ill, a person cannot have any other health problem unconnected to the mental health problem. They are stereotyped, labelled - they are “mental patients”. Whereas a person with a history of a surgical or orthopaedic problem is admitted and treated for his present problem - not sent to the surgical or orthopaedic ward.

The fact is that Emergency department staff do not like mentally ill people

\(^{636}\) Ibid.
\(^{637}\) Ibid.
coming into their department. A past record of the most minor mental problem is sufficient reason for them to dispatch the person to us no matter whatever else he may be suffering at the moment. He may even have a broken bone, but they don’t want to see him. They see it as solely our responsibility. I think the mentally ill should get a proper health assessment like any other patient. 638

Research carried out in Western Australia, and applicable nationwide, has found that a large proportion of people with mental illness have life expectancies more appropriate to some parts of Africa rather than to the rest of non indigenous Australia, which can expect to live another 25 or 30 years. It amounts to two and a half times the rate of premature death. And the reason is not just suicide. Far more important are things like heart disease, cancer, injuries and infections. When people with mental illness suffer from these problems they fare much worse than the rest of the population. They do not appear to receive the same standard of treatment as the rest. 639

This chapter outlined some views and attitudes of mental health professionals who are presently involved in mental health work in the Illawarra. Their observations based on first hand experiences in the service over many years emphasise the fact that mental health services have suffered from a shift of responsibility from government to mainly community based groups and charities. They deplore the continuing ignorance and stigma associated with mental illness. Not nearly enough is being done in the way of funding for mental health. Psychiatric waiting lists, shortage of acute care beds, early discharge and lack of follow-up after discharge are all serious problems the Illawarra is facing.

When mental health services are inadequate for the everyone in general it is not difficult to gauge the predicament of NESB people when they come into the mental health system. It is difficult enough, even for an English speaking person, to access the health system in another English speaking country, different from their own. 640 One can appreciate the difficulties NESB people encounter in an English speaking country. When NESB people enter the mental health system, language difficulty is not the only

638 Interview with S.Karpik.
639 Dr Norman Swan, in Sydney Morning Herald, 1 July 2002.
issue. Their cultural norms play an important part. It is not easy for staff trained in a monocultural background to understand where mental illness fits in their culture.

At any given time, about 15% of long stay patients in the Shellharbour psychiatric unit are of NESB. Long stay patients are usually kept for up to seven days due to the pressure on beds. When NESB patients are taken out of their home culture and installed in the very foreign environment of the hospital ward, seven days is not sufficient a period to familiarise them with the hospital system. Interpreter services may bridge the language difference but it would not bridge the cultural gap which is very important in the sensitive issue of mental illness. There is still a wide range of issues to be looked at in providing culturally appropriate services for NESB communities. Training and employing more NESB people to do health work may be one answer.

8.5 Migrant Health in the Illawarra Region - Some Views of Migrants and Migrant Health Workers

*I don’t think the Health Department is really very serious about migrant health issues because there is no crisis or drama around migrant health. The Department is interested in things like statistics about heart disease or cancer, large epidemics, the length of hospital admission lists and waiting lists for surgery. Migrant health deals with access to services for NESB people, peoples’ rights, issues around informed consent, interpreters. These are seen as mundane, expendable issues.*

Franca Facci

*Health professionals need to be more aware of cultural differences. Lack of sensitivity leads to misunderstandings. For instance, Macedonians talk very loudly and at times, all of them together. This has been, in some cases, interpreted as aggression. Some patients talk a lot - as if they cannot stop talking. This is often because they have no one to talk to at home - they do not like to discuss their health problems with friends and*

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640 Interview with S.Karpik (about her own experience when travelling overseas).
641 Interview with S.Lampe, 3 December 2001.
family for fear of gossip. For Macedonians, reputation is a big issue. Excessive talking is sometimes interpreted as a sign of disorder.

Angela Mitic

Interviews conducted with migrants and migrant health workers further supported the view that NSW health services were unevenly distributed and individual communities did not have equal access to health services. Those interviewed confirmed the view that the Illawarra was a significantly underfunded region and both general and mental health services for migrants were inadequately developed despite the needs of its large NESB population. The interviews also strengthened the argument maintained in this thesis that policies and services for migrants developed to a great extent due to the efforts of ethnic communities themselves and to the enthusiasm and dedication of those involved in working with these communities.

In the early 1960s Ruth Mataitis, a Lithuanian migrant, became a founder member of the Friends of Wollongong Hospital where she did voluntary work with NESB women. In 1974 she co-ordinated art and craft classes for NESB women. It was then that she realised how isolated migrant women were and that they needed much more than art and craft classes. So, together with an Australian woman, she started a sewing group in Cringila which had a dense NESB population. The aim was not just to teach sewing but to teach these women English and to educate them about health needs etc. There were women from forty different nationalities who did not have a common language for communicating which made them very eager to learn English. 642

Mataitis recalled:

At this time I was being paid for only two days work a week. All the rest of the expenses we had to find on our own. We even begged and borrowed sewing machines but for teaching English we needed money for material and teachers. So, I went to the Premier’s Department in Sydney and begged for money. The government gave us $18,000 through the Youth and Community services Dept.

to employ teachers.\textsuperscript{643}

This centre for migrant women became the Cringila Community Co-Operative, a model Australia-wide as a community centre for women. Mataitis was invited by NSW Premier Neville Wran to become a member of the Premier’s Advisory Council. She has been a life member of the Illawarra Ethnic Council since its inception. Through these positions she has worked diligently to improve the lot of ethnic communities.

The Cringila centre helped migrants with their health problems. Health was particularly problematic for migrant women not only due to language difficulties but because of the service provider’s ignorance of cultural issues. Mataitis personally helped many migrant women of the Muslim faith who got no support at home because it was not in their culture to discuss their ailments with their husbands. She would refer them to the Community nurse for help. She mentioned the case of a Muslim woman suffering from cancer whose doctor dismissed her as an ‘incurable case’ and left her to her own devices. Mataitis said:

I know the doctor did not speak her language but at least he could have spoken to the Community nurse about her. Few doctors were so thoughtful. They did their job and that’s it. This incident convinced me about the urgent need for health care interpreters. This was when I decided to go to the Premier’s Dept. and make the request.\textsuperscript{644}

Some migrants who arrived in the 50s and 60s with no knowledge of English, learnt the language through their own efforts and became voluntary interpreters at a time when there was no interpreter service in Wollongong. It was common practice for migrants to help each other when there was no help forthcoming from governments or other sources. Migrants who had the slightest advantage over others not so fortunate would not hesitate to help fellow migrants in whatever way they could.

\textsuperscript{643} Ibid.
\textsuperscript{644} Ibid.
Guilia Bonacina, an Italian migrant who settled in Wollongong in 1961, like Mataitis, first learnt English only after her arrival in Australia. She became a voluntary interpreter for Wollongong hospital even before she could speak English because she was Italian and could speak Spanish. She said:

The doctor spoke in English to the Italian cleaner who translated it into Italian for me and I translated it into Spanish for the patient. I don’t think the Italian cleaner knew much English and certainly, my Spanish was not the best! This is how difficult it was for migrants. At that time it occurred to me how important it was to have a proper interpreter but it took over ten years to get one.645

Bonacina went on to say that there were no health and welfare services for migrants, only the Good Neighbour Council (GNC) took any interest in migrants’ affairs. After she learnt some English she became a voluntary worker for the GNC and then went on to work for the Illawarra Migrant Resource Centre. In 1971 she started the Italian Social Welfare Organisation because she realised that her community needed help in all matters including health, which was very important. At the beginning the organisation got no government funding but it now receives a government grant. In the early 80s they were able to employ an Italian health worker.646

In an interview with Franca Cortesi, Italian community worker who has been with the Italian Social Welfare Organisation (ITSOWEL) since 1987, she said that health services have been slowly deteriorating. In the early 80s migrant health received attention but now the government has other priorities. Until 1999, the Illawarra Area Health Service (IAHS) employed two Italian interpreters, one full time for 40 hours and the other part time, for 20 hours. Now it has been reduced to two part time interpreters covering a total of only 40 hours. This, regardless of the increase in number of aged Italian persons being hospitalised. These interpreters serve only hospital patients. There are no interpreters to assist General Practitioners with Italian patients who are not fluent in English. The Telephone Interpreter Service (TIS) is not always readily available so patients have to provide their own interpreter - a family member or a friend. This is a

645 Interview with Efrim and Giulia Bonacina, 12 April 2001.
646 Ibid.
great drawback especially for older Italian women who arrived in the 50s and 60s. There were no English classes available for them at the time, and if there were, they were too involved in family duties to benefit by them. Most of these migrants were from poor backgrounds, some were not literate in their own language.\textsuperscript{647}

Cortesi said that the IAHS employs only one Italian health worker. Several submissions to employ another worker and more interpreters have been unsuccessful. She emphasised the need for an Italian mental health worker based in the Illawarra. Mental illness is a growing problem in the Italian community, especially among the aged women. They suffer from depression and emotional disorders as they age, mainly due to their isolation. The language barrier is a great problem; even when they do see a doctor they cannot express themselves satisfactorily. As a result, the doctor puts them on some medication as an easy solution without getting to the bottom of the problem. This is why interpreters are important at the GP level. These patients do not receive counselling as English speaking patients do. Cortesi sees the number of suicides in the elderly Italian community as a significant issue. She believes that there should be more information and a study made on suicide and its correlation with mental illness. There is no Italian mental health worker based in the Illawarra who could contribute to the study.\textsuperscript{648}

Ludwik Ihnat, a Ukranian, is another migrant to Wollongong who took on the role of working for his community and later, for all ethnic communities. He realised that the Ukranian community needed help in order to access services so he joined the Illawarra Ethnic Council (IEC) in 1977 as a member. He was later elected into the Welfare Sub committee of the IEC and worked his way up to become its Chairman in 1983, which position he held until 1990.

According to Ihnat, interpreter services and Aged care services were sadly lacking in the 70s. The former became available in the early 80s but was very unsatisfactory. He said:

\textsuperscript{647} Interview with Franca Cortesi, Ethnic Aged Worker, Italian Community, 19 October 2000.
\textsuperscript{648} Ibid.
When the Spanish interpreter went on leave his place would be taken by the Greek interpreter who could be of no use to the Spanish community. But that was how the government worked - on a tight budget. Government would provide only so much and no more. Instead of maintaining a relief Spanish interpreter they made do with the Greek interpreter. It is all a case of money. On paper there was an interpreter, if some people couldn’t use him, well, hard luck!  

Lack of interpreters and bilingual doctors made life very difficult for NESB migrants. In the early days all information leaflets were in English. There were no translations. The catch cry was “Learn English”! But this was not easy. Volunteers held some English classes for migrant women who had the time to attend. Many of them were too busy working.

Ukranian migrants came in the late 40s and by the 70s they were an ageing population. Aged Care services were vital but not available. Most migrants who arrived at that time were DPs from refugee camps. Ihnat believes there must have been a great number suffering mental illnesses due to trauma. At that time there were no services for such people so they must have just carried on. There were no satisfactory health services of any kind for migrants. There was no state health system like Medicare. To see a GP in the 50s would cost 5 shillings. BHP encouraged all its workers to take private health cover but Ihnat said:

I don’t believe most of them did. I know for certain that my father who joined BHP in 1950 did not. For him the paramount need was a house and he saved towards it and did not spend on health insurance. I know it sounds short sighted but that is the way most migrants were at that time. Next to employment housing was their great need.

In the very early days migrants did not lobby the government to obtain services. Later, they formed their own ethnic societies and voiced their needs through organisations

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650 Ibid.
such as the IEC, EAC and the IMRC. Ihnat said that the IEC worked tirelessly for ethnic communities. It was a non-profit organisation. ‘We had no real gain going for ourselves so we spoke out about ethnic issues without fear of stepping on peoples’ toes’.  

Fadel Benhima, member of the IECC and the EAC, currently chairman of the Illawarra Community Relations Commission, spoke of the general apathy that existed in the 1970s in relation to ethnic issues. He said, ‘In many cases government and employers had to be prodded into activity’. And this was a major function of the EAC which worked closely with every state government department to develop services for ethnic communities and to make these services accessible to the users. The EAC also procured funds from the government for ethnic communities to develop services.  

Benhima believes that the most important achievement of the EAC was the establishment of interpreter and translation services for ethnic communities. Most migrants who came to Wollongong were NESB and spoke little or no English. Those who knew some English would become voluntary interpreters but there were also cases where some migrants would charge exhorbitant fees from fellow migrants for this service. Those thus exploited could not make representations to authorities as they did not speak the language. It was by way of organisations such as the IMRC and the IEC that requests were made. The EAC lobbied government for interpreter services and in 1977, for the first time, government provided interpreter services of some sort. In the late 70s the EAC set up a Health Care Interpreter service for the IAHS. But Benhima sees the lack of interpreter services for GPs as a great draw back. He stressed,’This is a very important area because most major illnesses are discovered at GP level. The TIS is not appropriate for this and is not readily available either’.  

Gail Maurice, who worked for the department of Immigration as a social worker in the 70s deplores the lack of services for NESB migrants during that period. The lack of health services was pitiful. She said:

651 Ibid.
652 Ibid.
653 Interview with Fadel Benhima, Chairman Illawarra Community Relations Commission, 28 May 2001.
654 Ibid.
Some people would argue that because they underwent health screening before coming to Australia, migrants should have had a better standard of health than the average Australian. This should have been so theoretically: but the fact was that migration was such a major stress and could affect their health. In my role as social worker I saw many migrants in poor health, occasionally, one with mental illness. Finding appropriate support for them was very difficult. There was no interpreter service. There were no bilingual staff. Mental health staff were non-existent. It was an enormous gap. We would try referring them to hospital but we were not always successful. Most of the time it was left to well-meaning volunteers like the GNC and friends to help and care for these sick people. They provided emotional support but no one was actually getting professional help. 655

Maurice worked with ethnic communities who could not speak directly to government departments regard their needs. She made representations on their behalf to the relevant authorities in her capacity as an officer of the Immigration Department. She helped migrants to the best of her ability, especially NESB women. She recounted:

There were many migrant women with grown up children and working husbands who were alone at home. They knew no English and services, if any, meant nothing to them. They needed English classes and training to get into jobs. These matters were discussed at inter-departmental meetings. We did not always see results. We saw enormous needs but there were never enough resources to meet them. Government priorities were different from our’s so we were forced to make horrible decisions as to where the resources should go. Government policy changed all the time. We did not necessarily agree with it but we had to work to implement whatever was the policy of the government of the day. There were times when we, as departmental officers, jointly showed our opposition to the policy even if unable to reverse it. 656

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655 Interview with Gail Maurice, Centacare, Wollongong, 29 June 2001.
656 Ibid.
Maurice sees as one of the biggest problems with government policy in the 80s, the fact that it was oriented towards newly arrived migrants only while earlier migrants also needed assistance. They had enormous needs not met by government departments. They were abandoned and had to turn to their communities for help. Both Maurice and Benhima believe that the Wollongong City Council took little or no interest in migrant issues.657

An interview with Dr Pat Mowbray, former Director of Community services, further strengthened the view that the Illawarra was the most under funded health region in New South Wales. The reason for this, she believes, is that a majority of funds were channelled to the Sydney teaching hospitals; also, Wollongong was considered too close to Sydney to have its own services. Patients were expected to go to Sydney for their special needs. There was a political aspect to it as well. She said, ‘We had had a long period of Labor government in NSW and all the Illawarra MPs were Labor and there was a sort of atmosphere that grew of not rocking the boat’.658

In the early 70s, as Assistant Superintendent of Wollongong hospital, Mowbray was seeing a large number of NESB patients. She found it extremely difficult to deal with them as there were no interpreters. In 1973 when the Commonwealth government put forward a community health program for all Australia, Mowbray made representations to the Health Commission of NSW for the establishment of community services in Wollongong. She said:

I made the point that Wollongong had a large ethnic population, 39%, rising to 50% in some areas, in areas like Cringila, almost 98%. There was an urgent need to have services for migrants. One of my main points was the need for interpreters as services were not meeting the requirements of the NESB population. It was 1973 and there was still no provision for health care interpreters.659

657 Ibid and Benhima, op cit.
658 Interview with Dr Pat Mowbray, 11 October 2001.
659 Ibid.
In 1974 Mowbray was appointed to the newly established Regional Office of Health in Wollongong, to set up community services.

She continued:

At that time we were setting up community health services without connection to general practice. In 1974, with the help of Dr Stephen from the UK, I put forward a submission for a Medical School attached to the University of Wollongong which would train doctors, nurses, psychologists and social workers, all in conjunction with each other. It was a revolutionary concept - education carried out in small groups, involving medical professionals as well as community workers. We had strong support for this project from the late Dr Sax, head of the National Hospitals and Health Services Commission, 1973, but unfortunately in 1975, the Labor government was replaced by the Liberals, and the Medical school went to Newcastle instead of Wollongong. They used the ideas from our submission but it still did not have the combined training which we proposed.\(^{660}\)

This was yet another example of other health regions being given priority over the Illawarra. This was also a political decision.

The Fraser government was not enthusiastic about community health services. Services stagnated. In the early 80s, matters reached a critical stage when the Commonwealth decreased health funding, particularly for community health. In the year 1980-81, the Illawarra was a significantly underfunded region. There was a deficit of 30.8% between the actual budget allocation and the target allocation for the Illawarra while Inner Sydney, Northern Sydney and the Hunter regions were in surplus.\(^{661}\) The Illawarra region lost 100 hospital beds and 6 Baby Health centres. It was at this stage that the Illawarra Health Consumers’ Association was formed with the aim of fighting for health services for the region. Research carried out in the community by the Association found that the most urgent need was for mental health, developmental

\(^{660}\) Ibid.

\(^{661}\) NSW Parliamentary Papers, 1981-82, vol 2, p 10, Table 1.
disabilities and geriatric services. This Association was well supported at all levels of society - leading academics, church dignitaries, Unions, such as the Nurses’ Union and others. Mowbray said ‘It was an enormous publicity campaign - people sat up and took notice including the state government and the head Office of the Health department’ As a result of the endeavours of this Association the Illawarra region was given 1 million dollars extra for hospitals and another 1 million for community health services. No funds were allotted for mental health services.

Mowbray maintained that a number of proposals made by her for the betterment of health services for NESB migrants were rejected by the Fraser government. She said:

> From when I first began work I recognised NESB migrants’ health needs as a priority but couldn’t give it the due attention due to lack of funds. At the Regional Office we did not have much scope to introduce policy as we were directly under the Health Commission’s Central office which was primarily responsible for setting policies and allotting budgets. When money came in we improved services but it was never enough. There was little we could do, really.

It is ironical that the Illawarra region with its large ethnic population has always had to put up a struggle in order to obtain better migrant health services. Seniuk et al point out that in the Illawarra, as in no other health region, a taxing struggle had been necessary in order to obtain ethnic health workers. In 1983, a NSW Department of Health circular, “Guidelines to Improve Migrant Access to Hospitals”, referred to ethnic health workers as a useful resource for providing counselling and prevention services for patients in a linguistically and a culturally appropriate way. Yet, in 1983, Illawarra was the only region with a high concentration of migrants that did not employ such workers.

In 1983, when the Illawarra Regional Migrant Health Team, submitted an application to employ seven ethnic health workers the Department of Health granted funds for a

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662 Interview with Dr Pat Mowbray, 11 October 2001.
663 Ibid.
664 S.Seniuk, F.Facci and A.Vella Migrant Womens’s Health in the Illawarra: Service or Disservice?, September 1985, p 12.
period of 12 months only. Despite numerous requests, the Health Department made no
commitment to retain those positions in the future and no funds were forthcoming. In
retaliation, ethnic community members, realising the importance of ethnic health
workers, formed a lobby group to insist the positions be retained. In 1985, as a result of
continued pressure from community organisations these positions were made
permanent with continued funding from the Health Department.665

Seniuk et al continue:

The resistance that was displayed for the Ethnic Health Workers’ positions was
comparable with the resistance that had been faced in order to establish the
Health Care Interpreter Service only 5 years earlier. (The Illawarra was also the
last region to obtain a Health Care Interpreter Service).
In all the examples given, the provision of culturally appropriate services has
only been achieved through either one-off, short-term funding and/or after
extensive probing, hard lobbying and fighting.666

This chapter gives a picture of general health services for migrants as it was from the
1960s into the nineties. It will not be complete without stating some views of the
current Co-ordinator of mental health services, IAHS, Franca Facci, who was formerly
a welfare worker for the Italian community in Wollongong. She said:

In the early days there were no English language classes, no interpreters, no
welfare. Patients are known to have died for want of interpreters. There was a
charity mentality - helping poor migrants who had no resources. There were a
lot of problems due to assimilation. The focus should have been on the teaching
of English. Language is so important.
By the mid 70s there were large migrant community groups, some of them had
their own churches and welfare organisations. Through them, they lobbied the
government for services. Nothing much changed until the EAC was formed in
1978 to address issues of concern to ethnic communities.667

665 Ibid.
According to the IMRC, at the beginning of the twenty first century, migrant services are far from satisfactory. In the past fifteen years the situation has become worse. The government has decreased funds for the IMRC and at the same time requested more services for the money. In reality, the number of services provided for migrants has decreased as has access to these services. Decrease in funding has tightened the eligibility criteria, so less people qualify for services. Some migrants with genuine needs cannot be helped. Dental health care is a prime need for migrants yet government has responded by reducing services. The situation in mental health care is the same; decreased funding and stricter eligibility criteria. Less people qualify for mental health treatment but that does not mean mental illness is less existent. Those who do not meet the eligibility standard have to depend on the charity and goodwill of NGOs.668

The organisation called ‘South Coast Lifeline’ provides counselling services for migrants as it recognises the pressing need for this service for NESB migrants. This is an example of a humanitarian organisation, outside of the health department’s ambit, which is going out of its way to help migrants neglected by the government. The IMRC made a submission to the Department of Immigration to fund a bilingual or multilingual counselling service but it got no funds.669

The IMRC is sceptical of the government’s ‘good’ intentions. For the past twenty years the NSW government has run ‘efficiency drives’ to deliver services more efficiently. The IMRC Co-ordinator says

My impression is that they do not work. The health Department carries out consumer participation exercises where supposedly migrants themselves have input into their own health needs. Is the health authorities really serious in wanting this input? The end result is that the situation is worse. The government says it is trying to improve services but the reality is that they have deteriorated. There are no ethnic mental health workers. Even the general community workers are insufficient to meet the demands, as reflected in waiting lists. There

667 Interview with Franca Facci, 28 February 2001.
is a great deal of government rhetoric about social welfare and migrant programs. The question is, how far is this real?\textsuperscript{670}
Chapter 9

The Seven Svetlanas: In Their Own Words

I first heard about Angela (Macedonian mental health worker) when I was in hospital but my husband did not like to contact her in case others in our community would get to know of my illness. In our community it is a shame to be mentally ill. Finally, I did contact her and I am very grateful for her help. She listens to all my problems and is very understanding. No other professional explained anything to me about my illness or gave me advice.

Desanka

The doctors told me that I got this illness through stress and anxiety caused by my husband who drank alcohol to excess, gambled and had extra-marital affairs. He also physically abused me sometimes. I see a psychiatrist regularly who prescribes my medication which I have to take for the rest of my life if I am to keep well. My mother had an anxiety problem too but she was never on medication. Back home she took natural remedies. She took mineral baths regularly and got on quite well.

Milica

My quality of life is not bad now. My children and grandchildren make me happy. But I have some problems with my husband who had a head injury and has taken to alcohol since. He causes unpleasantness at home so I don’t go out much. I still feel some anxiety. Angela (the Macedonian mental health worker) is very kind and helpful. Once a fortnight I attend her group. She listens to me and even takes me to the doctor. She talks to us mental cases!

Stanka

The next two sections will look at the experiences of some NESB migrants living in the Illawarra region with mental illness. The testimonies cover the years from 1965 to
The principal source material for these case studies comes from transcripts of interviews with NESB migrants. All those taking part in the survey, apart from interviewee Anica, were interviewed through an interpreter. All the interviewees arrived in Australia between 1960 and 1985 and all, except Anica, were from rural backgrounds. And with the exception of Anica, the husbands of all the other interviewees were employed by BHP Steel in Wollongong.

The information gathered from these interviews refute some claims made by the department of health and the IAHS about services for NESB communities. The interviews lay bare the deficiencies which exist in the mental health system. Most outstanding among these is the inefficiency, or at times, the non-existence of interpreting services. Following the release of the Galbally Report in 1978, there was an increase in federal funding for State expenditure on migrant services. The NSW Ethnic Affairs Commission, established in 1978, was allocated funds for setting up education, translating and interpreting services for NESB migrants. Despite these government policies, two and a half decades later the situation has improved very little. Research carried out in 2003, by the Fairfield Health Service, NSW, revealed that while fifty percent of NESB service users at Fairfield hospital required a trained interpreter, only seventeen percent got access to one.

The researcher, Dr Cooper says:

Some of the people using ad-hoc interpreters were unaware that they could actually ask for interpreter assistance. I don’t think they either understood or were having it explained to them at the clerical registration that if they needed assistance with language they were entitled to ask for that and that was a free service. She noted that many people used family members or friends as interpreters, which can lead to confusion and sometimes misdiagnosis.  

The migrants interviewed were in the mental health system between 1965 and 2000, and have had poor access to the interpreter service. None of them were aware of the

availability of mental health literature in translation. Most of them suffered at the hands of their GPs. This points to the sorry state of family medicine in Australia where primary health care professionals are ignorant of, or apathetic to, mental health issues. It also emphasises the lack of communication between GPs and specialised mental health services. The unavailability of ready access to interpreter services for GPs is a further impediment to services. All those interviewed claimed that they found the ethnic mental health worker more helpful to them than the GPs or specialists, in understanding their illness.

The migrants interviewed were as follows:

**Anica**: Arrived in Australia in 1962, from Belgrade, Yugoslavia, at the age of twenty four. Onset of illness was in 1968. Has been diagnosed as bipolar disorder (Manic depression).

**Desanka**: Arrived in 1968 from a village in Macedonia, at the age of seventeen years. Onset of illness was in 1982. Diagnosed as depression with anxiety, later displaying psychotic symptoms.

**Dostana**: Arrived in 1982 from a minor city in Macedonia, at the age of twenty one. Onset of illness was in 1991. She has been diagnosed as suffering from schizophrenia and paranoia.

**Milica**: Arrived in 1977 from rural Macedonia, at the age of eighteen years. Her illness first manifested itself between 1990 and 1991. She has been diagnosed as schizophrenic.

**Dana**: Arrived in 1970 from a village in Macedonia, at the age of twenty seven. Onset of illness was in 1983. Diagnosed as severe depression with anxiety and psychosomatic symptoms.

**Nada**: Arrived in 1971, from a small city in Macedonia at the age of twenty four. Onset of illness was in 1975. Diagnosed as depression with psychotic symptoms.
Elica: Arrived in 1967 from rural Macedonia at the age of thirty years. Onset of illness was in 1982. Diagnosed as depression with anxiety and psychosomatic symptoms.

Anica arrived in 1962 and lived in Sydney for some time before she moved to Wollongong. She is an intelligent woman who speaks English fluently and has a good memory for past events and dates. Although the psychiatric categorisation of her illness is Bipolar disorder or manic depression, she claims to be subject only to depression. But her carer’s notes reveal that she is prone to euphoric episodes as well.

At the time that Anica arrived, in the early sixties, migrants were not eligible for social security payments. The Department of Immigration advised her to seek employment and because she had a sound, working knowledge of English, she found work without delay as credit clerk in a cosmetics factory. Anica and her husband experienced discrimination and openly derogatory remarks from Australians during the early years here. In her own words:

...I experienced a lot of prejudice from Australians. I felt unwanted. I have even been called a “dirty wog”. But you get used to being called names. I learnt to be indifferent. In 1963 I married a Hungarian migrant who worked for the Department of Defence and I was happy with him.672

Anica arrived in Australia before multiculturalism became official government policy. In the sixties Australians were more openly critical of foreigners. After multiculturalism, resentment and hostility towards ‘outsiders’ was not as overt. There was a feeling of having to conform to the current social norms; a subtle but insidious racism. Anica says her worst experience of racism was at work when a junior clerk called her a ‘wog’ and told her to go back where she came from. She thinks there was an element of jealousy in this remark as the junior had to take instructions from her. Derogatory remarks were almost a daily occurrence.673

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672 Personal interview (name withheld at interviewee’s request, henceforth designated as Anica), 28 April 2003.
Although Anica claims that she ignored all the unpleasantness and got on with her life she would undoubtedly have suffered a great deal of hidden stress due to constant racist taunts. It is not unlikely that there was an element of jealousy in the comments she received at work. An Australian worker would feel resentful having to take instructions from a ‘wog’. When the outsider is humble and subservient and seeks instruction from the host he or she is well received, even welcome. But the knowledgeable migrant will not be tolerated.

Adding to all this were the difficulties Anica experienced with her employer (at this time she was employed as a clerk with the Medical Journal of Australia). She said:

The room I worked in was small, with no window, only a door and with no air conditioning. I worked under difficult conditions and was always under terrible pressure because the manager, was very demanding and drove me hard. In 1968, after I had worked there for one month, I collapsed at work. It was an extremely hot day with the temperature around 40 degrees. The room was stifling and I was hurrying to get the work finished. When I collapsed the manager sent for my husband and told him to take me to Callan Park hospital saying ‘she is ready for a mental home’. I later got to know that Callan Park was a notorious mental hospital.\textsuperscript{674}

The circumstances prevailing on the day may have led to her collapse but were unlikely to have been the cause of her illness. Although Anica claims that there is no history of mental illness in her family, it is possible that her childhood experiences contributed to her depression. She lost both her parents during World War Two, in a very painful manner.\textsuperscript{675} It is most likely that this event left a psychological scar. Her workplace was fraught with tension. What is surprising is not the fact that she became sick but her employer’s attitude to it.

The manager’s attitude was stereotypical. Migrants were known to suffer from mental disorders, so he assumed that this was another such case. With absolutely no medical

\textsuperscript{673} Ibid.
\textsuperscript{674} Ibid.
knowledge, he diagnosed the patient as needing psychiatric treatment and sent her to Callan Park hospital. The correct and sensible procedure would have been to call an ambulance or send her to a doctor. Whether it was heat exhaustion and stress or the onset of her present illness, it was clearly for a doctor to decide.

At Callan Park, Anica was admitted by a nurse into a ward with twenty beds. She was asked to swallow some tablets which she was reluctant to do without first knowing what they contained, as she was allergic to many drugs including aspirin. On being questioned, the nurse refused to answer, instead grew very angry and prepared to give her an injection. In spite of the patient’s protests and attempts to break free, the nurse recruited help of other staff and Anica recalled what ensued:

Two female nurses held my limbs while a male nurse grabbed me from behind and encircled me with his arms, exerting so much pressure on my chest that I could hardly breathe. They dragged me to a cubicle which contained only a bare mattress on the floor, pinned me down on it, gave me the injection and locked me in for the night.676

That night Anica was given a second injection because she had the audacity to disturb the night nurse to ask for the toilet. She was thirsty but her requests for water were ignored, she was roughly pushed back onto the mattress by the male nurse. She said:

In the morning I was like a zombie. When my husband came to visit I could hardly speak to him or even keep my head up. The nurses told my husband that I was suffering from a very serious nervous breakdown. He advised me to be compliant as the nurses must know the correct treatment.677

Anica’s experiences at Callan Park confirm what we already know about that hospital. When she referred to it as a ‘notorious’ hospital, she was justified. The 1961 Royal Commission of Inquiry into Callan Park, headed by Justice McClemens, found it in a deplorable condition. He found many shortcomings, some evidence of ill-treatment of

675 Ibid.
676 Ibid.
patients and most importantly, that the standard of treatment was low due to shortage of qualified staff. He commented that psychiatric nursing lacked the prestige of other branches of nursing.\textsuperscript{678} This partly explains the aggressive and arrogant behaviour of the nursing staff towards Anica. She claims that her experiences at Callan Park have scarred her indelibly. She suffered nightmares after she was discharged. These persisted for years and affect her occasionally even to the present day when she wakes up in a frenzy of terror thinking she was still in that hospital. She says “I have such a fear of Callan Park. If I see it from the street I think I will get a nervous breakdown”.\textsuperscript{679}

Anica claims that she was not once seen by a doctor during her four week stay at Callan Park. We have only her word for it but it is well to remember that all the Reports of the Inspectors General of Mental Hospitals during this period emphasise the shortage of psychiatrists.\textsuperscript{680} It is a shortage that still exists. The Royal Commission made many recommendations and services changed but very slowly due to lack of funds. Anica was admitted to Callan Park in 1968, some seven years after the Commission, when service changes were still being implemented. The Commissioner also called for a change in community attitudes towards the mentally ill, but this was even slower to materialise.

Anica’s tragedy was that she was intelligent and had an inquiring mind. She had a good grasp of the language and asked too many questions. A migrant was expected to be subservient and carry out orders, not question her betters. Other NESB patients have had different experiences when in hospital. Desanka recalled her stay in Wollongong hospital’s psychiatric ward in 1982:

I was in hospital for two weeks. There were no interpreters. I could not understand anything the nurses said. I followed nothing. I simply obeyed.

And later, in the 1990s, at Shellharbour hospital she said:

\textsuperscript{677} Ibid.
\textsuperscript{678} Report of Mr Justice McClemens into matters affecting Callan Park Mental Hospital, \textit{NSW Parliamentary Papers}, 1961, vol 4, no 32.
\textsuperscript{679} Interview with Anica \textit{op cit}.
...the language barrier was a problem. I was given ECT. I was not told anything about it in my language. I was frightened and did not know what to expect. But I was submissive so I got on.681

Dostana, also an NESB patient said:

When I was in the psychiatric ward (Wollongong hospital) there were no interpreters. I knew very little English and could not understand much of what was going on. I spent two weeks there and took my medication as I was told although it did not help me. Then I was discharged.682

Milica had a similar story. She said:

I was admitted to the psychiatric ward in Wollongong hospital and diagnosed as schizophrenic. I could not understand what was said to me in English except for two occasions when an interpreter was present. A Bulgarian nurse who could speak Macedonian helped me. I was always co-operative so I improved and left hospital.683

All three patients have had uneventful stays in hospital and have nothing unpleasant to say about their experience. They have been compliant even when they did not understand the procedures which is how the staff would prefer patients to be.

The last three patients were in hospital between 1982 and 1992, at a time when interpreters were supposed to be available for NESB patients. But their experience does not bear this out. It points to a shortage of interpreters and a deficiency in the running of the service. The shortage exists to the present day, as confirmed by several Illawarra health workers interviewed for this thesis.684 Dostana and Milica had the good fortune to have the Macedonian mental health worker to interpret procedures for them in the

681 Personal interview with (name withheld at interviewee’s request, identified as Desanka), 5 May 2003.
682 Personal interview with (name withheld at interviewee’s request, identified as Dostana), 12 May 2003.
683 Personal interview with (name withheld at interviewee’s request, identified as Milica), 19 May 2003.
psychiatric unit. But in the 1980s when Milica was in the Wollongong public hospital for the birth of her children, a Macedonian patient had to act as interpreter.685

Another NESB migrant (Dana) who was interviewed recalled the birth of her child in the Wollongong public hospital in 1970. She said:

‘there were no interpreters. A Serbian lady acted as interpreter. I don’t think she was a real interpreter. I think she was a cleaner.’686

Nada, also a NESB migrant, who suffered serious panic attacks and depression and sought help from the Port Kembla hospital in 1975, related the following incident:

After a particularly bad attack, my Polish neighbours took me to Port Kembla hospital. Once there, I became worse and cried “I am going to die! Help me!” A doctor did a physical examination - he checked my pulse and my chest and said there was nothing wrong with me and sent me home. He did not give me any medication. I could not speak English. There was no interpreter so the doctor and I could not communicate. I was helpless.687

Later on, in 1975, this same patient, Nada, was admitted to Wollongong hospital where she was given ECT. She recalled:

There were no interpreters. There was a Polish nurse who acted as interpreter on some occasions. The doctors who gave me ECT would just look me over and go on with it. They could not explain anything to me. I knew nothing. I was disorientated. Lost.688

These incidents took place in the seventies. But they are no different from the experiences of Desanka, Dostana and Milica which took place between 1982 and 1992. Between 1978 and 1996, Nada saw two GPs regularly but was unable to communicate

685 Interview with Milica op cit.
686 Interview with (name withheld at interviewee’s request, identified as Dana), 16 June 2003.
687 Interview with (name withheld at interviewee’s request, identified as Nada), 26 May 2003.
688 Ibid.
with them satisfactorily due to the language barrier. No interpreters were available for GPs.

Elica recalled her stay in Shellharbour hospital for a gall bladder operation in 1982. There were no interpreters and her own knowledge of English was very poor. When the nurse told her about what the doctor thought of her condition, Elica took it to mean that something was seriously wrong with her. This frightened her so much that she slowly sank into a depressive state which continued after she was discharged. For the rest of her stay in hospital her daughter served as interpreter. She believes that this was the beginning of her depression and accompanying stomach problems. She said that at that time she did not even know that interpreters were supposed to be available. The shortage of interpreters appears to be the most serious setback to satisfactory access of services for NESB patients.

Professional staff often refer to problems caused by the ‘language barrier’ when dealing with NESB patients. But Anica’s experience shows that there are other reasons for staff arrogance and superiority. Anica had a good knowledge of English and a few words of explanation of her condition was all that was needed to avert much unpleasantness for her and the staff. When the nurse explained to Anica’s husband that she was suffering a ‘serious nervous breakdown’ Anica accepted the diagnosis and became compliant. Her behaviour was not out of perversity but because she felt she had a right to know what was being done to her. She did not realise that mental patients had no rights - least of all, the right to question their superiors, the ‘professional’ staff. Anica was not an unreasonable person. She only wanted to be treated as a ‘person’, instead of which, she said she was treated ‘like an animal’.

Some of the interviews confirmed the lack of care for the mentally ill from GPs, either through negligence or genuine ignorance of the prevailing mental health system.

The National Mental Health Policy of 1992 stated that

General Practitioners are often the initial point of contact for people with mental

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689 Interview with (name withheld at interviewee’s request, identified as Elica), 30 June 2003.
690 Interview with Anica op cit.
health problems and mental disorders. It has been estimated that they represent about a quarter of people visiting general practitioners.\textsuperscript{691}

Hence, an important objective of the Policy was to ensure that GPs received continuing education programs with adequate coverage of mental health issues and access to specialist mental health professionals. This would ‘...strengthen their capacity for assessment, diagnosis, treatment and referral of people with mental health problems and mental disorders’.\textsuperscript{692} But, as mentioned elsewhere in this thesis\textsuperscript{693}, GP education in mental health matters started late in Australia. It was the year 2000 before National Mental Health Strategy funding was released for the publication of a manual of mental health care for general practitioners.\textsuperscript{694}

In 1999, a sum of three million dollars was allocated from the budget of the Second National Mental Health Plan to provide education and support to GPs in mental health care and to promote shared care between them and mental health services. In 1999, educational packages were developed for GPs, to improve their skills in treating commonly seen psychiatric disorders and to familiarise them with the functioning of the mental health system. Higher Medicare Benefits were introduced for GPs participating in shared care which involved not only regular monitoring of the patient but periodic conferences with the patient, the community carers, the Area Health Service nurse and the caring psychiatrist.\textsuperscript{695} The above scheme, Consultation and Liaison in Primary-care Psychiatry, (CLIPP), was based on the Care Program Approach (CPA) which was introduced in Britain in 1990.\textsuperscript{696} GPs are busy professionals and this time consuming scheme, even with the incentive of higher financial gains has not proved to be very successful

Unfortunately, for patients like Dostana, Dana and Nada the scheme was too late. Their experiences speak of mismanagement and a sad loss of recovery time for the patient.

\textsuperscript{691} National Mental Health Policy, 1992, p 25.
\textsuperscript{692} Ibid.
\textsuperscript{693} Vide Chapter 3, in this thesis.
\textsuperscript{694} J.Davies A Manual of mental Health Care in General Practice, 2000, CW Department of Health and Aged Care.
\textsuperscript{695} Davies op cit, p 5.
Dostana had been hallucinating and ‘hearing voices’ for almost one year before her husband persuaded her to see a GP in 1992. In spite of her condition the GP did not refer her for psychiatric assessment or get her admitted to hospital. It was some time later that a Serbian social worker known to her family recognised her to be sick and took her to the Wollongong hospital. After two weeks of treatment she was discharged but the medication did her no good. Her illness got worse. Between 1992 and 1997, her GP sent her to a bilingual psychiatrist who spoke Dostana’s language. Dostana said, ‘We spoke in Croatian. She listened to me and spoke to me a lot. It was all talk and no medication. I now know that I needed some kind of medication to get well. I went to her a few times but with no positive result. I was still very sick.’

In 1997, it was the patient herself who helped herself. On a day of very severe illness, she called the police for help. The police took her to the Shellharbour psychiatric unit where she was finally diagnosed as schizophrenic and given the appropriate treatment. Dostana maintains that the monthly injection has done her so much good that she can now function normally. She said ‘..it is the correct treatment and I should have got it long ago’.

Dana also suffered at the hands of her GPs before she too took matters into her own hands in order to resolve her illness. She suffered from insomnia, grief and anxiety after the premature death of her husband at twenty nine years of age. She was in severe physical and mental distress and could not cope with her three young children and her financial commitments. She was reluctant to see a doctor as she could not speak English and she heard that no interpreter was available. In 1983, after six months of intense ill health, she heard of a Serbian speaking GP and went to her for help. She took her medication for some time but it did her no good. When she spoke to the doctor about it, she replied ‘..You are going to be like this always. I can’t find a cure for you’.

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697 Interview with Dostana op cit.
698 Ibid.
699 Interview with Dana op cit.
After a similar experience with another GP who was not bilingual, and had no interpreter, she reconciled herself to her condition. She said ‘..I struggled with my illness until the nineties, when my children were grown up because I did not know where to go for help’. In the mid nineties her children heard of the Macedonian mental health worker and contacted her. She took Dana to a GP who referred her to a psychiatrist. For the first time, she was diagnosed and given appropriate treatment which she maintains to the present day. She now enjoys a reasonable quality of life.\footnote{\textsuperscript{700} Ibid.}

Of all those interviewed, Nada got the worst deal from her GPs and the mental health system. In 1975, she suffered severe depression and panic attacks. After a suicide attempt, her Serbian GP admitted her to Wollongong hospital where she was given injections and ECT almost daily for two weeks. On discharge, she was given some sleeping tablets and one pack of Serepax and told that was all the medication she would need. There was to be no follow up. But this treatment was not sufficient. She put up with her illness as best as she could.

In 1978, the Serbian GP having left the practice, Nada saw the doctor who replaced him.(Dr 1).She related the following account:

He told me he was not an ordinary GP but was specialised in many areas, including mental health. He was competent enough to look after me and it was not necessary for me to see a psychiatrist. I saw him regularly. He tried many different medications on me but with no good result. Finally, in 1988, he gave me a tranquiliser, L.......This helped a bit but I got addicted to it. It did not cure my illness, it only helped me to cope with it. I went deeper and deeper into depression. I was full of unexplained fears. When I spoke to the doctor about it he said “I have tried everything. I have nothing more to give you”.\footnote{\textsuperscript{701} Interview with Nada op cit.}

Nada recounted that Dr 1 ‘had some trouble with the police’ and left the practice soon afterwards. She then started seeing the GP who replaced him.(Dr 2). He continued prescribing the tranquiliser but did not refer her for psychiatric assessment. Around this
time she developed body pains for which Dr 2 prescribed a pain killer. Nada said: ‘I did not know then that the pain killer was addictive. I was now addicted to a pain killer as well as a tranquiliser’. She had now been sick for almost twenty one years. In 1996, Dr 2 sent her to a psychiatrist who spoke her language. Unfortunately, she could not see this psychiatrist again because her husband objected to it for personal reasons.  

Nada’s GP then sent her to a non-bilingual psychiatrist. There was an interpreter present. The doctor only asked her for her date of birth, the number of siblings she had and their names. Nada said:

The rest of the time, he spent talking to my husband. He looked straight at him and addressed all his questions to him. I did not like it at all. I was the person unwell. I needed to be asked the questions. I don’t know how these doctors can make a diagnosis about me without even asking me a single question. I went to him once more and gave up. I was not pleased with how he went about treating me.

The above is a very perceptive comment coming from patient, about her treating professional. This psychiatrist (Dr X) has received harsh criticism from other patients as well. Anica had also consulted him. She said:

I once saw Dr X privately for which I had to pay $160. After a two and a half hour wait in his consulting room, all he did was to renew my prescription. He did not speak a word to me about my illness or anything else. He was just not interested. I never went back to him.

In this case, there was no language problem at all as Anica is fluent in English. Other patients have objected to the fact that Dr X does not ‘look them in the face’ and he answers numerous telephone calls during consultations.

702 Ibid.
703 Ibid.
704 Interview with Anica op cit.
705 From the notes of a carer (name withheld at request).
The experiences of these migrants show how ill-equipped most GPs are to deal with cases of mental illness and that some psychiatrists are not much better! GPs have had no training in recognising commonly occurring psychiatric disorders, therefore, they adopt the attitude that mental health is irrelevant to general medicine. Many psychiatric problems are masked by physical symptoms. When such a patient presents, the true nature of the problem experienced by the patient is not understood or treated because of the insensitivity of the doctor. This shortcoming is seen in the case of Dana who was suffering extreme anxiety and a feeling of her stomach bloating with fluid which went up into her head and into her limbs. She saw two GPs. Both treated her for her physical condition with no success. Surprisingly, one of the doctors spoke the patient’s language yet did not take into consideration her mental condition. The patient went without psychiatric treatment for nearly ten years.\textsuperscript{706}

Moraitis writes that general practitioners’ approach to psychosomatic patients must change. They must adjust their ‘own medical lore or social mores’. The treating doctor must realise that the psychosomatic symptoms arise out of the patient’s anxiety and insecurity. Rational reassurance with some medication is a most effective therapeutic measure. If the anxiety is deep seated, these remedies will be insufficient and other treatment, such as psychotherapy, should be sought. He says:

\begin{quotation}
We may condemn the symptom; do not let us condemn the patient because he (sic) is affected by it... It is up to the doctor to relieve some of the immigrant’s anxiety by becoming part of the supporting group not easily found in a new country.\textsuperscript{707}
\end{quotation}

Unfortunately, for most of the NESB migrants interviewed there was no such support forthcoming from their doctors.

Elica as well as Dostana suffered a similar fate. Elica was depressed and suffered severe anxiety which manifested itself in the form of chronic abdominal pain. Beginning in 1983, she saw a number of GPs who treated her for her stomach condition with no

\textsuperscript{706} Interview with Dana \textit{op cit.}
beneficial result. She cannot recall the number of doctors she visited but approximates it at eight or ten. It was only in the early 1990s that she saw a GP who, recognising her psychological symptoms, referred her to a psychiatrist.\textsuperscript{708} In 1992, Dostana’s husband took her to a GP because she was hallucinating and hearing voices yet he did not refer her for psychiatric treatment. When he finally sent her for treatment it was for psychotherapy, which the patient herself thought was of no help. She says ‘.it was all talk and no medication. I now know that I needed some kind of medication to get well’.\textsuperscript{709} She had all the symptoms of schizophrenia and had not yet received appropriate treatment.

The unprofessional behaviour of Nada’s GP is difficult to understand. For ten years he declined to refer Nada to a psychiatrist for her depressive state. Instead, he experimented on her, trying out various medications while her condition deteriorated badly. After ten years he prescribed an anti-depressant for her. His behaviour can be explained in one of two ways. Either, he was unaware of the functioning of the mental health system and referral procedures or as Davies points out, he was reluctant to refer patients because of concerns that the specialist service will take over the primary care of his patient and thereby cause him loss of income.\textsuperscript{710}

These experiences are testimony to the fact that obtaining satisfactory mental health treatment is an extremely difficult task for those of different background. None of those interviewed had ever seen literature about mental illness or the mental health system, translated into their language. Their experiences with the medical profession have almost always been grossly inadequate, even racist. Some of them have received arrogant treatment from professionals, others, no treatment at all. Everyone who was interviewed agreed unequivocally that their greatest help and strength came from the ethnic mental health worker. They affirmed that she helped them to understand their sickness in a way that no psychiatric professional ever did.

\textsuperscript{707} S.Moraitis “Medical and Health Problems” in H.Roberts (ed) Australia’s Immigration Policy, 1972, pp 88-92.
\textsuperscript{708} Interview with Elica, 30 June 2003.
\textsuperscript{709} Interview with Dostana, \textit{op cit}.
\textsuperscript{710} Davies, \textit{op cit}, p 2.
Epilogue

I was healthy till I went to Callan Park hospital. I have to take my present medication for the rest of my life. In my home country we have lots of herbal remedies. In Australia there is hardly any herbal medicines.

I am happy now and have no bitterness towards the country but I think I made a big mistake coming to Australia. I should have stayed on in England or somewhere in Europe. I have had very unpleasant experiences as a migrant both at work and outside. But I have met some very good Australians as well. My life became better after I met my husband and I learnt to ignore all the name calling. I think there is some jealousy too in their attitude. But things have changed somewhat in the past 15 years or so. Now Australian attitude to migrants is not so bad.

Anica

I was quite well till I came here. I don’t know why I got this illness. I have a happy family life. Of course, I never went to work here. Before I came here, I was working in Macedonia. I miss going out to work. I have to take the injection all my life. For many years I did not get the correct treatment and suffered as a result.

Dostana

Extensive research done in the subject of immigrants and mental illness shows that there is a higher incidence of mental disorders among migrants than in the host population.\textsuperscript{711} There is also contradictory evidence from other sources which shows that the existence of mental diseases among migrants is appreciably lower than its incidence among the native born population.\textsuperscript{712} Some studies done in the University of Western Sydney conclude that there is a similar level of mental health problems in NESB

\textsuperscript{711} Vide Literature Review, this Thesis.
\textsuperscript{712} For eg. findings of NSW state authorities as reported by H.Wunderly, Commonwealth Director General of Health, in Commonwealth Parliamentary Debates, 1957, vol 14, pp 505-6.
communities as in the general community. However, the debate between these opposing views fades into insignificance when one considers the real problem - the problem facing NESB migrants who are mentally ill. Whether NESB communities suffer more mental illness than the native born is not the important issue. The important issue is that NESB migrants, due to their cultural and linguistic diversity, suffer far more than their native counterparts when caught up in the mental health system.

Research into mental health services in the Illawarra found that services were inadequate for the population in general and not merely for NESB migrants. In such a situation migrants are worse off, for reasons that are obvious - cultural and linguistic differences being predominant. Since the end of the Second World War, Australia has admitted thousands of migrants every year, a large number of them from non-English speaking countries, some of them refugees, yet the mental health system does little to recognise their needs.

The problems facing migrants are those that befall the working class in most urbanised, industrial societies. NESB migrants are, to a greater extent than the host population, employed in occupations of low pay and social status. As a group they are unable to have access to a life style available to the rest of the community. Steady employment, regular income, proper housing, education and health care are seldom within their reach. They are socially deprived. NESB migrants are predominant in unskilled manual jobs. Their low socio-economic status means that they are socially excluded from gaining access to many valuable institutions available to the rest of the population. Research done in Australia has demonstrated that socio economically disadvantaged groups are more likely to experience poor psychosocial health. Studies carried out overseas also point to a higher incidence of mental illness in lower socio-economic groups. Although the problems of NESB migrants are the same as those suffered by the working class as a whole, they are greatly aggravated by their cultural and linguistic diversity.

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714 G.Turrell and C.Mathers “Socioeconomic Status and Health in Australia” in Medical Journal of Australia, 1 May 2000, vol 172.
Migrants in a new country have their unique problems. The outstanding problem is stress. Stress can occur due to isolation, loss of social networks and confusion brought about by the culture of the host country. Loss of occupational status is another major cause of stress. Prejudice and discrimination by the host population also play an important role. Chiu says of Australian migrants that:

with the stresses of uprooting, resettlement and the struggle to establish a life consistent with expectations of better living standards in Australia, immigrants are at risk of developing mental disorders.  

The group of migrants interviewed can be taken as typical of the Illawarra’s NESB migrant population of the 1960s, 1970s and 1980s. Yugoslav immigrants, particularly Macedonians, constituted the largest migrant group in the Illawarra. According to the 1986 census, there were 6,959 Yugoslav-born migrants living in Wollongong city alone. Over seventy languages are spoken in the Illawarra region. The major languages include Macedonian, Serbian, Croatian, Greek and Italian. A study carried out by the Regional Migrant Health Team in 1984 found a poor level of English language proficiency among NESB communities. Between 60 - 70% of NESB men and women had less than survival level proficiency; women being particularly disadvantaged. Of the female Yugoslav population surveyed in Cringila, (a southern suburb of Wollongong), 56.3% spoke little or no English as compared with a national average of 28% for their community. Of aged Yugoslav women, 84.9% spoke little or no English.

Of the seven women interviewed only Anica, from Belgrade, had acquired a knowledge of English before arrival in Australia. Dostana came from a minor city and had completed the eighth grade in school but had no knowledge of English. Nada was also from a small city but did not speak English. The rest were from rural backgrounds and their pre-migration education level was low. The Regional Migrant Health Team survey

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in Illawarra found that 96.7% of Macedonian women and 95.4% of Serbo-Croatian women in Cringila were from rural background.\textsuperscript{719} These factors have a bearing on the development of English language skills. To expect women who have not had the educational opportunities in their own country, to be able to learn English in Australia is unrealistic.

Havenhand observes that although speaking fluent English was an essential requirement for the full participation in Australian life, in actual fact, the opportunity to learn the language was unavailable for most NESB people. Of all migrants, NESB women had the least accessibility to language instruction.\textsuperscript{720} In addition to low levels of pre-migration literacy, low economic status and lack of supportive networks were also found to be a hindrance to the development of language skills. All the women interviewed had young children and with no extended family in Australia to help them, they could not cope with learning a new language. Once the children were grown up, the women had to go out to work in order to supplement the family income and they did not have the time to spend on studies. In the case of some, their illness had already set in, making it an impossibility. Dostana and Dana were not even aware of the existence of English classes for migrants. Most of the women thought that attending English classes would not have been possible because their husbands did not like them going about on their own.

Language is the most important link in communication and these women were severely handicapped for the lack of it. Desanka said that she was too frightened to travel by bus because of her language problem.\textsuperscript{721} Inability to communicate and to socialise added to their stress. Some of them had gone out to work in their home country but now it was not possible. All the women stated that they were extremely lonely, missed their families and friends and did not like being house bound. Lack of extended family was cited by all the women as a major problem in coping with their illnesses.

\begin{itemize}
\item \textsuperscript{719} Ibid.
\item \textsuperscript{720} A.Havenhand “Are NESB women limited in their access to health care serves in Australia?”, Masters of Nursing Thesis, 1999 (unpublished), University of Wollongong, p 44.
\item \textsuperscript{721} Interview with Desanka, op cit.
\end{itemize}
The Macedonians, especially the women, featured prominently among those suffering mental disorders. Wollongong, being a city, presented a challenge to migrants from a rural background. They were taken out of their environment and thrust into, what was to them, an extremely unfamiliar culture. Those interviewed spoke of the difficulties of adjusting to life in Australia; of the strange reactions they would arouse in people while they went about simple tasks like buying a loaf of bread or a pint of milk. They had the feeling that they were doing everything wrong. They felt that they were no longer in control of their own lives. These were some of the negative feelings experienced by these women. Except for Anica, none of them stated that they experienced overt racism, yet they felt alienated.

A report of the Task Force of the Interdepartmental Working Group on Womens’ Affairs stated that women from Yugoslavia, among other migrant women were often more isolated because

they may be reluctant, or may not be allowed, to go out alone, attend English classes.....may not have the supporting network of friends and relatives they would have in their own country. Many do not speak English and....the most basic health, welfare and social services are not accessible to them or their children.

All those interviewed believed that their illnesses arose from their life style in Australia although two of them had family members who also suffered from mental disorders. Their carer believes that they may have already had the potential for becoming mentally ill which the stresses of migration and adaptation would have exacerbated. She said

‘..these women lead such isolated lives here. In Macedonia, even if they become ill, life is so peaceful in their villages with their families around them, they can get on. They may not even be diagnosed as having a psychiatric illness. I know there are people there who have mental disorders who do not have to depend on medication’.724

722 Interview with A.Mitic, Macedonian Mental health worker, Wollongong, 9 July 2003.
Dana’s experience with the family doctor who cared for her children is an example of extreme insensitivity in the profession. When she took her children to him he blamed her for their illness. He said ‘You are a bad mother. You are starving these children’. When she explained that she was a very poor widow and was doing her best for them he responded by blaming her for not having used family planning methods to limit her family. She was already suffering stress and anxiety and she says the doctor made her feel so guilty that she wished to die. Her carer pointed out that Dana was a woman from a remote village in Macedonia, almost illiterate, and had not ever heard of contraceptives. What the doctor would not understand is that in Macedonian culture the woman had no say in matters like family planning. Every decision for women like Dana was made for her by the husband.

This is plainly a case where language and cultural barriers prevented proper communication between doctor and patient. The problems created are not the fault of the migrant alone. The medical professional lacked the awareness and the ability to overcome the barriers because he was not sensitised to the issues of service delivery to NESB persons. In a country with a large migrant population medical graduates had not been taught skills in cross-cultural communication. In order to provide useful services the medical workforce needs this training. This doctor did not see the need for an interpreter, or for acquainting himself further with the patient’s circumstances. If he did, he could at least have tried to help her in some way.

With regard to such incidents, Chiu observes that the present generation of doctors has not had the opportunity to develop a level of cultural awareness. He emphasises that in order to remedy this situation medical colleges should provide appropriate courses of study for their undergraduates and continuing education programs for medical professionals already in practice, to help them develop cultural sensitivity when dealing with NESB patients. By doing this, he says ‘..the psychosociocultural aspects of our patients’ lives will gain more appropriate attention’.

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724 Interview with A.Mitic, 9 July 2003.
725 Interview with Dana, op cit.
726 Interview with Mitic, op cit.
727 Chiu, op cit.
Language and cultural barriers prevent effective use of services to the present day. It is a factor of great concern especially in the area of psychiatric services. It can result in NESB patients missing out on valuable psychiatric help and their treatment being reduced to drug therapy even when not indicated. The Macedonian mental health worker sees the shortage of interpreters as a great obstacle to her work. She says:

There are many instances when I have been unable to obtain the services of an interpreter when a patient has to see a specialist. I think it is the specialist’s job to book one but it does not always happen that way. It is often such a struggle for me to get one. This system needs more education regarding migrants and mental illness.728

In a study carried out by David Cox regarding psychiatric illness in Greek immigrant women he says that:

Women whose families are beset by death or serious accident leading to a traumatic change in their situation which they may not have the personal strength or social support to cope with are likely to develop psychiatric illness.729

Dana is an example of such a migrant. In 1971, one year after arrival in Australia, her husband died and she was left to cope on her own, with three young children and an unpaid mortgage of $12,000 on her house. All the help she got was a monthly benefit of $32 and a sum of $2000 from BHP, at the death of her husband. She said ‘I was in arrears with the rates and got threatening letters from the City Council. I was in arrears with the water bill so my water supply was turned off. I had to go seven houses down the road to a Macedonian neighbour, to fetch water in buckets for our household needs’. In desperation she went to Social Security to ask for help only to be told ‘If you can’t survive here, go back to your own country’.730

728 Interview with Mitic, op cit.
730 Interview with Dana op cit.
To a distressed woman, ignorant of the workings of Australian bureaucracies, such a lack of compassion was incomprehensible. When a migrant appeared to have such urgent needs and no services existed to meet them it would have been humane to assist her by directing her to the Good Neighbour Council or other voluntary organisation. If no material help was possible, friendly counselling and support in resolving her problems would have made all the difference to a person in her position. It is not surprising that she soon presented with severe psychosomatic symptoms.

Bernard in emphasising the benefits of counselling says that ‘...the migrant’s need for assistance...was never of minor moment’. Migrants should be made aware of social and cultural resources available to them in the new country, be they governmental or private in nature. He says that there are ‘...special problems that can arise...which demand special counselling and treatment, such as psychological maladjustments, questions of mental and physical health, and the need for assistance in legal matters...when they do occur they must be given attention’. Counselling can help a migrant to make the necessary mental and psychological changes to confront any one of a host of problems.\(^\text{731}\)

These incidents may have occurred due to the prevailing attitudes in Australia at the time. Cultural insensitivity among the dominant group was not uncommon in the sixties and seventies. The expression of prejudice and discrimination has undergone important changes since, due to the Human Rights movement and legislation against racial prejudice. This does not mean that discrimination does not exist. It does, sometimes, and then, in a subtle, indirect way which is difficult to confront. Prejudicial attitudes may have reduced over the years but, as Jupp expresses it, they are ‘...still very pervasive’.\(^\text{732}\)

In all the interviewees except in Dostana, the signs of mental illness started from between five to twelve years after arrival. This points to poor adaptation to the new country. Krupinski found in a survey of mental illness in immigrants that those coming from rural areas with low cultural and educational backgrounds had the greatest


\(^{732}\) J.Jupp *Arrivals and Departures*, 1966, p 115.
problems in adapting. Their main reason for migrating to Australia was their wish to improve their low standards of life.\textsuperscript{733} For these women, although the material aspect of their lives did improve, the social aspect remained poor. They did not speak English even after many years of residence in Australia. Their husbands learnt some English at work and the children were fast learning the language and the Australian way of life. They became isolated not only in the community but within the family as well. In most of them the signs of illness appeared at the time the children were getting integrated into the community. Krupinski and Stoller found that children of migrants find it much easier to integrate into Australian society and in doing so often alienate themselves from their parents and their culture. Hence, parent-child conflict plays an outstanding role in mental illness.\textsuperscript{734}

Shortage of bilingual professionals is an important reason why NESB patients linger unnecessarily long in the mental health system before they obtain some relief. But Mitic believes there is an overall shortage of all psychiatric professionals in the Illawarra region. She says:

There are not enough psychiatrists. Patients are placed on a long waiting list. There are times when I have waited three weeks before my patient could be seen by the psychiatric registrar of a hospital. The waiting list in the private sector is long too. It is very rare to be able to get an appointment with a psychiatrist in one week. As for bilingual professionals, there is a shortage all round - nurses, counsellors, psychologists - all fields. It surprises me. We are supposed to be a multicultural society.\textsuperscript{735}

The experience of some of the migrants interviewed revealed that it was not the linguistic barrier alone that was the problem. The cultural component was lacking as well. Coming from close knit rural communities where members help each other, into Australian society where primarily persons have to fend for themselves would have left them confused and helpless. To Dana it was a very traumatic experience. She did not

\textsuperscript{733} J.Krupinski “Sociological Aspects of Mental Ill-health in Migrants” in Social Science and Medicine, 1967, vol 1, p 277.
receive any help in her adversity because no one thought of pointing her in the right direction.

The importance of incorporating the element of culture into interactions with NESB patients should not be under-estimated. Vega and Murphy emphasise this point:

> Obvious problems related to the lack of bilingual and bicultural staff to serve linguistically diverse cultural groups, can be solved in time with the proper resources. However, the more subtle aspects of cultural sensitivity require an approach that is grounded in an appreciation of the integrity, continuity and legitimacy of culture. This is an important point because practitioners can be recruited who have linguistic fluency, but have not formed the requisite attitudes and knowledge base necessary to work effectively with cultural minorities. This is a recurring problem in community mental health because most of the training received by professionals continues to stress clinical protocol over cultural awareness. The result is a “we-they” bifurcation between practitioners and community members, which prevents minorities from utilizing and benefiting from services.\(^{736}\)

Cultural sensitivity, as defined by Vega and Murphy, is ‘...the ability to penetrate the symbolic layers of meaning with careful observation and interpretation’. They find it particularly important for mental health professionals to develop this ability as each ethnic group has its own way of confronting and managing a similar problem. Mental health practitioners who do not understand this, label the patient as having a ‘cultural problem’. Such misunderstanding leads to confused diagnosis. Vega and Murphy illustrate this with the example of the case of a twenty eight year old Hispanic woman who, according to her culture, supported her parents and extended family, and was diagnosed by Anglo therapists as having a ‘mother complex’. Likewise, adult men and women for whom it is culturally appropriate to remain in the parental home until marriage, have been labelled ‘sheltered’ and ‘passive-dependent’.\(^{737}\)

\(^{735}\) Interview with Mitic op cit.
\(^{736}\) W.Vega and J.Murphy Culture and the Restructuring of Community Mental Health, 1990, p 71.
Psychiatric diagnosis and treatment are dependent on the complex interaction between the patient and the professional providing the service. In Australia, both diagnosis and treatment are based on Anglo-Celtic-Australian models of behaviour. This causes confusion when dealing with patients of other cultures. The importance of training the medical and psychiatric workforce in a manner appropriate to Australia’s multicultural context cannot be over emphasised.

Mitic speaks of a similar difficulty facing Macedonian patients. In Macedonian culture to be mentally ill bears a stigma; therefore, even to the practitioner, they would describe it as a problem of ‘nerves’. She believes there was some degree of confusion in cases such as Nada and Elica which delayed correct treatment. She says:

The mental health system is changing. Some professionals now have a better understanding of ethnic communities than they did in 1987 when I started work. Still, they don’t spend enough time with them. Ethnic patients need from ninety minutes to two hours to be counselled or assessed. I don’t know of any professional who devotes more than half an hour to a case and that is not always so. The profession is under-staffed. They do not have the time even if they have the inclination.738

On the subject of overseas qualified psychiatric staff, Mitic was adamant that Australia was making a mistake in not recruiting foreign psychiatrists. In Macedonia, for instance, all medical graduates study English during their training period and are fluent in the language. These professionals cannot pursue their careers in Australia because their qualifications are not recognised. If they were permitted to carry on a practice within their own ethnic group while undergoing training according to Australian regulations, they could render a great service to the community. In this way they would be making a valuable contribution to mental health services in the country during the bridging courses.739

737 Vega and Murphy op cit, p 73.
738 Interview with Mitic op cit.
739 Ibid.
Mitic has great faith in community mental health. In her role of ethnic mental health worker she has been of immense help not only to her own Macedonian community but to Serbian and Croatian clients as well. She regrets that no other ethnic community besides the Macedonian has a similar position. She stresses the benefits of group therapy for NESB patients. She herself runs a weekly group for clients of her community who are yet on medication but are mostly stabilised. She monitors their welfare regularly which goes a long way in reducing the need for re-admission. She acts as the link between her community and mental health services. In a busy schedule, she makes home visits to patients, counsels them and their families, explains the system to them, makes their appointments and even takes them to the specialist and acts as interpreter if necessary. She arranges for professional speakers to give talks on subjects related to mental illness which are of great benefit to the group. She sees a need for libraries in community health centres, which carry books and information about mental illness. These should be available at least in the leading foreign languages. The present random distribution of a few translated brochures is unsatisfactory. They are not even visible in GP waiting rooms.\(^{740}\)

The importance of involving families in ethnic mental health interventions cannot be under-estimated. Vega and Murphy observe that

‘...the original premise of the community mental health movement was to engage the community. However, “engaging” the community has come to mean physically setting up shop in minority neighbourhoods, and making contacts with prominent community leaders and other human services agency personnel.’\(^{741}\)

Even if strategies exist for tracing social networks, practitioners make little effort to understand and intervene in them because this type of work is labour intensive. But such methods are of central importance. Social and community networks are the basis for understanding cultural beliefs, norms and behaviours of ethnic communities. They explain their help-seeking processes. They are the greatest aids to deciding the course of treatment. Unfortunately, most practitioners have not been trained to practise this way.

\(^{740}\) Ibid.
\(^{741}\) Vega and Murphy op cit, p 78.
They use methods which they have been trained in, even if they are irrelevant to ethnic communities as real community involvement is seen as a threat to the clinical services model.\textsuperscript{742}

The above comments are applicable to Australia as well. For many years ethnic community leaders have agitated for more research into the specific health needs of migrant communities. Researchers, especially from the Victorian Transcultural Psychiatric Unit, have stressed the importance of studies in the characteristics of NESB communities, of their cultural backgrounds and different illness patterns. Such research will help in identifying the diversity of their needs and help in planning services.

Minas et al state that the development of community health services based on geographically defined catchment populations is ineffective for NESB groups. Neither should services be based on country of birth or the language spoken. They believe that ethnic communities are ‘..best described by social connections than by geographical and administrative boundaries.....Social groups, not necessarily living in the same area, should be targets for analysis and intervention’.\textsuperscript{743} The practitioner needs to be aware of the patient’s social situation in order to successfully deal with his or her presenting symptoms.

The degree of acculturation varies between ethnic communities. It is one of the main factors which decides whether or not the migrant accepts mainstream services. In order to be successful, community mental health services need to understand the beliefs, values and cultural behaviour of the communities they serve. NESB communities face difficulties in articulating their needs in a predominantly Anglo-Saxon social system. Lack of language isolates them from a mental health system designed primarily for an English speaking population; a system which has failed to keep pace with the changes brought about by a diverse population. The unfulfilled needs of hundreds of NESB persons who do not enter the current mental health system have to be identified if the system is to function satisfactorily. Once the nature and extent of these needs is evaluated, the provision of appropriate services ceases to be a problem.

\textsuperscript{742} Ibid.
\textsuperscript{743} Minas et al Mental Health Services for NESB Immigrants, 1996, pp 34-35.
Conclusion

This thesis has examined Commonwealth and NSW government health policies and services for migrants from 1960 to 2000. It has focused more specifically on mental health services for migrants in the Illawarra region of NSW. It has challenged claims made by Australian governments that the immigration program has been a total success, migrants have obtained security and a good quality of life while Australia has gained economic and cultural benefits.

Australian and overseas research have demonstrated that migrants suffer more mental health problems than the host population. Despite these findings, Australian health authorities have not always granted migrants the same access to, and delivery of, services as those accessible to the host population.

Government attitudes to migrants have been largely discriminatory. Until the end of the 1970s the government did not provide any special services for migrants in order to legitimize its policy of assimilation and to placate the Australian community that migrants were not in any way, a threat to them. In fact, they were an advantage as they boosted the Australian economy while not being a financial burden.

Meanwhile, many migrants were becoming disgruntled although they lacked the voice to express their dissatisfaction. It was early days yet - in the sixties and seventies - for dissenting voices to be heard, but ethnic communities were already in the process of forming their own organisations with their leaders as spokespersons.

The Commonwealth government too was becoming uneasy with its own policies. The large number of departing migrants was causing so much concern that the Federal Minister for Immigration ordered two inquiries into immigration and departing settlers between the mid-sixties and early seventies. In 1973, both migrants and Australians welcomed the Labor ideal for a multicultural Australia as a step in the right direction. But, whether multicultural policies have brought Australia genuine cultural pluralism is debatable as social inequality and disadvantage continue to be a problem for migrant communities.
Major policy changes followed the Galbally Report of 1978. The subsequent establishment of EACs and ECCs improved health services for migrants but not nearly enough. Mental health on the whole, has not been an important feature of Australian health policies which are traditionally monocultural and monolinguistic. There was no co-ordination of mental health services between the States and the Commonwealth until 1992 when the National Mental Health Policy and Plan were produced. Lack of research into ethnic communities has been a serious lapse. Without relevant research, planning of services for NESB communities has become ineffective. This is reflected in the under-utilization of services by NESB persons.

This thesis has selected the Illawarra region for it special study because of the large NESB population resident in Wollongong and outlying suburbs. It is a fitting example of a locality which has suffered through paucity of health services for migrants. A series of interviews conducted with mental health service providers and some mentally ill NESB migrants revealed the inadequacy of health services for the entire Illawarra population, more so for NESB communities by the very definition of their ‘migrantness’.

The interviews confirmed the view that the Illawarra was an underfunded health region and validated the argument that policies and services beneficial to migrants were developed mainly due to the efforts of ethnic communities themselves. All the mental health professionals interviewed agreed that the Illawarra was grossly underserviced and underfunded while being the most ‘needy’ health region in NSW due to its low socio-economic profile. In spite of a large NESB population it was the last health region in NSW to obtain a Health Care Interpreter service. Five years later it obtained seven ethnic general health workers after intensive lobbying by ethnic communities. The ethnic mental health worker appointed in 1983 remains, to date, the only worker in such a position.

Government policies, though influenced by economic considerations, are mainly derived from its philosophies and values. They are affected by the distribution of power in society. In Australia, migrants, the mentally ill, women and Aboriginals are among the most powerless in society. They lack involvement in formulation of health policies.
Policies formulated without input from all sections of society become irrelevant to some groups.

Traditionally, the Illawarra has been a Labor electorate. As such, a Labor government does not have to do much for the electorate with the knowledge that it is ‘safe’. The interviews revealed that the IAHS was a ‘very political body’. The CEO and the Board of Citizens which govern the IAHS are political appointments. Hence, the allocation of funds becomes a political issue. The mental health budget was known to have been spent on other projects which IAHS members fancied.

Policy changes which resulted from the Richmond Inquiry of 1983 adversely affected the Illawarra. The shift of responsibility for mental health services from government to mainly community groups and charities was a disadvantage for most patients but more so for NESB patients. Long psychiatric waiting lists, shortage of acute care beds, early discharge and lack of follow-up after discharge were very serious problems in the Illawarra. Added to these, linguistic and cultural barriers prevented NESB patients from accessing services and they had to depend increasingly on their own ethnic communities for help.

Access to health services is not always easy even for English speaking persons. It can involve a long procedure of making inquiries and gathering information from service providers before a patient can make a decision about treatment. In such a context NESB patients are so disadvantaged they would not know how to approach the health system. Mental illness would exacerbate the difficulties. The interviews with NESB patients amply illustrated this issue. They brought into question the attitude of medical professionals and employers and the lack of interpreting services. Following the Galbally Report of 1978, funds were allocated for setting up education and translating and interpreting services for NESB migrants. Despite these government policies, over two decades later, the situation has improved very little.

Australian national identity has been based on exclusion and restriction. Although the White Australia Policy is a thing of the past, the national identity remains predominantly Anglo, rather than multicultural. The National Agenda for a Multicultural Australia launched in 1989 promised social justice for all Australians. If
this implies equal access to all rights, opportunities and privileges for the whole community, it is not reflected in the circumstances of most NESB groups. In health care, an important social commodity, the tendency is to perpetuate the values and procedures of the dominant culture. NESB communities are generally disadvantaged due to inequal access to resources and lack of opportunities. NESB persons who are mentally ill carry not only the stigma of their ‘migrantness’ but that of their illness as well, thus relegating them to the lowest levels of a society which proclaims tolerance and equality.
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Macedonian ladies; (Fictional names. Real names withheld at the request of interviewees):

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Desanka, 5/5/2003
Dostana, 12/5/2003
Milica, 19/5/2003
Dana, 16/6/2003
Nada, 26/5/2003
Elica, 30/6/2003