MULTICULTURAL CENTRE FOR WOMEN'S HEALTH

VICTORIA State Government

Building Bridges

Promoting Mental Health and Wellbeing for Migrant and Refugee Women

Acknowledgement of Aboriginal sovereignty

Multicultural Centre for Women's Health (MCWH) acknowledges and pays respect to the Wurundjeri people of the Kulin nation, on whose land this research was undertaken. Aboriginal sovereignty was never ceded.

We recognise that as women of migrant and refugee backgrounds, we benefit from the colonisation of the land now called Australia and have a shared responsibility to acknowledge the ongoing harm done to its First Peoples and to work towards respect and recognition. Aboriginal and Torres Strait Islander people experience greater health inequities compared to non-Aboriginal and Torres Strait Islander people.

We acknowledge that Aboriginal and Torres Strait Islander people have been active leaders in health promotion and advocacy and our work should be accountable to the same aims.

MCWH Acknowledgements

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The research team would like to thank everyone who participated in this study. Your generosity, knowledge, and willingness to share your personal experiences enabled us to better understand the mental health and wellbeing of migrant and refugee women, non-binary and gender diverse people living in Australia.

Thank you to the stakeholders who shared their experiences of providing support to migrant and refugee communities in Victoria. Your time and expertise have helped guide the project.

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Special thanks to Patsy Rodriguez for her exceptional design and illustrations of this report.

About MCWH

Established in 1978, Multicultural Centre for Women's Health (MCWH) is a Victorian-based women's health service that works nationally and across the state to promote the health and wellbeing of migrant and refugee women through advocacy, social action, multilingual health education, research, training, and capacity building.

MCWH applies an intersectional lens to understanding and analysing all health issues, including mental health. This lens goes beyond explanations that use single categories, such as gender or ethnicity, to address structural inequality. Instead, it recognises that women's experiences of inequality reflect specific social, economic, and political contexts, systems, and structures.

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A note on language use

At MCWH, we are committed to promoting the health and wellbeing of all people who are impacted by the intersections of racial discrimination, gender inequality and the migration system in Australia, including migrant and refugee non-binary, gender diverse and trans people. However, we acknowledge the authors cited in this report often position and/or assume that the people they term 'women' are cisgendered. We recognise that this data is not inclusive of non-binary, gender diverse and trans migrant and refugee people living in Australia and does not always accurately reflect their experiences. This limitation also applies to our research, which predominantly reflects the experiences of cis migrant and refugee women.

To account for the experiences of LGBTIQA+ (lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual and other sexually or gender diverse) migrant and refugee people in the mental health system, we have drawn on stakeholder consultations. These consultations have informed our recommendations for a mental healthcare system that is more inclusive of LGBTIQA+ migrant and refugee women, non-binary and gender diverse people.

Additionally, we use the term 'migrant and refugee' throughout the report to describe people living in Australia who were born overseas or whose parent(s) or grandparent(s) were born overseas in a predominantly non-English speaking or non-Western country.

A note on content

This report contains content that may be sensitive or distressing to some readers. Please be advised that the following topics are discussed within this report: mental illness, suicide, and family violence. The following services are available 24/7 to support you:

- If you are in a situation that is harmful or life-threatening, contact emergency services immediately on Triple Zero (000).
- If you are not in immediate danger but need help, call NURSE-ON-CALL on 1300 60 60 24.
- For crisis support, contact Lifeline on 13 11 14.
- For counselling support, contact Beyond Blue on 1300 224 636.
- For domestic, family, and sexual violence counselling, contact 1800RESPECT.
- If you are looking for a mental health service, visit www.betterhealth.vic.gov.au.
- If you require an interpreter for any of these services, contact the Translating and Interpreting Service (TIS National) on 131 450.

Contents

Executive Summary

This report details the findings of Building Bridges, a one-year project run by the Multicultural Centre for Women's Health (MCWH) between 2022 and 2023 relating to migrant and refugee women's mental health and wellbeing. This project was funded by the Victorian Government, under the Diverse Communities Mental Health and Wellbeing Grant 2021-2022.

Building Bridges is a qualitative research project that engaged with 99 migrant and refugee women, non-binary, and gender diverse people from 21 cultural groups and eight stakeholder organisations across Victoria. Using a community-based participatory approach to conduct nine share circles, this project collected rich, in-depth information about participants' experiences of mental health and wellbeing, often shaped by gender inequality, racism, financial insecurity, precarious employment, migration process, and structural and interpersonal violence. The share circles were facilitated by Bilingual Health Educators in participants' preferred languages, and explored the following concepts:

- social determinants of mental health and wellbeing
- understandings of mental health and wellbeing;
- experiences in accessing mental health support services; and
- recommendations for improving communities' mental health and wellbeing, and mental health support services.

The project employed a feminist intersectional approach to recognise how gendered inequality intersects with migration-related inequalities to disproportionately impact migrant and refugee women, non-binary and gender diverse people's mental health and wellbeing. The Building Bridges findings demonstrate the ways that migrant and refugee women, non-binary and gender diverse people experience structural, institutional, and interpersonal forms of disadvantage that significantly impact their ability to experience good mental health and wellbeing.

In this report we show that mental health and wellbeing is impacted by a range of intersecting factors as identified from our research findings and outline a 'social determinants of health' framework. From our share circles we heard how gendered norms along with racialised societal expectations and stereotypes impact migrant and refugee women's mental health and wellbeing. Participants' experiences of family violence significantly affected their mental health and wellbeing, and was further exacerbated by limited access to culturally and linguistically responsive supports. Many participants also shared how migration-related stressors such as separation from family, trauma from conflict in their country of birth, acculturation, and insecure employment were factors that significantly impacted their stress and overall health and wellbeing. This closely related with participants' experiences of loneliness and social isolation, which was further amplified by health services which had not been responsive to their needs.

With respect to knowledge and awareness about mental health and wellbeing, we found that migrant and refugee women have robust knowledge and diverse understandings of mental health and wellbeing, with most participants identifying mental health as a fundamental component to good health and quality of life. Their strong awareness of mental health was a positive reinforcing factor in encouraging them to seek support.

Many participants expressed a strong willingness to access services. However, factors such as racial and gender discrimination in healthcare, lack of culturally and linguistically responsive services, lack of accessible information on mental health, inadequate in-language and interpreting services, a complex Australian healthcare system, long waiting times, and costly services were among some of the systemic factors that prevented many migrant and refugee women from being able to access the mental healthcare they needed in a timely manner.

The Building Bridges interviews with mental health service providers and community organisations highlighted additional systemic barriers that face migrant and refugee women when they seek care. A key limitation is a shortage of mental health practitioners who are of migrant and refugee background, and related, the lack of cultural safety in the mental health sector. There are also very limited tailored services for migrant and refugee community members who identify as non-binary, gender diverse and LGBTIQA+.

Strategies that build workforce racial and gender equity, and cultural safety into mental health services, as well as tailored specific services and supports, would make a significant difference to migrant and refugee women, in all their diversity, seeking to use the system. Stakeholders also identified the need to sustainably, and over longer periods, fund community organisations that are working to ensure the active engagement of diverse communities throughout planning and implementing the mental health reform.

This report shows that migrant and refugee women have the strength-based solutions to address barriers in the mental health system. Now, more than ever, we need to centre migrant and refugee women's call to build inclusive, equitable healthcare and migration systems which promote the wellbeing, leadership, and social and civic connectedness of the whole community. Building Bridges contributes to these efforts by advancing knowledge about the mental health and wellbeing priorities of migrant and refugee women.

MCWH welcomes the Victorian Government's recognition that diverse communities need to be actively engaged in the planning, implementation and management of future reforms that are aimed at improving the state's mental health system (State of Victoria, 2021a). As such, we conclude this report with a set of recommendations that are rooted in our learnings from migrant and refugee women and community organisations to reduce inequitable mental health outcomes and improve access to and quality of services.

Introduction

The mental health and wellbeing of Australians has been a key policy issue at all levels of government following the aftermath of large-scale disruptions, such as the bushfire season in 2019-20 and the COVID-19 pandemic. In March 2021, the Victorian Government tabled the findings of the Royal Commission into Victoria's Mental Health System in Parliament. A few months earlier, the Commonwealth Government had publicly released the Productivity Commission's Mental Health Inquiry Report. These findings indicate that after decades of reform, the mental health system as it currently stands has been unable to meet the needs of our growing and heterogenous population.

The political spotlight on mental health and wellbeing means it is time to consider how Victoria's mental health system can be reformed to better address the diverse needs of migrant and refugee people. An analysis by Barr et al. (2023) into Victoria's mental health system identified that several 'building blocks', namely policy settings, funding, services, and the workforce, have reinforced gender disparities in mental health. In MCWH's previous work in perinatal mental health, we found that the state's health system also reinforces intersecting racial and socio-economic inequalities, impacting migrant and refugee women's mental health, their health-seeking behaviours, and experiences of accessing mental health services (MCWH, 2022). Consequently, mental health services in Victoria have historically marginalised migrant and refugee women and provided inadequate support for their mental healthcare needs (Radhamony et al., 2023; Shafiei et al., 2018; WHIN, 2022).

In Victoria, migrant women make up 32% of the female population (ABS, 2021). They experience structural, institutional, and interpersonal forms of disadvantage that significantly impact their ability to experience good mental health and wellbeing. Research shows that violence against women, pre-migration trauma, settlement stress, social isolation, and pressures related to preserving cultural values in a new country are key issues impacting migrant and refugee women's mental health and wellbeing (Mwanri et al., 2022; Sullivan et al., 2020). For newly arrived migrant women, first-time mothers, and women on temporary visas, there are added risk factors such as low levels of social support and precarious immigration status (Hennegan et al., 2015; Shannon, 2021; WHIN, 2022).

Migrant and refugee women have also been disproportionately impacted by the COVID-19 pandemic, having missed out on timely and accurate multilingual information while facing increased risk of infection, accentuated social isolation due to the digital divide, and increased risk of family violence (MCWH & GEN VIC, 2021).

Despite the evidence illustrating that migration-related inequalities are a social determinant of mental health and wellbeing, migrant and refugee populations continue to be overlooked and/or treated as a homogenous group at a policy and programming level. This gap is rooted in a dearth of research that applies an intersectional lens to explore the intersection of gendered inequality and the migration process, which compounds health inequities and shapes mental health outcomes. As such, a gendered, intersectional analysis of the factors that shape migrant and refugee women's mental health is needed to ensure future practice and policies are culturally safe and responsive.

Building Bridges

Research that takes a community-based participatory approach is necessary to better understand migrant and refugee women's priorities and needs in the mental health and wellbeing space. In a literature review on migrant and refugee women's mental health in Australia, Sullivan Sullivan et al. (2020, p.31) argue that 'despite many research articles noting the importance of engaging community in mental health initiatives, community members have largely been excluded from the research process'.

MCWH delivered the Building Bridges project, a research project that employs a community-based participatory approach to investigate the protective factors of mental health for migrant and refugee women, non-binary, and gender diverse people, the barriers that prevent them from accessing quality support, and their preferred methods of intervention. Through our extensive network of Bilingual Health Educators, we conducted this research in participants' preferred languages and asked them about their:

- social determinants of mental health and wellbeing;
- understandings of mental health and wellbeing;
- experiences in accessing mental health support services; and
- recommendations for improving their communities' mental health and wellbeing, and mental health support services.

Our research documents the knowledge and lived experiences of migrant and refugee women, non-binary and gender diverse people and mental health service providers in relation to the Victorian mental health system. In doing so, Building Bridges supports the implementation of Recommendation 34(1) of the Royal Commission into Victoria's Mental Health System, which states that 'Victoria's diverse communities should be actively engaged in the process of planning, implementing and managing the reformed mental health and wellbeing system' (State of Victoria, 2021c). Our research findings inform the strategic direction of the mental health reform and guide the delivery of effective, tailored, community-based mental health and wellbeing programs for migrant and refugee people.

We acknowledge the limited representation of migrant and refugee non-binary, gender diverse, and LGBTIQA+ voices and experiences in this research project. Our findings and recommendations reflect the responses of predominantly migrant and refugee women who participated in this project. It is crucial that future research provides meaningful opportunities that centre migrant and refugee non-binary, gender diverse, and LGBTIQA+ communities' perspectives and leadership.

However, by using intersectionality as a lens to explore mental health and wellbeing, we envision the findings of this report will pave the path for the development and implementation of future programs and policies that are safe, inclusive, and responsive to the needs of migrant and refugee women, non-binary, and gender diverse people.

Method and Approach

In Building Bridges, we used qualitative research methods to investigate the mental health and wellbeing of migrant and refugee women, non-binary, gender diverse people and their experiences of accessing support in Victoria.

Our study consisted of three phases: share circles (focus groups), stakeholder interviews, and communities of practice.

1 **Phase 1: Share circles (focus groups)**
Share circles with migrant and refugee people in their preferred language

2 **Phase 2: Stakeholder interviews**
Consultations with key mental health and community organisations

3 **Phase 3: Community of Practice**
Applying intersectionality in mental health and wellbeing research. Sharing of preliminary research findings.

Share circles

Our primary data-collection method involved conducting share circles with migrant and refugee women, non-binary, gender diverse people who currently live in Victoria and are aged 18 years and over. We organised nine share circle sessions involving a total of 99 participants. Share circles are bilingual focus groups predominantly organised with existing community-based women's groups (so participants often knew each other). Our team of Bilingual Health Educators facilitated the sessions in participants' preferred languages. We recorded the sessions, translated, and transcribed them for analysis.

Stakeholder interviews

In addition to the share circles, we conducted eight interviews with key mental health and community organisations in Victoria to understand their experiences of engaging with migrant and refugee people. Across our interviews, we captured perspectives from general mental health service providers and organisations, as well as those who provide tailored support for women, multicultural, LGBTIQA+, and youth cohorts.

Through semi-structured interviews, we explored stakeholders' perspectives on:

- data collection strategies;
- common challenges and barriers experienced by migrant and refugee consumers;

- common challenges and barriers experienced by migrant and refugee service providers;
- the current mental health system; and
- support and services provision during the COVID-19 pandemic.

We recorded stakeholder interview sessions and later transcribed them for analysis. Findings from both the share circles and interviews were coded, analysed concurrently, then thematically organised for this report.

Community of Practice

For our third phase, we organised two online communities of practice for key mental health and community organisations in Victoria. These communities of practice were aimed at building relationships and sharing knowledge within the mental health space. In the first community of practice, our team shared MCWH's feminist intersectional approach to conducting mental health and wellbeing research. Drawing on the latest evidence and data, we brainstormed intersectional solutions to promote migrant and refugee women's perinatal mental health. In the second community of practice, we shared preliminary findings from our share circles.

Participant Demographic

In our share circles, almost all participants self-identified as 'women' (99%) and the majority did not identify as LGBTIQA+ (90%). Participants fell within the 25–44-year-old range, which reflects the age structure of the Victorian female population of non-English speaking background in the 2021 Census. Participants came from a variety of (self-defined) cultural backgrounds (21 in total) and countries of birth (18 in total), reflecting some of the fastest growing groups in Victoria.

We conducted share circles in different geographical areas across Victoria to ensure that the research was inclusive of diverse experiences of mental health and wellbeing, and access to services and supports, in different parts of the state. Guided by the Australian Statistical Geography Standard Remoteness Structure, our research categorises participants in two geographical locations: Greater Melbourne, or regional and remote. Overall, 20% of participants came from regional or remote Victoria and 77% from Greater Melbourne, which follows the general population distribution in Victoria (3% did not respond to the question). Around half of participants had been in Australia for more than 10 years and were Australian citizens. Our share circles also included permanent residents, temporary visa holders (including international students), and those on humanitarian visas. In terms of employment, 48% of participants were employed (full-time, part-time, casual) and 44% of participants were unemployed.

Stakeholder interviews

Total of 8 stakeholder interviews

	Number of stakeholders
Private	1
Not-for-profit	5
Social Enterprise	2

Share circle participants' demographics

Total of **99** share circle participants

Gender

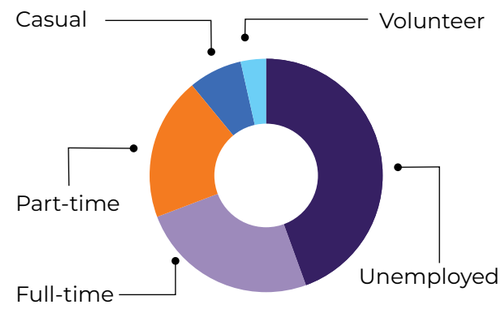
99% self-identified as woman,
1% self-identified as gender fluid

LGBTIQA+

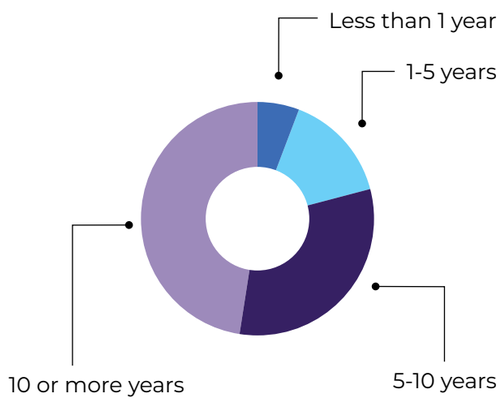
8% not stated

Age

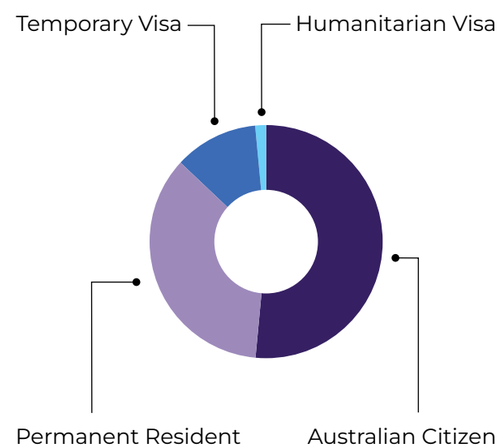
Employment status



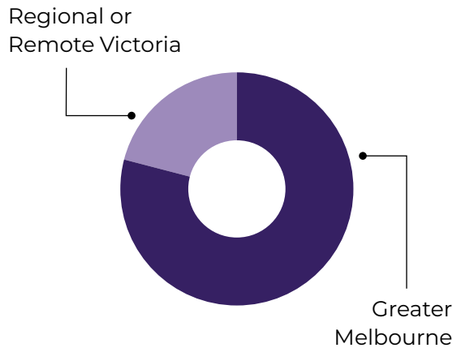
Length of time in Australia



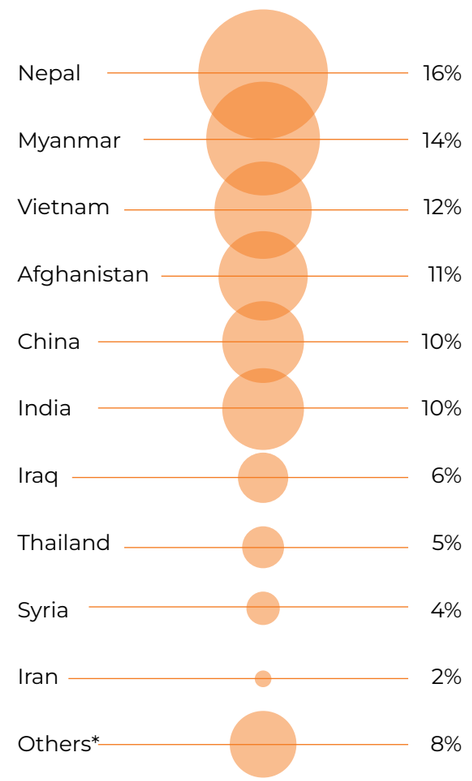
Residency Status



Geographical location



Country of birth



* Germany, Kuwait, Lebanon, Pakistan, Russia, Sri Lanka, Egypt, and The Philippines

21 cultural backgrounds

Discussion of Findings

Our findings contribute to evidence on how socio-cultural factors, including access to health-related information and services, the migration process, and gender and cultural norms intersect with systemic racism, sexism, health, and socio-economic inequalities. These factors actively shape mental health outcomes and disproportionately impact migrant and refugee women (Bhugra, 2004; Delara, 2016).

This chapter is structured into four key sections:

- social determinants of mental health and wellbeing;
- understandings of mental health and wellbeing;
- experiences in accessing and providing support for mental health and wellbeing; and
- systemic barriers from a stakeholder perspective.

The issues explored in these four sections are not necessarily discussed in order of priority but are organised thematically. They are inextricably linked to one another, providing a comprehensive picture of mental health and wellbeing in migrant and refugee communities across Victoria. The gendered, intersectional analysis we bring in this section underscores that migrant and refugee populations are a heterogenous group. As such, future policy reforms and programs need to be tailored and intersectional in their design and implementation, for the state's mental health system to be equitable, accessible, culturally safe, and responsive to the needs of migrant and refugee women.

Social Determinants of Mental Health and Wellbeing

In the share circles, participants shared many of the individual and systemic factors that impact their mental health and wellbeing. They identified a broad range of intersecting factors and in doing so, outlined a 'social determinants of health' framework: one that recognises women's unique experiences and the political and socio-economic realities in which they live their lives. As one participant described:

> **"Mental health would be impacted by other parts of your wellbeing, like social health, physical health, and spiritual health... it could be like the family, friends, and the environment that we live in, the office... everything can determine the mental health."**

In this section, these determinants are categorised under four domains: gendered norms, gender-based violence, migration-related stressors, and loneliness and social isolation.

Gendered norms

Gendered roles and expectations are based on prevailing socio-cultural norms that dictate how a person should behave based on their assigned sex. These norms disproportionately disadvantage women and are a key factor exacerbating women's mental health and wellbeing. The insights gained from our share circles align with Levy et al. (2020, p.225) who

emphasise that 'restrictive gender norms harm health and limit life choices for all'. This includes gendered norms which exist both within and outside migrant and refugee communities. However, we know that for migrant and refugee women, this can further intersect with inequalities experienced as a result of racialised societal expectations and stereotypes (Delara, 2016).

In particular, 'mental labour and cognitive load' are key contributing factors that shape women's mental health and wellbeing (Reich-Stiebert et al., 2023). This form of labour is invisible and gendered in nature, and typically includes tasks such as unpaid domestic work and childcare. Participants mentioned that being responsible for household duties, raising children and taking care of extended family members impacted their mental health and wellbeing. More specifically, they mentioned the lack of support from their partners in relation to household work contributed to them feeling "sad", "tired" and "stressed". This was particularly intensified when they had other commitments, such as study or paid employment.

As one woman expressed:

> **"Especially, for women when we work full-time and we have to do housework, shopping and all the laundry, it's not an easy job to maintain house clean... I think all of us are doing the same thing at home and we know that if we don't do that, no one does the job [house work]..."**

Participants also discussed gender roles and expectations in relation to raising children, with some highlighting the complexity of incorporating "Australian parenting styles":

> **"My mental health has been impacted by my children, raising the children in Australia is very difficult...I was struggling to balance between Vietnamese and Australian parenting styles, so it tends to be tension. I want to learn and explore what is the best ways to educate my child..."**

Furthermore, women discussed their additional role in caring for extended family members. Carers experience higher than average rates of physical and mental health problems, especially when there are low levels of family, community, and formal support around. Our previous research into informal care found that migrant and refugee seniors and carers have 'smaller family networks and lower rates of service use compared to the Australia-born population, potentially placing strain on caring families and leaving complex health needs unmet' (Aryal, 2017).

As one woman mentioned, "I felt tired of looking after my mum including sending her [to] appointments..." However, this responsibility was expected of women even when their families lived overseas. For example, another woman said:

> **"We are here but we have other commitment as well, family overseas. I think all the migrants they have expectation from their families that impact on your health, especially women."**

Despite having a strong understanding of how gendered roles and expectations impacted their mental health and wellbeing, participants often framed the need to "stay healthy" in relation to their role as caregivers. As one woman put it:

> **"...you start to think of your mental health, as I must stay healthy to look after my family and children..."**

Gender-based violence

Rigid gendered norms and stereotypes contribute to gender inequality, which has been identified by Our Watch (2021) as the key driver of gender-based violence. In Australia, the prevalence of violence against women is unacceptably high: one in three Australia women have experienced physical or sexual violence and/or emotional abuse in their lifetime. For migrant and refugee women, there is evidence that prevalence rates are even higher, and that the violence is more severe and prolonged (On et al., 2016).

Intimate partner violence contributes to approximately 2.2% to the burden of disease for all women and 5.1% to the burden of disease for women aged between 18-44 years. A study conducted by ANROWS on the disease burden of intimate partner violence indicated a strong causal link between exposure to violence and anxiety and depressive disorders. In that study, anxiety and depressive disorders, suicide and self-harm were identified among the top ten leading causes of the overall burden in women aged 18-44 years (Webster, 2016).

In our share circles, women identified family violence as a significant factor that shaped their mental health and wellbeing. Participants explained how violence led to experiences of poor sleep, loss of appetite, anxiety, depression, and suicidal thoughts.

> **"If people get help from family or elders or friends, they can cope with [family violence]. But sometimes a woman comes here alone...and there is no one here, and there are already problems in the family back home, she can't talk much, and she suffers under pressure in domestic violence."**

Our findings are consistent with literature illustrating that migrant and refugee women are significantly impacted by family violence and have less access to culturally and linguistically responsive services (MCWH, 2021; Vaughan et al., 2016). In discussions of family violence, women mentioned compounding factors, such as the lack of in-language services, social isolation and being unfamiliar with the Australian legal system, that hinder their abilities to seek support. Addressing these systemic barriers is needed to enable migrant and refugee women to access early and appropriate intervention.

Migration-related stressors

Migrant and refugee women face migration-related stress at different stages of their settlement journeys. In our share circles, participants discussed the impacts of migrating to a new country and identified leaving their family behind as a key determinant that shaped their mental health and wellbeing. As one woman put it:

> **"...living away from your family or people you love and travelling to a new place can deeply affect your mental health...you must leave everything behind..."**

Some women highlighted their ongoing experiences of trauma, having left countries affected by conflict. One participant explained:

> **"...your country's economic or political developments affect you, and especially being an immigrant, you are not in that immediate environment, but it still affects you cause your family lives there and you somehow belong to that particular culture and geographical area."**

Another woman spoke about some of the challenges that come with starting a life in a new country and adapting to a new culture:

> **"... in the context of acculturation and assimilation experiences in Australia...what is difficult is the complexities that comes [with] detachment with home...culture... values and...then coming to new environment...and basically starting from zero in some ways..."**

Another determinant disproportionately affecting migrant and refugee women is the lack of work opportunities in Australia that align with their skills and qualifications gained in their country of origin (WHIN, 2022). As one participant stated:

> **"The thing that causes me the most stress is career advancement. Although I have a successful career back home, I am under pressure to find work in Australia that is in line with my qualifications."**

Migrant women are forced to take up work that is low-paid and generally 'lower-skilled than was the case before migration' due to systemic barriers such as Australia's lack of recognition of overseas qualifications (Ziersch et al., 2022). Unpredictable employment opportunities couple with other settlement difficulties to contribute to migrant women's stress. As one woman stated:

> **"I had a good job, good position, I felt relax. Since I moved to Australia, I feel stress, lonely, a bit sad, belong to nowhere."**

Loneliness and social isolation

Loneliness and social isolation due to migration contributes to poorer mental health and wellbeing amongst migrant and refugee women. In our study, some participants said their feelings of loneliness and social isolation were reinforced by the nature of the healthcare services they received:

> **“For us as migrants, we tend to be already isolated… we are not only isolated at home but also be isolated at workplace, and we tend to be isolated by the healthcare services…”**

> **“As a woman in general we need a lot of supports after giving birth as we usually face with health issues at that time. As a migrant woman, we have to deal with everything to survive and start our new life in Australia without support from our family. So many things we have to deal with, and I found my health outcome decrease after many years deal with things in Australia.”**

Another woman said her social isolation was exacerbated by the lack of access to in-language services:

> **“For me, I was stressful when I arrived in Australia as I did not know how to navigate the new areas and I do not speak and understand English because of not having the chance to study…”**

When it comes to the mental health and wellbeing of migrant and refugee women, culturally and linguistically responsive services play an important role in fostering a sense of social connection and belonging, countering loneliness and social isolation.

Our findings show a need to incorporate a social determinants framework in the future planning and development of mental health policies and programs. Interventions and policies will need to recognise and account for the diversity of women’s lives and health needs to better understand and respond to their experiences of social isolation.

Understandings of Mental Health and Wellbeing

Migrants and refugees are often framed in policy and literature as having ‘poor mental health literacy’ who possess insufficient knowledge to recognise, manage and prevent mental health conditions (Sullivan et al., 2020). Such a frame tends to place a deficit on the individual rather than on services or broader policies that are actively influencing help-seeking behaviours. Our findings indicate that migrant and refugee women have diverse understandings of mental health and wellbeing and possess strong knowledge around approaches for seeking (in) formal support. Policies and programs aimed at reforming the state’s mental health system need to take these diverse understandings into account in order to be effective and responsive to the needs of migrant and refugee women.

In our share circles, many participants discussed the phrase ‘mental health and wellbeing’ as a state of positive emotions and feelings. They frequently used words and statements, such as “being happy”, “content”, “gratitude”, “relaxation”, “good sleep”, “good appetite”, “peace of mind” when defining mental health and wellbeing. Many of them defined being mentally healthy as having “an absence of illness”, being “stress free” or “living without anxiety”.

Many participants associated mental health and wellbeing with successfully managing and dealing with complex, intertwining issues in their everyday lives, such as emotional stress, family matters, social issues, work, and environment. For example, one woman said:

> **“I think it [mental health] is also being able to regulate your emotions and understand how you are feeling and be able to process any big emotions and being able to overcome them, not [only] overcome them but to be able to deal with them I suppose.”**

Participants viewed mental health and wellbeing as fundamental to good health, with many emphasising that good health reflects both a healthy mental and physical state. The two components are connected, since “without one the other is incomplete” as one woman described. Many of them emphasised that if their mental health and wellbeing was not maintained, mental illness would arise and impact their wellbeing.

Concurrently, participants discussed symptoms and signs of mental illness. They described symptoms as “non- stop intruding thoughts and worries”, “feeling depressed and upset”, “feeling hopeless”, and having “mood changes of high and low”. In another conversation, being “unable to sleep” was a symptom that was experienced and understood as having mental illness. One woman described her understanding of mental illness:

> **“When we start to see everything from a negative side, depression, anxiety, when all things start to get together…You feel like a big elephant is sitting on your head, you can’t move, you can’t do much.”**

Many participants across the nine share circles had an understanding of mental health and mental illness, although some were unfamiliar with the concept of ‘mental health and wellbeing’. This in turn impacted their ability to seek support when they experienced symptoms.

Additionally, some participants shared how their understandings of mental health were influenced by social attitudes in their countries of origin. For some, the term 'mental health' connoted people with mental illness or people who suffered from 'insanity'. The associated social stigma led them to feel reluctant to discuss their mental health and wellbeing with others.

> **"I did not know about the meaning of mental health until I moved to Australia. Back home if we mentioned 'mental health,' it would mean that the people are 'crazy', 'mad' and they have to go [to] the... X centre [name of a mental health hospital in her country]."**

Overall, most participants in this study comfortably discussed and defined 'mental health', recognised the importance of mental health in promoting behaviours for improving their quality of life, and identified signs of mental illness. Jorm et al. (1997) state that the ability to recognise mental health issues is an important aspect of mental health literacy that influences help-seeking behaviours. Our findings indicate that there are connections between being able to both comfortably discuss and define mental health issues, and actively seek support.

Approaches to Seeking Mental Health Support

Seeking support for mental health issues can be defined as a process of obtaining help from an external source to gain 'understanding, advice, information, treatment, and general support in response to a problem or distressing experience' (Rickwood et al., 2005, p.4). Help can be obtained from formal sources, such as doctors, psychologists, psychiatrists, social workers, counsellors, etc., and informal support, such as families, friends, communities, self-help, and online resources (Guruge et al., 2015; Krstanoska-Blazeska et al., 2023).

In our share circles, we asked participants about how they sought mental health support. Women shared a variety of informal and formal strategies which they used to seek support for their mental health and wellbeing. Importantly, the themes presented here indicate that participants have made considerable efforts to maintain their mental health and wellbeing.

Seeking support from informal resources

Self-help and self-care resources

When participants talked about managing and improving their mental wellbeing, discussions included effective self-care and self-help strategies. In terms of regulating emotions, many women spoke about overcoming challenges on their own and shared the importance of their faith or religion in maintaining their mental health and wellbeing. Praying, reading the Bible or Quran, listening to gospel songs and going to church were cited as powerful sources of strength and hope.

Other women managed their mental health through recreational activities. Some openly shared strategies with one another on how they maintained a healthy body and mind. These strategies included artistic and creative engagements, such as painting, writing in journals, making TikTok videos, as well as physical activities, such as exercise, yoga, dance, gardening, and meditation.

Support from social networks

In many migrant and refugee communities, there is a preference for seeking informal support for mental illness compared to formal services and sources (Byrow et al., 2020; Donnelly et al., 2011; Krstanoska-Blazeska et al., 2023). Women's social networks, made up of friends, families, and diaspora communities, are important and meaningful sources of support for addressing mental health issues (Donnelly et al., 2011; Guruge et al., 2015). In almost all the share circles, participants described seeking help from their family members, friends, colleagues, supervisors, religious community, and others within their social networks. Many of them noted that their social networks were their first port of call for seeking support.

> **"I considered all – my family, my sister, my sister's friends, my own friends, our Sikh community who gave support spiritually, relating to Gurbani [Sikh religious literature] – that supported a lot. Someone should seek support from colleagues, friends, some girlfriend from your own area back home."**

> **"I personally talk to my friends. Trust is very important and to me and to express how I feel even before the professional counsellors. I trust my friends more than the professional support."**

The above examples provide insights into why participants first approach their social networks for mental health support. Feelings of non-judgment, trust, familiarity, and connection were essential for meeting their support needs. Some women described how their friends helped them gain an understanding and awareness of mental health and encouraged them to see a professional for further mental health support.

> **"I didn't realise I had a mental health problem until friends advised me to see a psychologist."**

> **"It could be a trustworthy person or a friend who listens to me without judgement. Who understands my situation and gives me a helpful advice. This person could advise me to see a doctor if it is complicated."**

Seeking support from formal resources

Although informal resources can provide effective support, people who experience mental health issues may also require appropriate and professional support from formal mental healthcare services and health practitioners (Jorm, 2012; Rickwood et al., 2005). In the share circles, the majority of women reported that they would see a professional if they needed further support for their mental health. Some mentioned that they would seek support from health professionals to know "what exactly is happening". Others noted that their family members "were just good listeners" and "might not have enough professional knowledge about mental illness", so they would seek mental health services for further support. Many women understood their mental health problems might worsen if they did not seek help from a health professional in time.

Participants who were students sought help from counselling services offered by their universities. Other women reported seeking help from GPs, counsellors, and psychologists from community services or mental health care clinics in Victoria. Some participants mentioned specific channels of seeking support, such as Beyond Blue and Employment Assistance Programs offered in workplaces.

GPs were mentioned across all focus group discussions as a common first point of contact for formal support. Participants mentioned the benefits of seeking support from GPs and counsellors, which include confidentiality and accessing referrals for further treatment. Many expressed a preference for consulting health professionals who could understand their culture and first language.

> **"It is better to meet with counsellors and share with them rather than friends as I don't want my friends know about my issues. The benefit of meeting counsellors is confidential. They listen to us, and they don't spread out the information."**

> **"I would go to a GP because I can find a GP who can speak my preferred language. They may know of psychologists who speak the same language and can refer me."**

“My GP is of the same cultural background and she referred me to a psychiatrist who was able to understand where I came from and which culture I belong to.”

In some share circles, understandings of the supports available were underpinned by a fear of punitive consequence – an issue that has been previously reported in the literature (Satyen et al., 2018; Vaughan et al., 2016). In some instances, there was fear that disclosing mental health concerns to a mental health professional would mean losing a driver’s licence. For others, there were concerns that disclosing anything about mental health might result in the removal of their children. One woman recounted how she was warned about seeking support:

> **“...someone who lived for a long time in Australia said to me do not go to see any psychiatrist because the government would take your children if they knew you are not mentally stable.”**

There were also discussions about the fear of being misunderstood by mental health professionals, resulting in judgement around parenting practices. As one mother said:

> **“If someone from western culture they might not understand my issues, they might think what I did with my son is family violence or they might misunderstand husband wife relationship.”**

Migrant and refugee women possess diverse understandings of mental health and wellbeing and are well-equipped with strategies and approaches for seeking further support, whether that be formal or informal. To be effective, future policy reforms and programs must recognise the diverse understandings of migrant and refugee women and build upon their preferred methods of support.

Challenges Accessing and Providing Support for Mental Health and Wellbeing

Challenges within the mental health sector are putting many migrant and refugee women at higher risk of experiencing poorer mental health outcomes. Literature in the field indicates that issues such as complex healthcare systems and the lack of culturally and linguistically responsive services prevent migrant and refugee women from accessing support for their mental health and wellbeing in a timely manner (Fauk et al., 2021; Moss et al., 2019; Radhamony et al., 2023; Shafiei et al., 2018).

In this section, we outline some of the challenges migrant and refugee women face when accessing mental health and wellbeing services. We support these findings with insights from our interviews with stakeholders from mental health and community organisations based in Victoria.

Racial and gender discrimination

In our share circles, many women discussed their experiences of being dismissed by health professionals particularly when they sought support for their mental health concerns and needs:

> **“I thought it was depression and went to see the GP five times telling her that I have depression symptoms but every time she kept saying it was not depression...”**

Discrimination in healthcare was a common occurrence for many of them, with some describing the experience of not being taken seriously. This finding was consistent with a study that highlighted how migrant and refugee women are continuously ‘ignored or dismissed’ by clinicians and in many instances encounter disrespect from health professionals (Filler et al., 2020). As a result, many women discussed having to change their health professionals on multiple occasions until they found someone who would listen to their concerns and provide solutions. In some instances, this directly intersected with a lack of cultural responsiveness in the sector:

> **“...because they are not minorities and I find myself having to explain what it’s like to be a minority, which eats up a lot of time and doesn’t allow me to get to my point and then I do feel quite brushed off. It’s been a recurring pattern.”**

Moreover, the experience of not being taken seriously was sometimes coupled with a downplay of migrant and refugee women’s traumas and needs by health professionals. This was mainly shown when health professionals would overtly focus on women’s need to be resilient instead of offering formal mental health supports. In recent years, activists have warned against the negative connotations of labelling marginalised communities as ‘resilient’ (Srivastava, 2021). Such labelling focuses on the glorification of having to survive injustices and inequalities, rather than

providing meaningful solutions to systemic issues faced by communities.

Additionally, we know from the increasing evidence that the experience of not being taken seriously or being dismissed is a persisting issue, especially when it comes to mental health and experiences of family violence (Radhamony et al., 2023; Vaughan et al., 2016). The experience of being dismissed adds to the complexity of seeking support, which is already present from the isolation of family violence and migration. One participant shared their experience of not feeling supported when they reached out for support:

> **"We always receive information about family violence…and when you talk about it to a professional or someone, they tell you it is hard to prove. So, what is the point of mentioning it if no one would believe you?"**

These experiences with service providers reflect interpersonal and systemic racial and gender discrimination, in the sense that the healthcare system more broadly is not designed to centre the needs of migrant and refugee women. Our findings in this area underscore the importance of having integrated support systems that address interconnected barriers in ways that encourage rather than deter people from seeking help.

Lack of accessible information on mental health

Many women in our share circles said they did not have access to plain English or in-language information on mental health and wellbeing and service pathways. In some cases, participants were unaware of where to go for help, and in other cases those who had searched for information online found that it was too complex. Some women living in regional Victoria discussed how this issue was further compounded by a lack of refugee health nurses in their area. Refugee heath nurses support refugees and asylum seekers in their health and wellbeing by developing referral networks and linking individuals, families, and communities in with GPs and other health providers, social supports, and orientation programs.

The lack of accessible information was a recurring theme across the share circles. Participants shared that it actively limited their access to mental health care and impeded their right to make informed decisions. As one woman described the importance of:

> **"…understanding what options are there and maybe to have more transparency on the system… just be able to navigate through that and make choices."**

Interviewees from mental health and community organisations across Victoria also identified the lack of accessible information as a key challenge for migrant and refugee people. Many of them spoke about the limitations of monolingual mental health resources and information channels, such as service providers' websites having limited language options. These issues result in difficulties for many migrant and refugee people, particularly newly arrived migrant women, who need to know what services are available and may be seeking information about mental health and wellbeing.

The lack of accessible information is also tied to digital access and literacy, which is becoming an increasingly important feature of Australia's healthcare system. Technology-based modes of service delivery further exacerbate the digital divide, running the risk of excluding migrant and refugee women from accessing timely intervention services. Stakeholders mentioned how limited digital access disproportionately impacts older adults, as well as young migrant and refugee people who are dependent on a caregiver to consent to participate in mental health and wellbeing initiatives. Our findings in this area indicate that access and equity to health information must consider both language and digital literacy to resonate with migrant and refugee populations.

Inadequate in-language and interpreting services

Mental health services that are predominantly delivered in English are a barrier for migrant and refugee people. Especially for women living in regional Victoria, the lack of access to interpreters is a critical barrier to receiving adequate mental health support. For instance, one regional participant said:

> **"My mum needs the regular psychiatrist consultation for her assessment and medication adjustment. Though long waiting for the appointment, only telephone appointment is available. Even interpreter via the telephone is not easy to get, face-to-face interpreter is more far away…I am tired of it now."**

From a stakeholder perspective, many interviewees considered using interpreters to support clients of migrant and refugee backgrounds, but they found it difficult to find workers who could speak clients' preferred languages. There were other challenges in using interpreters, such as aligning availabilities with clients, providing emotional support in sessions, and the high cost of services.

> **"With the third party, it doesn't carry their emotion. And sometimes they [clients] need help immediately while the interpreters are not available at that time… When the emotional [crisis] passes, the communication is not effective, they couldn't express themselves to the health professionals."**

> **"[If the clients need an interpreter] I have to have [interpreting company] on the phone and they will be translating. The client is then paying for that service. The client is then paying for my service as well and the process of therapy, it takes double the amount of time."**

The above examples reinforce the complex problems related to available interpreting services in clinical and healthcare settings in Australia, which are well-documented in the literature (Sullivan et al., 2023; Wamwayi et al., 2019). These challenges place many migrant and refugee people with low English language proficiency at further risk of experiencing poorer mental health outcomes.

Lack of tailored, culturally responsive services

Participants who saw mental health professionals often noted that it was difficult to talk about their mental health with someone who did not understand their cultural and migration context. They commonly mentioned how explaining their experiences as a migrant or refugee person took time away from them discussing their mental health concerns during their already limited and costly sessions. This also included instances where participants had experienced inadequate support from a mental health professional who would apply their own belief system to sessions.

> **"They would sort of apply their beliefs…with what we were talking about which is obviously very, very different and they didn't really understand where we were coming from."**

Some women acknowledged that mental health professionals were often supporting the best they could within a system that did not effectively equip them to provide culturally responsive and appropriate care. As one woman shared:

> **"Our community people have come forward – they have taken up careers of psychologists and psychiatrists. But the systems, strategies, the way of treatment is still developed according to Australians."**

Interviewees from mental health and community organisations were also concerned about the lack of culturally responsive

approaches to mental health care and support. Current approaches to service delivery utilise a Western mental health framework that does not recognise alternative methods of support that may be more responsive to the needs of migrant and refugee people (Savic et al., 2016; Wamwayi et al., 2019). As one interviewee explained:

> **"Essentially mental health services all sit under the big umbrella term of psychology, which is very Western, very Eurocentric practices and it is a framework that understand health and relationships and happiness all from only a Eurocentric perspective... We are trying to provide services within a system that only recognises health from a very Western perspective, when actually, Eastern practices have always promoted very, very different ways and understandings of health."**

No mental health framework is 'culturally neutral or universal' (ECCV & VTMH, 2021, p.7). Rather, mental health systems, models and services are products of the dominant culture, reflecting Eurocentric, biomedical understandings of the human condition. While this approach has given us the conceptual tools and frameworks to address mental illness, the embedding of 'normative hierarchies' into health systems – one that privileges Western understandings – is a form of structural violence that constrains migrant and refugee women's access to support and runs the risk of lasting health inequities (ECCV & VTMH, 2021).

Long waiting times and costly services

Many participants listed extended waiting periods, costly services, and practitioner shortages as barriers to accessing adequate support for their mental health and wellbeing. These are symptoms of a poorly designed mental health system that has not kept up with the needs of Victorians. Such systems run the risk of inadvertently harming patients. Our findings in this area confirm the challenges migrant and refugee communities face when accessing support, which has been well-documented in relevant Australian literature (Adhikari et al., 2021; Fauk et al., 2021; Khatri & Assefa, 2022). For instance, women discussed how long waiting times negatively impacted their mental health during difficult periods and had even deterred some from seeking formal support. As one woman shared:

> **"I would have a wait time of at least two months and that was almost always enough to talk me out of asking for support."**

In both our share circles and interviews with stakeholders, Medicare ineligibility was an issue that further limited people's mental health care options when they needed support. This was exacerbated during the COVID-19 pandemic, where one interviewee noted that some people were left with very limited options:

> **"International students I think suffered disproportionately. We work with quite a few of them... they can't access Medicare rebated services...some of them...wanted in-language services and their mental health support is limited...it was very hard."**

To avoid these challenges, some women sought support for their mental health and wellbeing overseas:

> **"I chose to use the online service in [country of origin] as I find it cheaper, the counsellor shares my language and culture, and I am unaware of any alternative service."**

Many women voiced their frustrations about high out-of-pocket costs when seeking formal support for their mental health, reflecting wider trends in Victoria's mental health system which stratify access according to socio-economic status. The Productivity Commission's Report on Government Services found that between 2021-22 in Victoria, the proportion of people who had a mental health condition but delayed seeing or did not see any mental health professional due to cost was 19.4%, up from 14.3% in 2020-21 (Productivity Commission, 2023).

When the Royal Commission tabled its findings, it described the state's mental health system as 'broken' (State of Victoria, 2021a). Migrant and refugee women divulged the extent of how broken the system is by listing racial and gender discrimination, inaccessible information, the lack of culturally responsive services, long waiting times, and high costs as some of the challenges they face when accessing support for their mental health and wellbeing. However, from our interviews with stakeholders, it is clear the state's mental health system is not only broken. It is inaccessible and unresponsive, resulting in the further marginalisation and exclusion of migrant and refugee women.

Systemic Barriers: A Stakeholder Perspective

In our share circles, it was clear migrant and refugee women were proactive about maintaining their mental health and wellbeing. One stakeholder importantly pointed out:

> **"People are really keen to engage... The conversation about them being hard to reach and not engaging in mental health services has been the opposite of what we have experienced."**

However, as alluded to previously, there are systemic barriers that significantly impact migrant and refugee women's access to and the quality of mental health care they receive. In this section, we present our findings from discussions with mental health and community organisations on some of the systemic barriers they face in providing the best mental health support for migrant and refugee communities.

Shortage of mental health practitioners who are of migrant and refugee background

Migrant and refugee women reported the benefits of being connected to health professionals of a similar cultural background, which was reflected in their preferences when seeking support for their mental health and wellbeing. In our interviews with stakeholders, many highlighted the importance of staff who are of migrant and refugee background and/or have lived experience as gender diverse and non-binary people. They said these staff members were "huge points of connection for a lot of clients", encouraging clients to access further support for their mental health and wellbeing.

However, many interviewees noted the sector has a shortage of mental health practitioners/professionals of migrant and refugee background, which has been driven by racial and migration related employment-discrimination.

> **"There are so many barriers to people of colour getting hired [in mental health service sector], including racial bias and discrimination...I had to go through a very long process to get my overseas qualifications recognised as eligible to work in Australia. Many people don't have the resources to go through that process and get registered here and end up falling out of the sector. "**

The recognition of overseas qualifications in mental health service sectors has remained a critical issue in Australia. There is an urgent need for the timely and practical recognition of overseas qualifications in the state's mental health support services.

Lack of cultural safety in the sector

While there is a workforce shortage, attempts to reform the mental health system must be

coupled with increasing workforce capabilities to deliver culturally responsive care to people from migrant and refugee background. As it currently stands, interviewees from mental health and community organisations identified that cultural safety is lacking in the sector. Cultural safety is a fundamental component to ensuring healthcare services meet the social, cultural, and linguistic needs of patients (Nair & Adetayo, 2019). Although some interviewees noted their staff attended cultural competency and cross-cultural awareness training, a big gap remains around cultural safety:

> **"They study for 10 years and they get about 2 hours of culturally responsive training – and that covers literally like everyone from First Nations, to refugees, to migrants. It's completely inadequate support...Like even myself, in my Master's degree, I had a 2-hour unit about culturally responsive mental health and same as a clinical psychologist."**

Interviewees underscored the need for relevant training amongst mental health staff who work with migrant and refugee communities. But to ensure the entire workforce becomes responsive to the needs of migrant and refugee women, relevant training should be integrated into education at undergraduate and postgraduate levels, and as part of continuing professional development for mental healthcare workers (Wamwayi et al., 2019).

Lack of stable funding

In our engagements with organisations working with migrant and refugee populations, unstable and short-term funding was a recurring issue. For instance, an interviewee from a non-profit said:

> **"We are very busy with our community. Some of the project has been funded by the government, but some other projects haven't been funded but we still deliver the projects to our community. We are passionate in supporting our community... The biggest issue we face is funding."**

Comparatively, an interviewee working as a private service provider stated that:

> **"The same organisations get funded to do the work and for grassroots and smaller organisations, we really struggle to get funded to do things even though we do things out of pocket. We actually have had more support from philanthropic, grassroot community funding than government funding for anything that we have done."**

In its final report, the Royal Commission formally acknowledged the important role local services in the community play in delivering mental health and wellbeing support across the state. However, 'budget constraints and short-term funding often stifled what communities were trying to achieve' (State of Victoria, 2021b). Another interviewee alluded to the complexities of health financing and noted that the fee-for-service funding model underpinning the Medicare Benefits Schedule makes the provision of care to migrant and refugee populations difficult. They said:

> **"Finances are another great barrier because the way the Medicare system is set up, it basically excludes a lot of service providers. So not all service providers are eligible for Medicare rebates and that is again a systemic issue that directly impacts those providers. Some people, because of financial restrictions, want to access Medicare-rebated services. But like I said earlier, if organisations are not hiring us, then we are working in this kind of private individual service provider space and we don't have access to everybody."**

The funding challenges faced by organisations delivering mental health and wellbeing programs are not unique to Victoria. As acknowledged in the Inquiry into Mental Health, the lack of investment in community-based care is a national problem (Productivity Commission, 2020). The dizzying array of primary and specialist mental health services, and of Commonwealth- and state-funded initiatives has resulted in a highly fragmented mental health system that is unable to deliver integrated care. These systemic barriers not only cause difficulties for service providers and the mental health workforce, but has flow-on effects to consumers, carers, and families.

Tailored services to meet LGBTIQA+ community needs

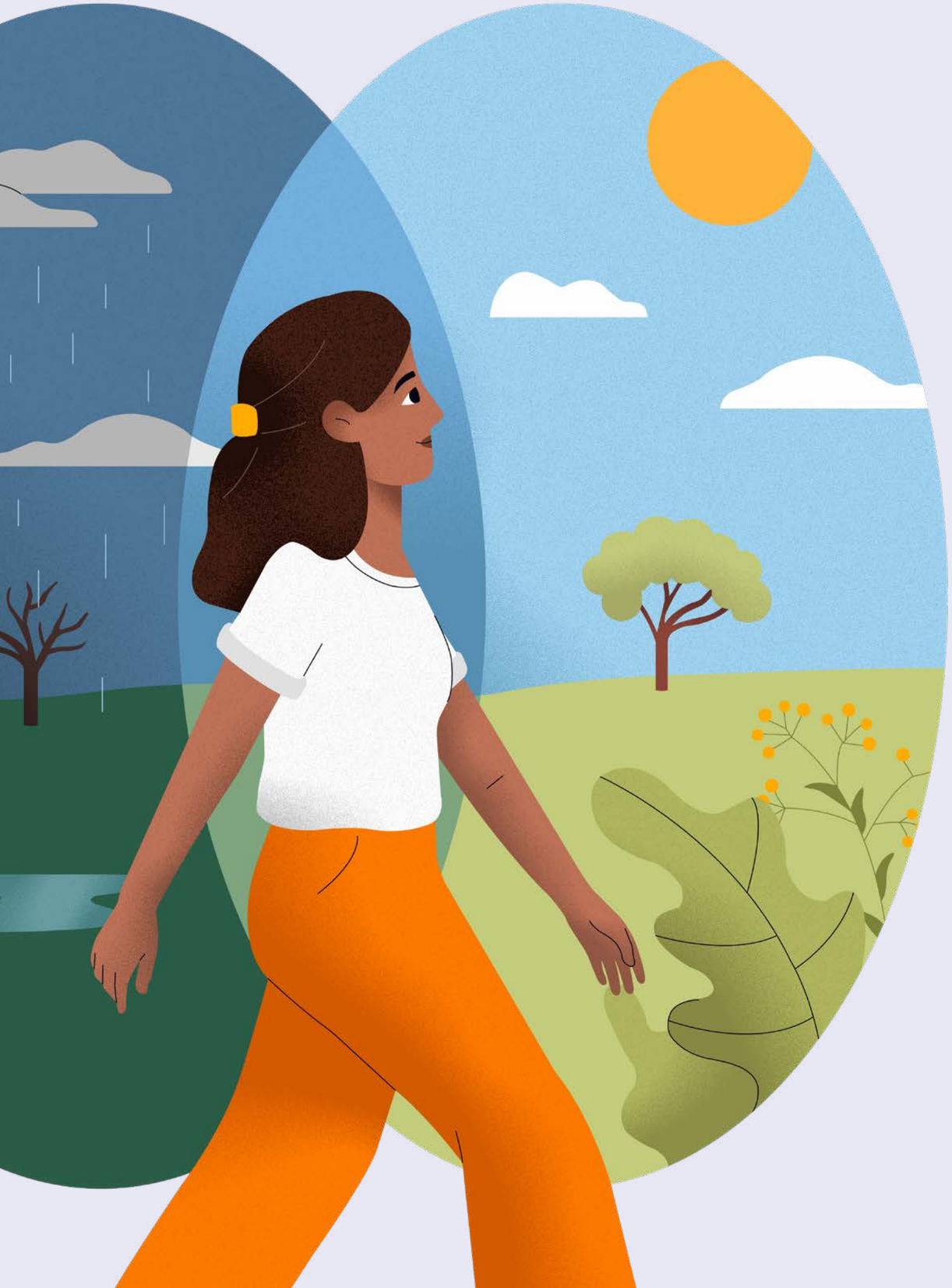
One of the limitations of our research has been the underrepresentation of share circle participants from LGBTIQA+ communities. To understand the needs of LGBTIQA+ migrant and refugee people, we interviewed stakeholders who actively work with this cohort. In these interviews, we heard how:

> **"Mainstream organisation sometimes aren't equipped to deal with that specific intersection – being a person of colour, migrant and refugee background and also being part of the LGBTIQA community."**

> **"People don't really understand the intersectional experience... the third gender has always been present in so many Asian cultures but yet, queer culture is a very white dominated space in Australia that leaves a lot of queer people and non-binary people and gender diverse people outside of any support space...intersectional care is definitely lacking. It's like are you Asian or are you non-binary? Like you can't be both, that's too much for the world to understand."**

Stakeholders noted that mainstream mental health services are not often tailored to meet the needs of these communities, which can sometimes result in a lack of engagement. Additionally, there is a limited number of multilingual mental health resources and online platforms where migrant and refugee communities can go for information that is LGBTIQA+ inclusive. To address this issue, interviewees shared the importance of applying an intersectional lens to provide appropriate support for LGBTIQA+ migrant and refugee people that is culturally and linguistically responsive. Additionally, interviewees pointed out that more leadership from LGBTIQA+ and multicultural communities is needed across the state's mental health system.

These insights indicate that migrant and refugee people actively seek professional mental health support and are drawn to tailored services that are culturally, linguistically, and LGBTIQA+ responsive. However, the limited access to these types of support needs to be addressed at a systems level for all migrant and refugee people to freely access and benefit from them.



Conclusion and Recommendations

Migrant and refugee women are proactive about maintaining their mental health and wellbeing. However, the mental health system has not been systematically responsive or inclusive of their needs and lived experience. Socio-political factors, such as access to health-related information and services, the migration experience, visa restrictions and gendered and cultural norms are intricately linked with migrant and refugee women's mental health, and consideration of these must be incorporated into mental health service provision. Future research, policy, and practice will need to consider how these factors intersect with systemic racism, sexism, health, and socio-economic inequality to shape the mental health outcomes of migrant and refugee women, non-binary, gender diverse people.

Recommendations

Drawing on what we learned from listening to migrant and refugee women, we offer evidenced-based recommendations that provide guidance across many of Victoria's Mental Health System reform priorities, including practical solutions to the implementation of Recommendation 34 of the Royal Commission into Victoria's Mental Health System (State of Victoria, 2021c). The recommendations below respond to the Royal Commission's call for a mental health and wellbeing system that is safe, responsive, and inclusive, and that meets the needs of the whole community, including migrant and refugee women.

They offer ways to ensure that migrant and refugee women have the community-based support they need to navigate the mental health system, ensuring more equitable access to services. The recommendations also suggest ways for migrant and refugee women to access the knowledge and awareness they need, in their preferred languages, to incorporate mental wellbeing strategies into their everyday lives. With respect to the mental health system reform, the recommendations provide a pathway to a mental health system and workforce that provides equitable and culturally responsive services to migrant and refugee women, when they need it.

The recommendations also include strategies to ensure that migrant and refugee women are actively engaged in the planning and implementation of the mental health reform. They suggest a strength-based approach which empowers and supports the self-determination of migrant and refugee women and promotes the leadership of those with lived and living experience of mental illness and psychological distress in the system reform and service delivery.

To ensure that Victoria's mental health reform is inclusive, accessible, and culturally safe, it is essential that a culturally and linguistically diverse health education and mental healthcare workforce is sustainably funded.

1 Establish a statewide, specialist, multicultural women's mental health program that provides:

a. In language mental health education focusing on health promotion and prevention.

b. Access to multilingual mental health information resources in a range of formats and access points.

c. Transparent referral pathways for migrant and refugee women to Mental Health and Wellbeing Locals and other mental health services.

d. Secondary consultation, capacity building and training to mental health services.

e. Specialist intersectional policy and practice advice to the current mental health reform, including developing best practice guidelines for accessible, ethical, culturally responsive, and trauma-informed service delivery.

2 Build the capacity of the mental health system and the mental health workforce to deliver a culturally responsive and safe service to migrant and refugee women by:

a. Promoting and investing in a culturally and linguistically diverse mental healthcare workforce, and supporting processes for recognising the qualifications of overseas-trained mental healthcare professionals.

b. Ensuring accessibility to translation and interpreting services by investing in a secure, well-paid translation and interpreting workforce, and ensuring interpreters are familiar with mental health and wellbeing terminology that is in-language, inclusive and non-stigmatising.

c. Providing ongoing capacity building and professional development for mental health professionals and the interpreting workforce in gendered and cross-cultural awareness.

d. Improving digital and non-digital access: Recognise that many technology-based booking systems and modes of service delivery make it more difficult for women with low English proficiency to access timely early intervention services and may further exacerbate health inequality.

e. Ensuring that there are established community-based, health promoting and preventative programs that can act as liaison points to clinical mental health services.

f. Implementing best-practice and trauma-informed service provision, and encompassing person-centred, whole-of-the-system approaches that promote cultural safety and responsiveness from the beginning of women's journeys with the system.

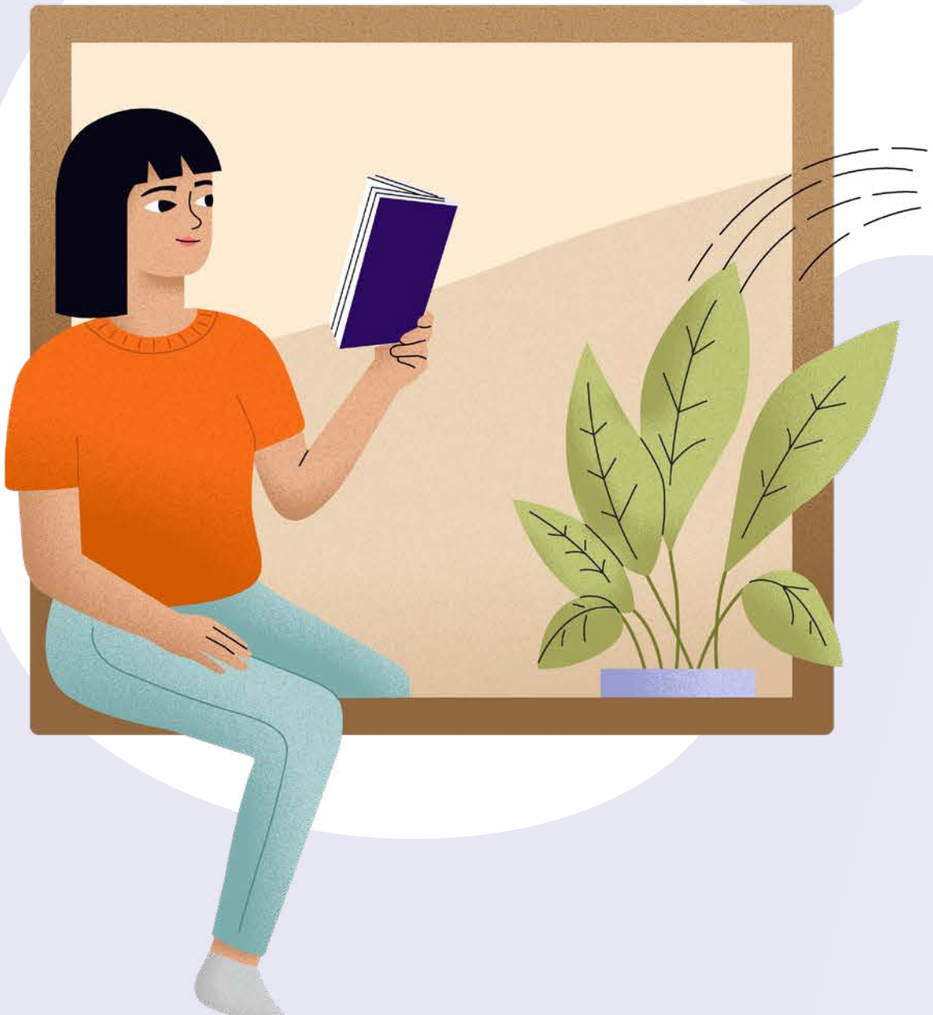
g. Continuing to develop and enhance the existing models of perinatal mental health surveillance/screening and assessment to improve early identification and intervention at the primary care level that meet the specific needs of migrant and refugee women.

3 Build migrant and refugee women's rights, inclusion, and sense of belonging by:

a. Sustainably funding MCWH's PACE Leadership Program to build the leadership, workforce participation, civic and political inclusion and mental wellbeing of migrant and refugee women.

b. Ensuring all social support and health services are accessible to all women regardless of visa status to avoid a multi-tiered discriminatory system.

c. Ensuring universal access to healthcare by removing costs and addressing long wait-times associated with accessing mental health prevention, early intervention, and treatment services.



4 Build the mental health evidence-base and program evaluation capacity by:

a. Commissioning new research on migrant and refugee women's mental health, delivered through equitable research partnerships with migrant women's organisations, ensuring research is led by migrant and refugee women.

b. Commissioning new research on the mental health of non-binary, gender diverse, and LGBTIQA+ people, ensuring that the research is led by community members and representative organisations.

c. Developing a framework for collecting disaggregated health data (by gender, sex, ethnicity, disability, place of birth and visa status) and outcomes data relevant to migrant and refugee populations, and ensure medical research reflects the principles of racial and gender equity.

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