

Productivity Commission Issues Paper
The Social and Economic Benefits of Improving Mental Health
Department of Local Government, Sport and Cultural Industries
Submission March 2019

The Western Australian Department of Local Government, Sport and Cultural Industries' (DLGSC) welcomes the opportunity to provide comments on the Productivity Issues Paper The Social and Economic Benefits of Improving Mental Health (January 2019)

DLGSC comprises the divisions of Culture and the Arts, Sport and Recreation, Racing, Gaming and Liquor, Local Government, the Office of Multicultural Interests (OMI), and Aboriginal History. The following feedback responds to questions posed in the consultation paper.

Assessment Approach

What suggestions, if any, do you have on the Commission's proposed assessment approach for the inquiry? Please provide data or other evidence that could be used to inform the assessment.

DLGSC notes that the inquiry will consider the extent to which the mental health of individuals is improved as well as the flow on benefits of increased social participation, engagement and connectedness, and economic participation and contribution through employment. It is suggested that the inquiry also consider social cohesion as a measure, for example through the Scanlon Foundation's social cohesion indexⁱ particularly its domains of belonging; worth; social justice and equity; and acceptance and rejection, which have a strong relationship to mental health. For example, the 2018 report notes that:

- the proportion of respondents indicating belonging 'to a great extent' has declined from a high point of 77 per cent in 2007 and is at 64 per cent in 2018
- there has been a negative shift in the proportion indicating the strongest level of happiness: in 2007, 34 per cent indicated that they were 'very happy', in 2017 a statistically significant lower 26 per cent, and in 2018 a marginally lower 25 per cent
- in response to the proposition that 'Australia is a land of economic opportunity where in the long run, hard work brings a better life', the level of 'strong agreement' has declined from a high of 40 per cent in 2011 to 33 per cent in 2017 and 34 per cent in 2018
- reported experience of discrimination on the basis of 'skin colour, ethnic origin or religion' had increased from nine to 10 per cent in 2007–2009 to 19 per cent in 2018ⁱⁱ

DLGSC supports the methodology for the inquiry but notes the importance of collecting and disaggregating data and feedback in relation to specific population groups including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse (CaLD) backgrounds, young people, seniors, people with disability and Lesbian, Gay, Bi-sexual, Transgender, Inter-sex and Queer/Questioning given that experiences and effectiveness of interventions for groups may differ.

It is noted that there is significant stigma and discrimination around mental health, which can be particularly acute for some cultural groups. DLGSC therefore advocates for an approach that takes a culturally sensitive and appropriate approach to engaging with people from CaLD backgrounds about their mental health experiences.

DLGSC supports the use of available research that examines the benefits of physical activity as intervention strategies including comparative assessment pre, during and post intervention to determine impact on mental health.

Structural Weaknesses in Healthcare

Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms?

DLGSC notes that the inquiry acknowledges “gaps in services and supports for particular demographic groups such as ... individuals from culturally diverse backgrounds”. Evidence shows that CaLD groups have poorer access and outcomes when seeking mental health care. Overlooking cultural differences and diversity in health care contributes to further health disparitiesⁱⁱⁱ. It is acknowledged that people from diverse cultural backgrounds have a range of protective and risk factors in regard to their mental health and wellbeing.^{iv}

A person's cultural background will affect how they interpret and respond to life experiences. A combination of factors including low English proficiency, culture shock, social isolation, cultural and spiritual beliefs, access to employment and housing, the effects of trauma through experience of war, natural disaster or torture make people from CaLD backgrounds less likely to seek early intervention for mental health problems and more likely to be in crisis at presentation. The Australian Early Childhood Mental Health Initiative ‘Kids Matter’ identifies a number of influences in the health and wellbeing of children from CaLD backgrounds including migration and resettlement, language and communication, effects of trauma, discrimination and racism, and parenting across cultures.^v

DLGSC is aware of many barriers that people from CaLD backgrounds face in accessing mental health services in addition to barriers faced by ‘mainstream’ populations including those identified by Mental Health in Multicultural Australia (MHIMA) including lack of knowledge or understanding about mental health services; stigma related to mental illness or seeking help; concerns about confidentiality; language barriers; cultural misunderstandings; previous unfavourable or negative experiences with health or other services; and concerns about being heard, understood or respected, especially in relation to their own explanation of their problem or issue.^{vi}

Lack of knowledge and understanding of available services can include lack of information about mental illness and mental health services in appropriate and accessible formats. Service access issues also include difficulties in understanding and accessing mainstream systems of care and lack of services that are culturally safe and appropriate. DLGSC therefore recommends that people from CaLD backgrounds are included in among the list of disadvantaged groups (page 5) and that structural improvements be made to address these issues including:

- adoption of customised multilingual communication strategies and give the end-user a voice, particularly the lived experience voice, through employment of peer workers, consumer and carer representatives including people from diverse population groups
- implementation of language services policies and strategies to encourage engagement of interpreters and bilingual and bicultural workers where appropriate
- adequate funding to providers to enable provision of appropriate linguistic and cultural support
- approaches that engage with communities and build their capacity to develop and promote prevention strategies and support members affected by mental ill-health
- a holistic approach to healthcare in which collaboration, partnerships and information sharing feature within a framework that protects individuals’ privacy

DLGSC also notes that social identities are multi-dimensional because we belong to different groups at the same time. It is important for policies, programs and services to acknowledge the intersection of these identities with culture, language or religion. Women, young people, seniors, people with disability and people who are Deaf or hard of hearing and who are from a CaLD background, may experience particular barriers when accessing services.

For example, Headspace's November 2018 'Cultural Conversation' event addressing young people from CaLD backgrounds highlighted that many do not feel comfortable talking to parents about their problems because they believe they will not understand, and this can lead to depression, anxiety and other forms of mental illness. Experiences of racism at school can impact mental health. However, responses from family to admissions of sadness, depression and anxiety can include being told 'to snap out of it', that the problem is 'not a big deal', to 'toughen up', particularly for young men. Young men particularly can feel pressured to be 'strong', leading to poor mental health or suicidal thoughts.

Mental health is still stigmatised in CaLD communities and there are added difficulties where there is no language to define or describe mental health. Young people from CaLD backgrounds have also revealed the significant related issue of shame—shame for young people to admit they have a mental health issue, shame experienced by family if any issue of mental issue is talked about and, for young men, shame that they are not 'manly'.

Older people from CaLD backgrounds have a higher risk of mental health issues than those born in Australia but underuse mental health services resulting in presentation at later stages of illness. Language barriers and lack of knowledge of available mental health services increase the difficulties of access and timely treatment. There is also a need to consider cultural differences in mental health assessment tools for older people from CaLD backgrounds to support appropriate diagnosis. For example, culture and ethnic background can have an impact on dementia diagnosis, and culturally sensitive assessment tools are required and should be used where they exist.

Differing cultural practices and norms can lead to misdiagnoses. Many cultural groups have different views and health practices, and some use traditional medicines to self-manage their health conditions. Examples include applying Vicks on the forehead, or praying, to counter feelings of sadness and/or anxiety. There is a need for clearer instructions on taking medications correctly as well as for improved cultural understanding and acknowledgement of traditional medicines.

It is important that service providers including general practitioners, specialists, nursing and allied health workers employ a culturally inclusive approach to addressing the mental and physical health needs of people from CaLD backgrounds. This includes engaging interpreters, providing translated materials and developing other multilingual strategies, and recognising and valuing the bilingual skills of staff, including allied health professionals.

Noting the links between mental health, alcohol and other drug use, family and domestic violence, and homelessness, DLGSC also encourages establishment of appropriate information sharing mechanisms between sectors to enable appropriate and effective service delivery to those affected.

DLGSC also supports placed-based plans and servicing, in which lead agencies and designated service providers play a role along the stepped model of care. It is recommended that a more coordinated approach be adopted in respect to lead agencies working with other agencies for mental health outcomes.

What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments? How should they be addressed and what would be the improvements in population mental health, participation and productivity?

Collection of data on the prevalence of mental illness and treatment rates of CaLD communities is critical to inform future mental health prevention and treatment initiatives. Given disparities in service access by people from CaLD backgrounds, it is recommended that demographic data is collected for priority populations to enable measurement of improvements in service access. Collection of sufficient, consistent and reliable data is vital to support research and policy and program formulation and is imperative in designing appropriate strategies and prevention models. Evidence suggests that such data is currently not available in respect of areas such as suicide. The collection of cultural and linguistic data

in relation to investigating the cause of death of a person is crucial in the development of appropriate and effective suicide prevention and other causes of death.

DLGSC recommends that cultural and linguistic data is collected wherever possible by health and allied health services, and in line with the Australian Bureau of Statistics (ABS) Standards for Statistics on Cultural and Language Diversity. This sets national standards for measuring diversity through a core and standard set of cultural and language indicators. It includes standard questions to be asked. By using the core and standard sets, it provides consistency in the collection of data and enables comparisons to be made between agencies, jurisdictions, local government areas, regions and against census data. The core set comprises country of birth; main language other than English spoken at home; proficiency in spoken English; and Indigenous status.

The other indicators in the standard set are: ancestry, birthplace of parents, first language spoken, languages spoken at home, main language spoken at home, religious affiliation and year of arrival in Australia. DLGSC recommends collection of at least the minimum core data set and to identify and include other standard variables as appropriate. The DLGSC Office of Multicultural Interests' Guide to cultural and linguistic data collection for the WA public sector is based on the standards. See:

<https://www.omi.wa.gov.au/Resources/Publications/Pages/ViewPublication.aspx?DocID=61>

Specific health concerns

Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs?

DLGSC supports prevention strategies that acknowledge that culture and cultural factors, among other social factors are powerful determinants of health-related behaviours. For example, the MHIMA—Framework for Mental Health in Multicultural Australia: Towards Culturally Inclusive Service Delivery Organisations—Implementation Guide which highlights the importance of giving attention to the social contexts impacting on mental health in CaLD communities and the cultural beliefs and values relating to mental health within individuals, groups and communities. Noting that many of the risk and protective factors for mental health problems people occur in the daily lives of individuals and communities, MHIMA notes the importance of building strong partnerships between mental health services, and multicultural sector organisations and diverse communities.

Many people from CaLD backgrounds are from a collectivist culture and therefore the response to mental health can be different to 'western' and 'mainstream' ideology. This can shape how a person is treated with their family and community and can be either positive or negative depending on the family and/or community's response.

Approaches which implement standardised mental health promotion and prevention programs and require people from CaLD backgrounds to conform to receive services will be unsuccessful. More successful approaches are those which can:

- fully integrate diverse beliefs, perspectives and values of mental health of the group being targeted to underpin the content and delivery of the program
- be delivered collaboratively; where agencies and groups from the multicultural sector and sectors impacting on mental health and well-being of CaLD communities (such as health, education, employment, housing, immigration, and justice) work together to collectively develop a culture of inclusion. ^{vii}

Which forms of mental health promotion are effective in improving population mental health in either the short or longer term? What evidence supports this?

Promotional campaigns that promote inclusion and reduce racism and discrimination against people from CaLD backgrounds would be beneficial in promoting mental health among these population groups. A 2012 VicHealth survey^{viii} found that nearly two-thirds of CaLD Victorians interviewed had experienced racism in the previous 12 months. The study highlighted that CaLD Victorians who experience high levels of racism are more likely to also have elevated levels of psychological distress. This places them at an increased risk of developing mental health problems.

Survey results indicated that experiencing any form of racism was associated with worse mental health. The likelihood of being above the threshold for high or very high psychological distress was significantly higher for people with medium and high levels of experiences of racism. Promoting acceptance and preventing discrimination is therefore vital.

DLGSC supports strategies that create and maintain supportive environments including those that increase community connectedness, social cohesion and inclusion and the use of targeted education to increase the reach of key messages to specific groups through targeted campaigns and advocacy. Examples are the Peel Mental Health Project^{ix} which aims to help parents, carers, teachers and community members better support young people.

DLGSC also advocates for promotion campaigns that target community groups and organisations to support networks of the community, such as sporting clubs. Accordingly, local governments make a contribution to healthy communities by directly providing or funding services that contribute to creating and maintaining supportive environments.

DLGSC also notes the role of sport and recreation and arts activities in the promotion of mental health. A significant body of research demonstrates the physical and psycho-social benefits of participation in group activities, exercise and development of social connections. People who participate in sports clubs and organised recreational activity enjoy better mental health, are more alert, and more resilient against the stresses of modern living. Participation in recreational groups and socially supported physical activity is shown to reduce stress, anxiety and depression¹

There is also an increasing body of research that quantifies the relationship between mental wellbeing and arts engagement in the general population. 2016 research conducted at the University of Western Australia found that engaging in the arts for enjoyment, entertainment or as a hobby, for two or more hours per week, is associated with good mental wellbeing.^{2xxi}

The Australia Council for the Arts 'Connecting Australians: Results of the National Arts Participation Survey, June 2017' found that more Australians recognise the many positive impacts the arts have on their daily lives and in our communities. In 2016, 17 million Australians acknowledged the significant positive impacts of the arts (86 per cent of the population aged 15 years and over) with 60 per cent of Australians believing that the arts have a 'big' or 'very big' impact on their sense of wellbeing and happiness (from 52 per cent in 2013).

Arts and health is recognised as a specific and often specialised genre of arts practice. While the creation of art has its own intrinsic value, artists practicing in arts and health have a focus on achieving health and wellbeing outcomes and reducing health inequality for those with whom they work. The arts has a place across the continuum of health services from the promotion of health and wellbeing, through prevention, early intervention, treatment, rehabilitation and recovery as well as in end of life care.

¹ <https://www.dsr.wa.gov.au/support-and-advice/research-and-policies/organised-recreational-activity-and-mental-health>

² Davies CR, Knuiman M, Wright P, et al. BMJ Open 2014;4:e004790. doi:10.1136/bmjopen-2014-004790

The therapeutic health benefits shown to be positively associated with participation in artistic and cultural activities are mostly gained through social interaction and personal skills development, which boost confidence and self-esteem. ^{xii} A number of studies identify that arts participation and attendance is related to the following health outcomes: improved overall health and wellbeing^{xiii} and mental health; ^{xiv} reduced depression/anxiety^{xv}) and lower levels of stress;^{xvi} and reduced risk of dementia in people over 75^{xvii} and of fall/fall related injuries in persons over 65.^{xviii}

In Western Australia the arts and mental health sectors are delivering programs in both the community and health care environments. For example, the Music Feedback program was first developed in 2009 by the Western Australian Department of Health's Mental Health Division (now Mental Health Commission), the then Department of Culture and the Arts and the WA Music Industry Association.

The Music Feedback program used music and popular culture to promote positive mental health and reduce stigma associated with mental illness for young people (aged 12 to 25 years) from risk groups. Evaluation of the program found that the compilation and distribution of an annual compact disc was a very important tool for organisations starting conversations with young people around mental health. The Program was delivered from 2009 to 2017, most recently by the Youth Affairs Council of WA (see page 24: <https://www.yacwa.org.au/wp-content/uploads/YACWA-AR2017-ONLINE.pdf>)

DLGSC supports strategies that empower communities to plan, design and develop approaches that build their skills and capacity and increase the community's capacity to take an active role in planning and developing programs. This is relevant to particular population cohorts—such as CaLD communities, Aboriginal people, people with disability, young people and seniors—and particular activities, such as arts and culture, and sport and recreation. For example, the FIVE project was developed by DADAA and Rio Tinto to raise awareness of mental health particularly targeting fly-in, fly-out workers and their families through arts practice. The project was delivered in five different communities across regional, rural, and remote Western Australia and engaged with more than 7,000 people over a two year period.

The interventions require that there is necessary social infrastructure and safe spaces, including in low socio-economic communities, that allow for the intervention to take place while at the same time providing programming that addresses and intervenes in potential suicide for example youth drops in centres and wrap around services that can address mental health, AOD and physical health issues.

Health Workforce and Informal Carers

Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current arrangement? How would this improve population mental health, participation and productivity?

DLGSC supports the principles articulated in the Western Australian Mental Health Commission (draft) Mental Health, Alcohol and other Drug Workforce Strategic Framework 2018-2025 as relevant to the professional health workforce: ^{xix}

- The preferences of consumers, families, carers and communities are appropriately reflected
- Workforce planning and development occurs across the service spectrum
- Equity, respect for diversity, cultural inclusivity and cultural security are of paramount
- All workers, including clinicians, are offered the opportunity to be involved in addressing workforce planning and development issues
- Recovery-oriented practice underpins service delivery

- Holistic, whole-of-person services are common practice.
- Trauma-informed and family-inclusive methods are common practice.
- Workforce configuration is flexible and responsive.
- Changes within the workforce are sustainable

DLGSC particularly supports:

- recruitment of suitably qualified, diverse workers across the service spectrum
- strengthening relevant links between mental health, AOD and other relevant agencies with strong connections to diversity at clinical, professional and management levels and ensure appropriate interagency referral processes are in place
- ensuring workforce development programs are available to increase workers' capacity to deliver appropriate services for specific populations including Aboriginal, LGBTIQ, CaLD, seniors and youth populations
- where relevant, contracts and service agreements include a requirement for workers to undergo diversity training.

It is crucial that Aboriginal people are employed and adequately trained to provide culturally appropriate services to Aboriginal people including advocating on behalf of Aboriginal people. DLGSC notes the Royal Australian and New Zealand College of Psychiatrists recommendations in relation to the Aboriginal mental health workforce as well as the consumers and carers that interact with mental health services. These include recognising the role of Aboriginal and Torres Strait Islander mental health workers as an integral part of any multidisciplinary team caring for Aboriginal and Torres Strait Islander consumers and communities, and their roles in providing consultation and liaison on cultural safety and security to the team and in providing peer education on cultural competency, and consultation on specific consumers.^{xx}

It is also vital that the workforce more generally reflects the community it serves, that staff are culturally competent, and that staff are aware of when and how to engage interpreters for people with low levels of English language proficiency and who speak languages other than English.

DLGSC also supports increasing consumer, family and carer partnerships in workforce development, noting that this level of involvement can be crucial to the development of effective approaches with CaLD communities.

DLGSC recognises great potential in the cross-sector development of employment opportunities for arts professionals as well as health staff, to support programs and projects that use arts and culture as a vehicle for achieving health, mental health, recreational, social, educational and general wellbeing goals. Inclusion of the arts in the formation and professional development of health and social care professionals can provide health professionals with valuable tools for their practice as well as driving innovations in their work environment.

Arts and culture activities encompass a variety of social interaction and show connections between the arts and culture and health sector by:

- training arts and culture professionals to be able to assist at a certain level if needed
- using arts and culture activities as a vehicle for achieving health, mental health, recreational, social, educational and general wellbeing goals.

Both areas relate to establishing a knowledgeable generalist workforce that finds innovative ways to integrate services and helps deliver holistic, whole of person support.

There are many opportunities for consumer and carer representation to be developed and for the workforce to be supported and strengthened. The 2018 WA Peer Supporters Network 'The Peer Workforce Report, Mental Health and Alcohol and other Drug services' notes that:

“there is a shortage of statistical information on the size and characteristics of the peer workforce for mental health and alcohol and other drug services. Peer workers are not recognised as workers by the Australian Institute of Health and Welfare (AIHW) for health workforce data collection purposes, and thus peer workforce rates are not available for primary care or private hospital settings.”

Representation of consumers and carers on all committees, panels and boards would provide greater opportunity to review policies, systems and procedures during the planning, implementation and review stages. DLGSC supports a requirement for Aboriginal people and people from CaLD backgrounds to be represented on all panels, committees and boards wherever possible.

It is also important for roles and responsibilities of consumer and carer representatives to be clearly defined; for remuneration to be commensurate with their skills and experience; and for consumers and carers to have access to relevant and required training and ongoing support, mentoring and training.

What changes should be made to how informal carers are supported (other than financially) to carry out their role? What would some of the benefits and costs, including in terms of the mental health, participation and productivity of informal carers and the people they care for?

It is important to recognise that ‘carers’ are not a homogeneous group and that they differ in terms of Aboriginal status, age, gender, cultural and linguistic background, and geographic location. Carers include people from diverse cultural and linguistic backgrounds, young people, seniors and the elderly, Aboriginal people and people with disability. It is also important to acknowledge the range of activities they may perform including:

- personal care—such as dressing, meal preparation and exercising
- assisting with participation in educational, employment, cultural, social and sporting activities and transport.
- property maintenance
- social and emotional support for a person with mental ill health or psychosocial disability
- decision making
- coordinating care amongst other family members and friends or neighbours.

In addition to these activities, people from CaLD backgrounds may carry out other activities such as assisting with communicating where a person is not proficient in English, and monitoring assistance to ensure it is congruent with a person’s cultural and religious practices.

With these issues in mind, it is important that:

- relevant agencies promote the services available to carers, particularly those who are new arrivals in Western Australia and are unlikely to be aware of, or have access to, supports
- recognise the challenges faced by carers in general, and those of particular cohorts
- promote the development and delivery of programs and services to respond to the diverse needs of carers to enable them to fulfil their caring role and maintain their own health and wellbeing, including the provision of respite care
- carers are involved in the design, delivery, provision and evaluation of services that impact on carers and the role of carers.

ENDNOTES

- ⁱ <https://scanlonfoundation.org.au/wp-content/uploads/2018/12/Social-Cohesion-2018-report-26-Nov.pdf>
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- ^{iv} http://www.responseability.org/_data/assets/pdf_file/0009/4797/Multicultural-Issues-and-Mental-Health.pdf
- ^v https://www.kidsmatter.edu.au/sites/default/files/public/KM%20C1_Cultural%20Diversity_Culture%20Matters%20for%20Development.pdf
- ^{vi} www.mhima.org.au/LiteratureRetrieve.aspx?ID=146907&A=SearchResult&SearchID=149107446&ObjectID=146907&ObjectType=6
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- ^{xvi} Fancourt, D., Willamon, A. (2016) *Attending a concert reduces glucocorticoids, progesterone and the cortisol/DHEA ratio*, Public Health, 132, Pages 101-104
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