Submission to the Royal Commission into Victoria's Mental Health System

Submitted by the Centre for Muslim Wellbeing (CMW)

5th July 2019

Contents

Acknowledgement

Thank-you for the invitation to make a submission to the Royal Commission into Victoria's Mental Health System.

We welcome the opportunity to comment on the mental health system with reference to the experience of Victorian Muslim community members. It is a timely conversation being held in many corners of the Victorian Muslim communities.

Members of the Executive Committee for the Centre for Muslim Wellbeing, Monique Toohey (Registered Psychologist) and Dr. Senem Eren (Registered Psychologist) have authored this submission.

We would like to acknowledge the support and open dialogue that has taken place in the Muslim community over a very short time frame through community consultations that took place with members of Muslim communities from across metropolitan Melbourne to Bendigo. We would also like to thank the many individuals, Imams, community leaders, advocates and mental health practitioners that responded to our survey based on the Royal Commission's guiding questions. The majority of which have been collated and documented in this submission.

We are aware of its shortcomings and look forward to the opportunity to consult more extensively with our community, and compile research that builds on our understanding of mental health and wellbeing as it affects diverse sections of the Muslim community and their access to the Victorian mental health system.

Summary of Recommendations

1. We recommend an adequately funded social service for Muslim young people, families and adults, led by Muslim and culturally intelligent professionals is essential to reduce the risk of Victorian Muslims showing up at crisis points in the service system and importantly to improve markers of wellbeing.
2. We recommend support for the social and emotional wellbeing of at risk groups within the Muslim community.
3. We recommend investment in health promotion campaigns that capitalise on the use of social media advertising, particularly featuring different bi-lingual, bi-cultural and faith diverse communities.
4. In a Victorian context our recommendations focus on developing the capacity in the Muslim community to generate and support an approach to mental health that is appropriate and effective for both religious Muslims and Muslims from all cultural and linguistically diverse backgrounds, including at risk groups such as Aboriginal Muslims and Muslims who are members of the LGBTIQ communities. The research we have done in this area indicates that there are growing demand for mental health services that are able to better integrate Western mental health approaches with holistic models of wellbeing (social, psychological, ecological and spiritual health).
5. This primarily means encouraging young Muslims, as well as mature Muslims, to become involved in mental health as a career and a profession, at all levels – from psychologists, to social workers and counsellors. Initiatives in this regard include raising awareness among young Muslims, through careers seminars in schools and providing Internship and trainee opportunities to university students on field placement located both within Muslim community contexts but also in publically funded mental health facilities.
6. Imams/ religious leaders, community leaders and community workers would benefit from Mental health first aid training and on-going participation in seminars related to mental health and wellbeing. This would develop their existing pastoral care skill set.

7. There needs to be a drive both to conduct more research about the prevalence of Mental illness as well as levels of resilience among Muslim young people and adults. There needs to be more research conducted on the impact of Islamophobia, racism and discrimination on Muslim mental health.
8. The development of a comprehensive mental health promotion strategy is needed not only to educate Muslim community members of existing mental health issues, and treatment options, but also to raise the profile of the prevalence of mental illness in the community to combat the stigma associated with mental illness. Raising the profile on mental illness prevalence within the community and available the treatment options will also inform students considering study or employment options with information that may reflect possible future work opportunities.
9. We recommend the establishment of strong support networks for Muslim mental health professionals as a high priority as a means of peer support and sector development.
10. The delivery of mental health awareness education and targeted wellbeing programs delivered by Muslim practitioners that are culturally intelligent and that integrate psycho-spiritual strategies that are familiar to Muslim community members which engenders trust and credibility with evidence based information on mental health.
11. There is significant scope for improving the curriculum of undergraduate and postgraduate university courses to better qualify psychologists and counsellors to work effectively with Aboriginal and culturally and linguistically diverse communities and clients. Universities need to be engaged on the topic of qualifying their students to work effectively in mental health with clients from all cultural backgrounds, not only white Anglo-Celtic backgrounds and through a largely Eurocentric academic lens.
12. Mental health practitioners in our view would benefit from improving their cultural competency skill sets through on-going training and that organisations develop ATSI and or CALD quality assurance frameworks to improve their credibility in the eyes of the communities they should be seeking to engage.

Men

13. We recommend investment of funds into the Muslim community where qualified Muslim practitioners can facilitate informal or formal social and sports groups where mental health issues can be discussed.
14. We recommend a Men's SHED for Muslim men and young men.
15. We recommend investment into effective and culturally appropriate Men's behaviour change programs, with participant's being linked up to one-on-one support with a qualified counsellor.
16. We recommend emotional intelligence training for Muslim men to help them succeed in personal relationships.
17. We recommend CALD communities having high profile mental health ambassadors in a similar way White Ribbon has ambassadors to help destigmatise mental illness, accessing treatment and support.

Women

18. We recommend more mental health awareness programs targeted at culturally and linguistically diverse women's groups.

Young People

19. We recommend investment in programs that recognise young people for the outstanding contribution they make to the community, such as the Young Australian Muslim of the Year (YAMY) project that was run between 2005-2011.
20. We recommend research is conducted to better understand the resilience of Muslim young people and followed up with the development of needs based interventions.
21. Professional development to assist teachers to recognise, address and assist students experiencing racist bullying.
22. We recommend that to enhance wellbeing of Muslim young people that projects and programs be strength based.

Muslims living in regional areas (Bendigo)

23. We recommend Imams to be considered as part of a referral pathway for Muslims accessing a range of services.
24. We recommend resilience programs aimed at tweens (ages 10-12) to facilitate prevention and early intervention.
25. We recommend investment in parenting programs to support parents to help their children navigate psycho-social stressors common to adolescents and identify symptoms of mental health early.
26. We recommend that Muslim GP's in the local area play a bigger role in educating the community about mental health issues.
27. We recommend that locals are skilled in Mental health first aid.
28. We recommend that there needs to be more low cost or bulk billing Psychological services being offered.
29. Mental health practitioners themselves should reach out to communities to become trusted sources of information and to be seen as credible by the organisations who use them.
30. We recommend investment in boy's camps or high adventure programs where mental health issues are addressed.

LGBTIQ+ Muslims

31. We recommend support for investment in the early identification and intervention of mental health problems of at risk and intersectional groups within the Muslim community.

Reducing Stigma & Discrimination

32. We recommend support for the delivery of mental health awareness workshops designed to improve the mental health literacy of the Muslim community.
33. We recommend support for strategies that help make mental health issues more visible within the Muslim community, therefore destigmatizing the taboo surrounding mental illness and allowing more people in the future to come forward to access prompt treatment.

34. We recommend support for the development of media campaigns promoting mental health awareness amongst Muslim youth.
35. We recommend that further research is needed to better understand the role and the impact Imams make when community members seek out their assistance for personal and mental health problems.
36. We recommend support for programs that strengthen the mental health literacy of Imams.

Preventing Mental Illness

37. We recommend support for the development of programs that provide Muslims with meaningful opportunities for community participation.
38. We recommend support for the development of a centralized directory of mental health professionals with cultural competency who are able to meet the needs of CALD and faith diverse communities.
39. We recommend that all mental health directories have listing of not only bi-lingual counsellors and psychologists but also bi-cultural and faith-based psychologists.

Suicide Prevention

40. We recommend a focus on promoting wellbeing and preventing suicide in vulnerable and at risk Muslim populations, including indigenous peoples, asylum-seekers, refugees, newly arrived migrants and international students.
41. We recommend the development of a framework that assists organisations and individual practitioners to provide culturally appropriate mental health services for Muslim families who have been bereaved by suicide.
42. We recommend the development of youth programs aimed at building intracommunity connections, facilitating strong identity development and a sense of belonging.
43. We recommend investment of resources into CALD qualified professionals that have extensive links to their community to build networks with public mental health services, hospital triage units, and people in government

responsible for better mental health outcomes at State and Federal level to follow up on these recommendations.

Carers & Families

44. We recommend mental health and substance abuse awareness workshops delivered in different languages to different communities that provide information on not only what symptoms constitute mental illness and addiction, but improved literacy of the available supports and service system.
45. We recommend that culturally appropriate group counselling programs are provided for Muslims with suitably qualified and experienced therapists.

Introduction

Muslim Mental Health

Members of Victorian Muslim communities are not immune to mental health issues or social circumstances that compromise their wellbeing.

The problems experienced by Muslims in the area of mental health are probably among the least understood, judging by the lack of direct research that has been undertaken in the area. We can safely assume that Muslims experience mental illness at a level not less than the wider Australian community. What we are certain about through largely anecdotal evidence and limited research that there is a problem that is largely unaddressed. When we also include a number of risk factors such as unemployment, racism, discrimination, socio-economic background, culturally influenced stigma and taboos towards mental illness and an aversion to seeking professional support to, a picture is formed that suggests the prevalence and impact of mental illness might be higher than the general population. The latter would be similar to prevalence of mental illness in other culturally and linguistically diverse groups.

Like other Victorians, Muslim community members experience depressive and anxiety disorders, trauma and stressor related disorders, schizophrenia and other psychotic disorders and mental health issues that arise from neurocognitive disorders and medical conditions. Some Muslims are affected by addictions, chronic pain and persistent insomnia, all of which interrupt one's ability to participate in family, vocational and community life.

What we have known for decades is that across Muslim communities there is stigma associated in having a mental health issue. There is also stigma associated with seeking out professional support services in the area of mental health for example psychological support, counselling or psychiatric treatment. In fact, the stigma is also present in some families of students pursuing psychology at university.

Delays in treatment as a result of any barrier that prevents uptake of early intervention services, can make individuals from Muslim communities more vulnerable to presenting at the crisis end of the service system, such as in Emergency Department triage, the Justice system, or as a family violence statistic. Muslim community leaders have also noted a rise in Muslims completing suicide, an issue once unheard of in the Muslim community.

Problems with Existing Service Providers

Despite the significant presence of large-scale reputable organisations such as Beyond Blue, Headspace, SANE and the Black Dog Institute, the lack of Muslim community awareness around mental health issues is a challenge that needs to be addressed right now and is on the forefront of the minds of Muslim practitioners, leaders, parents, schools and community members. The public mental health awareness campaigns of the aforementioned organisations and prolific Muslim community advocates of better mental health have effectively ignited the question, Who is helping the Muslim community in this area?

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Many Muslims have reported multiple reasons for not accessing the public mental health service system. These include a lack of trust of non-Muslim services and practitioners, a fear that non-Muslim practitioners will misunderstand aspects of their cultural and / or religious identity and practice and misattribute religious or cultural scripts as causal factors for the presenting symptoms, illness or social problem for which they seek support.

Many community members believe that they will not be 'understood' by a non-Muslim practitioner due to their lack of cultural competency and pervasive lack of cultural knowledge and bias, both unconscious and conscious. Therefore an assumption is made that they will not connect with the therapist or service provider. This assumption leads to service providers lacking the credibility and trust required to secure community engagement in their services.

There are commonly held fears related to religious interpretations of their symptoms being conflated with 'being crazy' and 'being locked up'. These significantly contribute to the stigma held by the community in accessing all types of services related to psychological and emotional wellbeing.

It is a commonly held belief by some, that following the tenants of Islam as a way of life protects Muslims from being afflicted with a Mental illness and that if one doesn't practice the religion or has low Iman (faith) that one is susceptible to mental illness. Therefore in some families, mental illness is perceived to reflect a lack of faith, and this perception can in some cases bring shame to the person or the family. Where there is shame, there is silence.

In a climate of Islamophobia, negative sentiments towards Muslims living in Australia fuelled by racist and ill-informed media and political commentary are having an impact on psychological wellbeing and on Muslims accessing range of support services. Such services range from support services affiliated with schools to the public mental health system. The pathogising of Muslims combined with pervasive negative stereotypes from the 'oppressed' Muslim woman to the Muslim male

'villain' is impacting Muslim mental health. The extent of the problem in an Australian context is unknown due to limited research of Australian Muslim mental health.

Many Muslims in Victoria seek out faith similar practitioners to support their mental health. Faith similar psychologists are perceived by community members to be culturally safe and culturally intelligent, motivated to provide services that will effectively navigate the interplay between culture and religion and the presenting social-psychological symptoms.

It is assumed that Muslim practitioners will be able to draw on cultural knowledge to strategically utilise cultural and religious scripts (beliefs and practices) towards recovery and management of symptoms. A significant reason why Muslims seek out Muslim mental health clinicians is because they do not want to feel judged over cultural or religious identity or personal practices in addition to already feeling the stigma of having to see a psychologist.

However within the Muslim community, there are less than 20 qualified Psychologists working in private practice in Melbourne. There are no Muslim psychologists working in regional areas, which Muslim communities in those areas cited as a major reason why Muslims have low mental health literacy and low uptake of mental health services. There are Muslim communities that are well serviced culturally and linguistically by culturally similar psychologists and psychiatrists who provide a bi-lingual service. For example, there are many Turkish-speaking psychologists in Melbourne who have effectively serviced thousands of Turkish Australian clients for decades. However there are many communities for which there is not one qualified mental health practitioner, psychologist or counsellor. Bi-lingual and bi-cultural psychologists are highly sought after and often have long waiting lists.

There are also many Muslim practitioners who do not work specifically within Muslim community or private practice settings, but rather they work in mainstream organisations providing services to the broad community.

A Needs and Services Audit conducted by the Islamic Council of Victoria (ICV) in 2007 identified a number of problems with existing mental health service providers that led to their under-utilisation by the Muslim community. Among these was the issue of language. Muslims are among the most linguistically diverse religious communities in Australia in terms of language. For those who do not speak English well or at all the services of mental health providers would be very difficult to access. Whilst interpreters are used in public mental health facilities, the use of interpreters in the private sector where many people access early intervention mental health services is scarce and clients themselves are often expected to pay for interpreters, that preclude people from using the service. Telephone interpreting services are difficult to use for hour-long counselling sessions. Usually only 50% of what can be accomplished in an hour long counselling session using a bi-lingual counsellor can be achieved using an interpreter. There is also some anxiety in using interpreters by CALD individuals, there is a fear about the standards of confidentiality of interpreters, particularly in tight knit communities and particularly because mental health issues are being discussed. Some community members feel there is a loss of face (embarrassed) by speaking about personal problems in front of other people.

Community workers have noted that the problem Muslims face in accessing existing mental health services is the actual approach to mental health itself. Examples of this were found in a study of paramedics and their approach to Muslim patients. In one instance paramedics demonstrated lack of cultural understanding when a Muslim woman who suffered a miscarriage was diagnosed as suffering from acute depression. Paramedics could not understand why she was refusing a referral to a psychiatrist. The patient said the problems they were undergoing were their “test” which they needed to work through themselves.

This type of approach to personal life problems is found not only among Muslims but also more generally among people of many religions who come from Southeast Asia, for example, and beyond. While the paramedics’ response does demonstrate a lack of cultural awareness, it can also be interpreted as symptomatic of a disconnection that Muslims (and those from other non-Western cultures) may experience when

interacting with mental health service providers generally. Furthermore it can be said that differing explanatory models of illness are employed by culturally different members of the community. This means that they may have different explanations for symptoms and ideas and beliefs about modes of recovery. Some Muslims fear that their culturally and religiously influenced interpretations for symptoms will not only be misunderstood by non-Muslim clinicians but actually contribute to part of the diagnosis. Therefore non-Muslim clinicians may never secure full engagement in the therapy or treatment process by clients who fear they will be misunderstood.

There may be a tendency among some providers to adopt a medical model to mental illness that does not treat the individual holistically – meaning it does not treat the religio-cultural aspects of a person's identity with the attention and respect. Using a purely biomedical model is inadequate for appropriate assessment & treatment in a multicultural society (Kleinman et al., 1978). It is also the case that Muslims from all over the world for over 1400 years have relied on Islamic traditions to inform remedies to treat people with mental health issues, those that integrates the spiritual or religious aspects of a person. Developing models of care based on elevating spiritual and emotional health are largely unfamiliar to modern practitioners, whether Muslim or non-Muslim, but they may be helpful to acknowledge and integrate in certain circumstances moving forward.

Some Muslim mental health professionals have noted also that approaches other than the traditional Freudian psychoanalysis may be more appropriate and have a higher success rate among Muslim patients. For example, many Muslim Psychologists interventions are drawn from Cognitive Behavioural Therapy (CBT), Solutions focused therapy and Strength-based therapies as preferred and effective treatment approaches with Muslim clients.

Culturally intelligence or CQ is the measurable capability to function effectively across various cultural contexts (Soon Ang & Linn Van Dyne, 2008). As a framework it can help practitioners and service providers to work effectively with clients and consumers from diverse cultural backgrounds. The intercultural framework assists

clinicians to see themselves as part of a dynamic to develop an effective therapeutic relationship.

Ascertaining cultural knowledge about any group is useful but the CQ model also purports motivation, strategy and action to account for systemic change.

Learning about Islam and CALD Muslim communities living in Australia, beyond highly embedded stereotypes among mental health professionals is a desirable objective but so is promoting unconscious bias training and cultural self-awareness training.

There is evidence pointing to the fact that the problems encountered by religious Muslims in dealing with mental health professionals stems not only from a lack of awareness about the diverse cultural groups that just happen to also be Muslim, but also flow from the approach taken by the professionals themselves. At the risk of making a very broad generalization, it is not unreasonable to imagine that mental health service delivery evolved and adapted to meet the needs of Australia's very secular society and as a result will have some problems meeting the needs of religious Muslims, whether their cultural backgrounds are Indigenous, European, Middle Eastern or South East Asian.

We can therefore identify a need for an approach to mental health that is adapted to the needs of this segment of the Muslim community (and perhaps of other communities). The easiest and quickest way to set this in motion is to develop the skills and human resources among the Muslim community itself. To do this involves encouraging young Muslims to see this area as a career option and to provide the few that are already starting out in the field with the appropriate support, mentoring, and networking to maximize their chances of success in the profession.

Community workers have noted that low numbers of individuals from their own communities studying disciplines such as psychology or social work or holding professional roles such as psychologist, social worker, mental health worker or

mental health nurse. The lack of visible representative of professionals from diverse Muslim communities can perpetuate the idea that mental illness doesn't affect those culturally diverse Muslim communities. The opposite has also found to be true, in that the more members of the Muslim community that have entered mental health roles, they act as cultural bridges educating their communities of origin in the topics of mental health and referral pathways to private providers such as doctors for psychopharmacological treatment (e.g. anti-depressants), psychologists and public mental health services, such as Orygen Youth Mental Health and Crisis Assessment Team services.

It should also be noted that Victorian Muslims seek out mental health and psychological care from practitioners that are not Muslim and public mental health systems of care. The perceived advantages are confidentiality, anonymity and a non-judgmental approach related to behaviours that the individual seeking the support considers un-Islamic, for example, substance abuse or relationships outside of marriage.

In addition the stigma is sometimes perpetuated from "religious" leaders, influencers and "religious" family members which purport that having a mental health issue or seeking out professional psychological help suggests one is low in religiosity or spiritual connection to God. There is no religious evidence for this thinking, but it is a prevalent view amongst some culturally diverse Muslim communities unfamiliar with mental health issues and lack of familiarity with the type of supports given by mental health practitioners.

Lack of community understanding towards Mental illness and the Service system

There is a consensus among Muslim Psychologists, social workers, medical practitioners, community leaders, workers and members that there are low levels of mental health literacy across diverse Muslim communities. This includes knowledge of what constitutes mental illness, the role of services and service providers and knowledge of the mental health sector service landscape. This could be said to mirror the lack of knowledge about mental illness in Australian society as a whole

but compounded by other social factors such as being newly arrived and diverse levels of English proficiency. Culture can influence signs and symptoms of mental illness that may be expressed in somatic, spiritual or behavioural ways that may not be congruent with symptoms of mental health as presented in public mental health campaigns. Cultural differences can account for why some Muslims may believe the public mental health system or a Western trained Psychologist may not be able to help them.

Community workers have noted that a factor in the lack of community awareness of mental illness is also related to the lack of available information in languages other than English, and limited access to information from large mental health campaigns which are on TV, on billboards or on social media platforms in English only. A review of the translated resources does indicate a vast amount of information on mental illness has been translated into languages other than English, however accessing information via websites such as Beyond Blue or Mental Health in Multicultural Australia is very difficult. One needs to navigate a website in English to access translated information about mental health issues in other languages. This makes it impossible for consumers with low English proficiency to access information unassisted. The English-speaking practitioner is met with an arduous process of log-ins and error pages in an attempt to download information about mental health conditions in languages other than English.

One needs to navigate a website in English to access translated information about mental health issues in other languages. This makes it impossible for consumers with low English proficiency to access information unassisted.

Existing Services for the Muslim Community and Mental Health Professionals

Existing services for the Muslim community appear to be inadequate in many respects. Although there are some Muslim mental health professionals in Victoria, their numbers are very small compared to the reported level of demand.

Case Example:

"To improve mental health outcomes within the Muslim community, it is important to establish support groups. These support groups can include members of the community who have overcome mental health challenges. As an individual who has experienced depression and anxiety, I would have benefitted from the advice of a peer support worker or volunteer who shared the same belief system".

In Victoria, the networks that enable Muslim professionals and other service providers to interact, compare notes on experiences of service provision of Muslim clients are in the infancy stages of development.

Whilst there are some ethno-specific social services that support some members of culturally diverse communities, there is no overarching social service for all Victorian Muslims. Prior to the Centre for Muslim Wellbeing being funded by the Victorian State government in 2019, there has been very little investment into addressing mental health issues within Muslim communities. Ethno-specific services and other Muslim community not-for-profits have been funded to assist particular populations within the community, e.g. newly arrived groups, refugees, Arabic, Turkish and Afghani women's groups and many youth leadership programs have been funded.

Most other recipients of grants are to fund one-off projects, events and brief programs aimed at improving participation, leadership and employability. More recently the community has attracted the attention of researchers and short-term projects under the umbrella of the Countering Violent Extremism (CVE) industry and several Muslim community organisations have secured funding to prevent and address family violence.

Recommendations

- In a Victorian context our recommendations focus on developing the capacity in the Muslim community to generate and support an approach to mental health that is appropriate and effective for both religious Muslims and Muslims from all cultural and linguistically diverse backgrounds, including at risk groups such as Aboriginal Muslims and Muslims who are members of the LGBTIQ communities. The research we have done in this area indicates that there is growing demand for mental health services that are able to better integrate Western mental health approaches with holistic models of wellbeing (social, psychological, ecological and spiritual health).
- This primarily means encouraging young Muslims, as well as mature Muslims, to become involved in mental health as a career and a profession, at all levels – from psychologists, to social workers and counsellors. Initiatives in this regard include raising awareness among young Muslims, through careers seminars in schools and providing Internship and trainee opportunities to university students on field placement located both within Muslim community contexts but also in publically funded mental health facilities.
- Imams/ religious leaders, community leaders and community workers would benefit from Mental health first aid training and on going participation in seminars related to mental health and wellbeing. This would develop their existing pastoral care skill set.
- There needs to be a drive both to conduct more research about the prevalence of Mental illness as well as levels of resilience among Muslim young people and adults. There needs to be more research conducted on the impact of Islamophobia, racism and discrimination on Muslim mental health.
- The development of a comprehensive mental health promotion strategy is needed not only to educate Muslim community members of existing mental health issues, and treatment options, but also to raise the profile of the prevalence of mental illness in the community to combat the stigma associated with mental illness. Raising the profile on mental illness prevalence within the community and available the treatment options will

also inform students considering study or employment options with information that may reflect possible future work opportunities.

- We recommend the establishment of strong support networks for Muslim mental health professionals as a high priority as a means of peer support and sector development.
- We recommend an adequately funded social service led by Muslim and culturally intelligent professionals is essential to reduce the risk of Victorian Muslims showing up at the crisis points in the service system and importantly to improve markers of wellbeing.
- The development of a centralised hub of services (face-to-face and an online platform), a sustainably funded social service agency offered by the Muslim community to its members, that provide culturally and religiously appropriate services, that has very strong networks and affiliations with Muslim leaders, organisations and members across Victoria. An agency that is also well connected to the broader social service and mental health system to act as a conduit to Muslims seeking early intervention, treatment and crisis support.
- The delivery of mental health awareness education and targeted wellbeing programs delivered by Muslim practitioners that are culturally intelligent and that integrate psycho-spiritual strategies that are familiar to Muslim community members which engenders trust and credibility with evidence based information on mental health.
- There is significant scope for improving the curriculum of undergraduate and postgraduate university courses to better qualify psychologists and counsellors to work effectively with Aboriginal and culturally and linguistically diverse communities and clients. At worst students may only receive 1-2 lectures in multicultural counselling or cross-cultural implications in 6 years of study. At best the Australian Catholic University was the only university to run a full 12-week unit dedicated to the study of multicultural counselling. Universities need to be engaged on the topic of qualifying their students to work effectively in mental health with clients from all cultural backgrounds,

not only white Anglo-Celtic backgrounds and through a largely Eurocentric academic lens.

- As a result of this gap it is safe to say that the absolute majority of qualified mental health practitioners have had little to no training at all on how to adapt their practice for clients from culturally and religiously diverse backgrounds and have little idea as to what cultural competence is, despite it being a practice standard by APHRA for registration for most health professionals. It is largely a tokenistic exercise and the existing health disparities that exist for Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities, including Muslim communities suggest this needs to be taken seriously and challenged.
- Mental health practitioners in our view would benefit from improving their cultural competency skill sets through on-going training and that organisations develop ATSI and or CALD quality assurance frameworks to improve their credibility in the eyes of the communities they should be seeking to engage.

About the Centre for Muslim Wellbeing (CMW)

In October 2018, the Centre for Muslim Wellbeing Inc., a non-for-profit organisation was awarded a seed grant by the Victorian State government to begin to address the pervasive social services gap through the provision of mental health awareness workshops and wellbeing focused programs delivered to diverse groups across the Victorian Muslim community.

The Centre for Muslim Wellbeing was founded and incorporated in 2018 to be a leading provider of social, health and wellbeing services for Victorian Muslims and a provider of cultural competence training in the health and mental health sector. Experienced Psychologists and community workers lead CMW.

The Centre for Muslim Wellbeing seeks to understand the extent of the health disparities that exist for Victorian Muslims through advancing the limited research base on Australian Muslim mental health and other markers of wellbeing.

We aim to craft innovative projects and practice that can be shared with other culturally and linguistically diverse communities facing similar challenges.

The CMW's Three Key Priority Areas for 2019-2020 are:

1. Service Delivery: Deliver mental health and wellbeing services and projects.

2. Wellbeing Education & Cultural Competency Training: Community wide mental health promotion, delivering professional development that supports those organisations both within the Muslim community and to the broad social service and health sectors to work effectively and therapeutically with both Multicultural and Muslim communities.

3. Community-led: Establish the first Muslim wellbeing hub centralizing service delivery to address priority areas underpinned by relevant research and evaluation, and the development of a 10-year mental health and wellbeing strategy for Victorian Muslims. This model will support the broad service sector and government

departments to effectively collaborate with the Muslim community.

We acknowledge that Muslims are not bound to seeking support from the Muslim community itself and as such we will be supporting the broader service sector through the provision of evidence based cultural competence training initially to mental health service providers and social service organisations to improve treatment and psycho-social outcomes for Muslim patients and clients.

Our three service principles are:

1. Resilient. Being able to bounce back after adversity.

2. Respected. Respectful of our complex cultural/religious identities, respectful of one's right to self determine ways of being, and ways to wellbeing. Respectful in the way we demonstrate care for others and the environment in which we share space.

3. Connected: Belonging is the single most important attribute that contributes to resilience and flourishing in a society.

Mental health needs of CALD community members

Cultural diversity also influences the interpretation of symptoms and the management of mental health; the way in which we communicate about our health problems; the way we present our symptoms; when and whom we choose to go to for care; how long we remain in that care and how we evaluate that care are all affected by cultural beliefs.

Where mental health education and service delivery is concerned a '*one size fits all*' approach in a multicultural society has been proven to be ineffective.

Did you know?

'Historically, people from CALD backgrounds have been, and continue to be under-represented in mental health service access and utilisation figures, for both outpatient and most inpatient services.

People from CALD backgrounds typically present late to mental health services and are therefore generally more unwell than the mainstream population.

GP Practitioners are also more likely to prescribe medication at the outset to people of CALD backgrounds than to patients from the mainstream.'

(MMHA)

50% of clients from minority groups do not return to counselling after their first session. (Sue & Sue, 2013)

We have no reason to believe that the above research would not apply to Australian Muslim communities.

Case examples

I (a Psychologist) remember saying to an Imam a few years ago, “Sheik, why are you referring people to me when they’re in crisis? If you refer them to me earlier I might be able to help them”. He said, “because they’re coming to me in crisis”.

I (a Psychologist) remember speaking to a 15-year-old Muslim girl who said “I’m on anti-depressants, just like my mum and my aunties.” Neither she, nor her relatives were accessing counselling support through which psychosocial strategies may well have been the most appropriate treatment approach.

Successful mental health awareness and service provision in culturally diverse communities is grounded on the principle that organisations are perceived as **credible** and **trustworthy** by the consumers that seek out that information and care.

Securing trust with specific populations such as the Muslim communities enables other crucial advocacy work to occur such as breaking down stigma not only about mental illness, but also family violence.

At-Risk groups within the Muslim community

Men

Muslim male uptake of psychological services and other mental health services is extremely low when compared to Muslim women. Men are less likely to self refer and less likely to act on a referral by a GP.

Young Muslim men are more likely to self refer and act on a referral by a GP, or guidance from a family member or friend, than older men due to higher levels of mental health literacy in young men. Many young Australian Muslim men have been exposed to counsellors in schools and public mental health campaigns such as Beyond Blue and Headspace and their higher proficiency with internet technologies are likely to expose them to information about mental health issues. We anticipate older men (50+) would not have had exposure to school counsellors or public mental health campaigns that are often targeted towards younger people. We also anticipate a higher reliance on traditional understandings of abnormal behaviour and cultural or religiously influenced interpretations of mental illness in older men.

We are seeing some Muslim men, young and mature at points of crisis in the service system. For example we are seeing some Muslim men show up in statistics in the justice system. We are also seeing some young men and older men involved in drug related crime and family violence.

Mental illness, childhood trauma and substance abuse have been key factors underlying the majority of high profile cases of violent extremism in Australia, but those factors are downplayed against the backdrop of ISIS and extremist ideologies.

Most Australian men face gendered stigma in accessing all types of psychological and psycho-social supports and Australian Muslim men are no different. In addition to gendered stigma, Muslim men face culturally influenced stigma in accessing support services which is leading to Muslim men delaying treatment or not accessing any form of treatment. Suicide in Muslim men is reported anecdotally to be increasing,

however there is no organisation tracking numbers of suicide in the Muslim community.

Muslim men and relatives of Muslim men often seek out male psychologists (Approximately 5) who work in private practice but they are very low in numbers in Victoria and the majority of the community are unaware of who they are and where they are located. The majority of practitioners are women. Some Muslim men choose not to access health services offered by women on religious grounds, but many Muslim men are increasingly accessing health care offered by both Muslim and non-Muslim women.

Recommendations

- We recommend investment of funds into the Muslim community where qualified Muslim practitioners can facilitate informal or formal social or sports groups where mental health issues can be incorporated into the program.
- We recommend a Men's SHED for Muslim men and young men.
- We recommend wellbeing programs led by qualified facilitators for young men incorporated into existing well- established youth groups.
- We recommend investment into effective and culturally appropriate Men's behaviour change programs and that they be linked up to one on one support with a qualified counsellor.
- We recommend emotional intelligence training for Muslim men to help them succeed in personal relationships
- We recommend continued and on going professional development of Imams to be able to effectively deliver religious sermons on Mental health, respectful relationships.
- We recommend CALD communities having high profile Mental health ambassadors in a similar way White Ribbon has Ambassadors to help destigmatise mental illness accessing treatment and support.

- We recommend social media campaigns or media ads that utilise ambassadors or high profile members of religious communities to destigmatise mental illness and accessing treatment and support.
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Women

Access to culturally, linguistically and faith appropriate counsellors and psychologists, often located in private practice are increasingly providing early intervention and crisis support for Muslim women in addition to accessing other social networks for emotional support. Many women's groups, both formal and informal exist in the community and provide psycho-social support for women in

need. Many more women are accessing individual counselling support than Muslim men and they are more likely to be the ones initiating referrals their young, adolescent and adult children to access mental health care.

There has been a significantly higher investment into women's wellbeing, social participation and family services than those targeting men's wellbeing. This is due in part to mainstream organisations partnering with Muslim women's groups and co-coordinating programs. It is also due to an increasing number of Muslim women effectively initiating groups run by volunteers to cater for perceived social and emotional needs. Some groups go a step further creating networks and incorporated organisations to further support women and families on a range of matters.

In the absence of a well-funded social service, for decades Muslim women's groups have organically and responsively provided psychosocial and physical support to women in need. However there is a limit to which these altruistic volunteer groups can support other members of the community who have moderate to severe mental health issues.

"It's all about personal connections, especially for women. Our immediate connections have the greatest influence on whether we seek treatment early or not" – Community member

"Women in particular are more willing to share their experiences with those who they have confidence in" - Community member

"The pervasive negative portrayal of Muslims in the media can prevent Muslim women from accessing support services from family violence to mental health support"

Migrant Muslim women and women with low English proficiency can often be at greater risk for Mental health issues as they have greater dependence on family members to navigate the service system. They may be less mobile due to not

having a car licence or who they seek support from could be dependent on male members of their family or adult children. Many migrant Muslim women put up with severe symptoms of anxiety and depression without any assistance for many years. This group are much more likely to treat their symptoms by confining themselves to their homes because they feel safer and the symptoms are less, or being treated by prescription medication.

Parent mental health

It is now common to see adult children who have been raised in Australia who have exposure to the mental health service system recognise that their parents are struggling with a mental health issue and encouraging them to attend counselling or access psychological or psychiatric support. This helpful dynamic cannot be underestimated. Many adult children seek out information in how to address parent mental health and encourage them to get the help they need. Notably supporting fathers to get psychological help is reported to be much more difficult.

Recommendations

- We recommend more mental health awareness programs targeted at culturally and linguistically diverse women's groups. Improving the mental health literacy of women will have a huge impact on society as a whole.

- We recommend investment in health promotion campaigns that capitalise on the use of social media advertising, particularly featuring different bi-lingual, bi-cultural and faith diverse communities.

Young people

There is little to no Australian data, either quantitative or qualitative, to inform an understanding of prevalence of mental health or levels of resilience among Australian-Muslim young people aged 9-18.

The more resilient a young person has the less likely they are to experience alcohol

and drug problems, make violent threats and carry a weapon, engage in risky behaviours, experience poor mental health and depression, and suffer anxiety and low self esteem.

In addition to the vulnerabilities that all Australian young people face, Muslim youth for over 15 years have been subject to racist narratives that pervade both media and political commentary. Muslim young people have to navigate the development of their identities around labels such as terrorist, radicalized, oppressed, unAustralian (identity denial) and negotiate the social contexts where these labels are used (E.g. school yards to Parliament).

Many Muslim young people reside in geographical areas of concern for higher rates of youth unemployment, higher rates of certain types of crimes, residing in and are coming from low socioeconomic backgrounds. These can be barriers to community connectedness and participation.

Achieving a sense of belonging in families and communities is a goal that amplifies social connections and establishes a basis for positive emotional experiences. In minority collectivist communities, it is important to understand an individual's connection with groups, such as ethnic or religious groups towards their psychological wellbeing. Whether an individual perceives their group is doing well, coping, succeeding or not doing well, not coping or prevented from succeeding has implications for their psychological wellbeing (Tummala-Narra, 2016).

To date we do not know the impact of Islamophobia, racism and racist bullying on specifically Australian Muslim young people's mental health due to the lack of research. However the research more broadly indicates young people's mental health can be negatively impact self-esteem, a sense of belonging and putting young people at higher risk of psychological disorders such as anxiety and depression. Research on At-risk groups, such as Muslim young people is needed.

Establishing an evidence-base of the levels of resilience of Muslim students and young people in Victoria provides a powerful basis on which to plan intentional interventions for students across Victoria more broadly. Given the considerable

amount of time and resources employed to increase wellbeing, assessing the strengths and vulnerabilities of young people enables us to use that knowledge to design and evaluate effective interventions.

More than ever, it is important to understand resilience in Australian Muslim young people in the current socio-political environment. Resilience can be a crucial protective factor against documented psycho-social and mental health consequences of racial hatred, wide spread public bigotry and from discrimination and abuse that they may face directly or vicariously.

The following are some examples of experiences of young Muslims on what it's like to live in Australia, excerpted from the Sydney Morning Herald (SMH), May 2016.

"Muslim students abused on a train. Group of Muslim students say they feared for their lives during a racially targeted attack on a Melbourne train"

"I don't tell my footy team (that I'm Muslim)"

"When I decided to cover (wear hijab), I lost two friends, because they couldn't hang around a person who covers or doesn't drink. There should be no difference between a girl who decides to cover herself from head to toe or someone that wants to reveal everything. We should both be treated with respect"

"Once I was crossing the road at Federation Square and this man walked right up to me and spat on my shoe. I was really shaken because he was really big"

"I shouldn't have to wake up every morning thinking about how I am going to respond to verbal or physical abuse"

"It's hard to feel hated by the majority of people just because we practice our faith in a peaceful manner. We should not be painted with the same brush as extremists"

(Examples collated from Sydney Morning Herald (SMH), May 2016)

The 'Islamophobia in Australia Report' released in July 2017 revealed an alarming fact that Australian Muslims are being abused in a multitude of locations, indicating

perpetrators have enough courage or feel legitimised to abuse:

"Living in multicultural suburbs, being in discrete indoor locations or surrounded by people in places like shopping centres, trains and trains stations, as well as schools and school surroundings, did not deter perpetrators from abusing Muslims. Indeed, the severest of these incidents were observed in indoor places. These locational details alarmingly indicate that Islamophobia is becoming "acceptable" for everyday Australians while becoming "expectable" for everyday Australian Muslims."

Women and children in particular bear the brunt of Islamophobia. The report revealed that children's direct and indirect exposure to Islamophobia reaches 47.7%.

When Muslims, including Muslim young people read headlines suggesting that over 40% of Australians have very negative views towards Islam and Muslims living in Australia, we cannot ignore the negative impact this has on one's sense of belonging, self esteem and mental health. When a person who identifies as Muslim commits a crime, and their faith identity is publically linked to that crime, many Australian Muslims feel collective threat.

Cohen & Garcia (2005) demonstrated the existence of collective threat, the fear that an in-group member's behaviour can reinforce a negative stereotype about one's group. Collective threat results in lowered self esteem, lowered academic performance, self-stereotyping and physical distancing from the in-group whose behaviour reinforced the negative stereotype. The latter leads to further alienation from a largely protective community and sense of belonging. When a sense of belonging to a society or community is threatened, the most powerful antidote people have to mental health issues, suicide, violence and to drug abuse is compromised.

Many members of the Muslim community, including Muslim young people report that they feel compelled to excel in community, educational and vocational spaces to counteract the negative public image of Islam. Whilst many feel a deep sense of meaning in coping this way, it is also reported that they feel pressured in doing so.

Many report that this pressure becomes heightened post terror incident and in light of the negative and opportunistic political and media commentary.

"Constant negative representation in the media from both the Federal government and other associated politicians remains a constant obstacle to wellbeing in the community" – Mental Health practitioner

Investing in building resilience through programs, projects and policy frameworks that tap into intrapersonal and community strengths is an effective long-term preventative strategy. Such programs have the potential to reduce the psych-social trauma that is incurred by direct and indirect racial hatred.

Building resilience involves creating the three things every parent wants for their children and every teacher wants for their students, **Connected**, **Protected** and **Respected** lives. Making these pathways possible for young people helps them to create positive relationships while protecting them against mental health problems, substance abuse and involvement in destructive extremist groups or crime more broadly.

Projects supporting the mental health of Muslim young people should ideally be solution focused and strength based because they empower individuals and communities to see that all problems have exceptions that expose strengths and capacities and that those strengths can be fostered to create more of the solution. When projects focus on uncovering capacity, hidden talents and strengths, community engagement, rapport and trust are more easily secured.

However when projects and programs are problem and deficit focused, in the same way that the newly formed industry of Countering Violent Extremism (CVE) have purported to address deradicalisation, they are broadly viewed with suspicion, community engagement, rapport and trust are not easily secured.

Building relationships with communities require commitment by governments to implement projects over longer timeframes, particularly when wanting to support

solutions around social- psychological change, such as fostering resilience and improving mental health and wellbeing.

Recommendations

- Investment in programs that recognise young people for the outstanding contribution they make to the community, such as the Young Australian Muslim of the Year (YAMY) project that was run between 2005-2011.
- Research on the Resilience of Muslim young people, followed up with needs based interventions.
- Cultural competency programs conducted with school teachers and school counsellors to better address mental health in CALD and Muslim students.
- Professional development to assist teachers to recognise, address and assist students experiencing racist bullying.
- We recommend that to enhance wellbeing of Muslim young people that projects and programs be strength based.

Aboriginal Muslims

The mental health disparities of Aboriginal and Torres Strait Islander communities are well documented. However no information exists on ATSI Muslim mental health. It is an area that needs further exploration with sensitive collaboration with ATSI Muslims and ATSI health services. Our resources did not permit us to make a significant contribution for the submission at this time.

Refugees & Asylum Seekers

Refugees and asylum seekers are at a high risk of mental health problems. This can be due to a variety of reasons including their general experience of being a refugee, the displacement from their country and the stress and anxiety of waiting for the decision to be determined on their migration status. Refugees may also be experiencing the psychological effects from any trauma they experienced prior to

resettlement (Murray et al. 2008). Other psychological symptoms of trauma may include feelings of fear, sadness, guilt and anger, which may result in depression, anxiety and substance misuse (Murray et al. 2008). If the refugee has spent time in mandatory detention, this can exacerbate the impacts of any traumatic experiences and is generally a negative socialisation experience (Murray et al. 2008).

In a recent study by Shawyer and colleagues (2017), the mental health status of refugee and asylum seekers attending a refugee health service in Melbourne was examined. A total of 63.4% of the sample identified as being a Muslim. Results showed that around half the surveyed refugees and asylum seekers screened positive for a mental health condition over the previous month, while nearly a quarter screened positive for PTSD.

The level of distress in the refugee and asylum seeker population was more than three times the matched Australian-born sample. This was greater than to be expected from socio-economic disadvantage alone and therefore, likely causally associated with the high levels of exposure to traumatic events, stressful migration experiences and the additional barriers to health care such as culture and language experienced by refugees and asylum-seekers, all of which present additional challenges in providing equitable mental health care (Minas et al., 2013).

Muslims who live in rural areas

To better understand mental health as it affects Muslims living in regional Victoria and access to better mental health care, one needs to understand the migration history of the communities living there and the social context of the particular region.

Issues faced by Muslim communities living in regional areas are similar to the issues faced Victorian Muslim communities living in metropolitan areas and issues of access to and quality of mental health services are similar to the issues faced by other Victorians residing in regional towns.

Case Example: City of Greater Bendigo

The Muslim community make up approximately 500 members of the greater Bendigo community (0.4%). The Muslim community is culturally diverse and represents mostly skilled migrants with young families with children of primary school age and also International students who attend local tertiary institutions.

- Main psycho-social drivers of mental health issues identified in skilled migrant group related to the psychological toll of racism, racist messages, overt attacks on Islam and the hate filled protests that ensued during the application process of the Bendigo mosque. Bendigo Muslims feel pressured to mitigate the negative portrayal of Muslims and Islam and felt it affected the way they were raising their children, specifically they felt the need to teach their children how to deal with racism.
- Main psycho-social drivers of mental health issues identified in International students studying in Bendigo included pressure to excel academically from families in their home country, feeling isolated and not having many social connections in towns and feeling home sick.

Mental health literacy

Mental health literacy of Muslims residing in Bendigo is described as mixed. Low mental health literacy among community members mean that community members don't recognise that they might be experiencing a mental health issue and lack familiarity of the purpose in seeing a qualified mental health practitioner. Mental health issues are largely misunderstood and stigma and taboos in having a mental illness were described as pervasive. Many in the community were described as interpreting abnormal behaviour through the lens of lowered religious belief and used religious and cultural explanatory models to understand and cope with symptoms of mental illness. A lack of knowledge as to social-psychological and biological origins of mental health issues amongst some community members keep them distant from accessing medical, psychological or psychiatric treatment.

It was felt Imams (religious leaders) play a key role in supporting community members in times of crisis, both emotional and physical but that they lacked awareness of the different mental health issues, the types of treatment available and referral pathways. It was considered a huge area of opportunity to train Imams and other influential people in the Bendigo Muslim community in mental health first aid to effectively support other community member's mental health.

Links with local services

Whilst the Muslim community have reportedly established good links with local community health organisations, access to mental health care and mental health awareness is described as limited. Families in Bendigo were described to be utilising health services in Bendigo, but not mental health services. Members of the Bendigo Muslim community described experiences of having their mental health concerns played down and not taken seriously by local GPs who are the gatekeepers to specialist allied health services. There were also fears in disclosing mental health concerns to GPs in regional areas because of their close social ties to the community and fear of breach of confidentiality and social awkwardness. There were also fears disclosing mental health concerns to GP's because community members were unsure as to whether there would be any repercussions on their employment, studies or visa application. Community members were not aware of privacy laws on medical, primary and allied health practitioners.

Long waiting lists and the lack of culturally competent mental heath service providers (counsellors and psychologists) are seen as a major barrier to accessing support. In addition, where there is a recognised need to access a support service, not being able to access the services from a culturally and linguistically similar mental health practitioners was described as a barrier to accessing a type of care that was perceived as culturally safe. Culturally and religiously similar practitioners are preferred because having a shared understanding about the role of culture and religion in their lives. It was noted there are no Muslim or culturally similar counsellors or psychologists in Bendigo and this was seen to be a major barrier to accessing care.

Stigma and taboos that surround mental health issues, were reported to be a key factor in addition to not understanding the role of counsellors/ psychologists/ social workers and limited understanding of the interplay between culture, religious beliefs and practices, illness and modes of recovery.

This is also compounded by a lack of interpreters available in regional areas and that because interpreters are often local members of the community, disclosing mental health issues which is accompanied with stigma. Using interpreters known to individuals and families provoked concern about issues of confidentiality. Telephone interpreting services were not always accessed when needed and there are many limitations to using interpreters in hour-long counselling sessions.

It was also noted that whilst community health centres and multicultural services reach out to minority groups in Bendigo, that individual practitioners such as counsellors and local psychologists in private practice do not. Reaching out to CALD communities was seen as an effective tool to build trust and increase engagement in mental health services.

"There is a perception among some Muslims that if we see an organisation flying the Australian flag alone that they are a racist service, but when we see an organisation flying both an Australian flag and an Aboriginal flag that the organisation respects culture and therefore the service is perceived to 'safe' for members of CALD backgrounds"

What's working?

Community led leadership, participation and mentoring programs for Muslim young people were believed to be effective in increasing a sense of belonging, identity development and supporting better mental health. Camps and camping were used by community leaders to give boys a space to develop interpersonal skills and to talk around the camp fire and whilst bush walking.

Parents being part of local primary school council's acted as impromptu cultural liaison officers, which helped schools and families navigate small challenges as they arose.

Muslim families who have lived in Bendigo for a long time (Old families) were seen as having a big influence on what happens in the community, and it was seen as important for service providers to build relationships with the families with clout when introducing new services.

Local community service organisations have partnered with Muslim community members to run an Introduction to Islam workshop as a way of supporting practitioners to understand Muslim community members, but it was not cultural competency training and it did not provide any direction for mental health practitioners to work therapeutically with Muslim or CALD clients.

Strong community connections fostered through community led events (both Muslim community and involvement with greater Bendigo events) were seen as protective factors to prevent mental illness and suicide. Suicide in the Bendigo Muslim community was unheard of.

Recommendations

- Workshops to support better mental health in individuals and families to be delivered by qualified Muslim mental health trainers
- Imams need to be considered part of a referral pathway for Muslims accessing a range of services.
- Local services need to reach out to religious leaders and other influencers in the community and educate them about the services on offer and exactly how those services work to improve mental health.
- Local services need cultural competency training by experienced Muslim cultural competency trainers to work more effectively with Muslim communities in Bendigo.

- Due to many families having young children, resilience programs aimed at tweens (ages 10-12) were seen as important for early intervention.
- Parenting programs were also seen as important to support parents to help their children navigate psycho-social stressors common to adolescents and identify symptoms of mental health early.
- It was felt Muslim GP's in the local area could play a bigger role in educating the community about mental health issues.
- Skilling locals in Mental health first aid.
- Making mental health care easy to access by having access to low cost or Psychologists that bulk bill in their local area.
- Mental health practitioners themselves should reach out to communities to become trusted sources of information and to be seen as credible by the organisations who use them.
- Funding boy's camps or high adventure programs and embedding information about mental health issues across like programs.

LGBTIQ+ Muslims

A comprehensive report was compiled in June 2018 by Dr Maria Pallotta-Chiarolli School of Health and Social Development, Deakin University; AGMC (Australian LGBTIQ Multicultural Council) in collaboration with Muslim Collective titled 'Safe Spaces, Inclusive Services': Support service access and engagement by LGBTIQ+ Muslims.

A key finding was that LGBTIQ+ Muslims often experience discrimination against their sexuality by their faith community, and against their faith, by the LGBTIQ+ and broader communities. This 'border positionality' of LGTBIQ+ Muslims makes it more difficult to access a wide range of services including general medical services, specialist medical services (including mental health services), community support services (including pastoral care) and crisis services (homelessness). Our findings

indicate that approaches to service engagement vary depending on personal experiences and knowledge of services available.

Recommendations

- We recommend support for the social and emotional wellbeing of at risk groups within the Muslim community.

- We recommend support for investment in the early identification and intervention of mental health problems of at risk and intersectional groups within the Muslim community.

Response to the key submission questions

Methodology: Community consultations

CMW facilitated consultations with the Muslim community to collect insights, views and suggestions about important themes relating to Victoria's mental health system. A total of 35 individuals participated in two community consultations that were ran in the North and the South-East of Melbourne and included lay community members and consumers of mental health services, teachers, community engagement officers, community leaders, school counsellors, social workers, retirees, general practitioners, nurses and psychologists.

The consultations provided the Muslim community with an opportunity to articulate their concerns about attitudes and access to mental health services and identify the appropriate responses and service solutions. Information gathered from these community consultations have been collated below to help address the mental health disparities that exist within CALD communities.

In addition, one-on-one interviews were conducted with Muslims in regional areas, Imams and key community leaders who have valuable insights into the mental health needs of Victorian Muslim community. Muslim community members were also invited to complete a survey based on the Royal Commission's guiding questions and 8 community members completed the survey. This submission was also authored by two of the most experienced Muslim Psychologists in Victoria in the area of Australian Muslim mental health, drawing on jointly 35 years of experience and supported by the Centre for Muslim Wellbeing.

Reducing Stigma and Discrimination

Mental illness and stigma in the Muslim Community

Mental illness comes with a strong presence of stigma and misinterpretation among Muslims and is often viewed through the lens of weak character, attention seeking, demonic possession or deficiencies in an individual's faith. Studies have shown that

Muslims suffering from mental illness are likely to face discrimination from community members when it comes to issues like socialization, business relationships and marriage proposals (Ciftci, Jones & Corrigan, 2013).

The experience of mental illness stigma was noted to be more complicated for those from racial and ethnic minority groups. For example, a Somali mother who sought psychological support to deal with her son having a drug dependence was labelled as being "crazy" by her community because she could not deal with this on her own. In another example, an Albanian woman who went to see her Muslim general practitioner to get a mental health treatment plan was told that Muslims don't have mental health problems. It was noted that stigma causes shame and that the shame received by family, friends, partners and even doctors by people experiencing mental health issues was invalidating and felt worse than the mental health problem itself.

It was noted that stigma causes shame and that the shame received by family, friends, partners and even doctors by people experiencing mental health issues was invalidating and felt worse than the mental health problem itself.

The underlying cause of this stigma, in many cases, can be attributed to simple ignorance and lack of understanding of mental illness. As a result of this stigmatization, individuals suffering from mental illness are unable to approach their family or community members for support, reducing the likelihood that they will access services or contributing to them ceasing treatment prematurely. A study conducted in Australia with 35 individuals from Arab communities indicates that stigma is the most significant barrier to accessing mental-health services due to the shame of disclosing personal and family issues to outsiders (Youssef & Deane, 2006). The consultation revealed many examples of individuals seeking psychological support under a cloud of secrecy and being fearful of their spouse, parents or community finding out.

Mental illness and discrimination in the Muslim community

In culturally and linguistically diverse communities, barriers such as language, lack of knowledge of available services and cultural prejudices that lead to isolation and discrimination prohibit the utilization of appropriate support and services. Typically, individuals from CALD families report that they don't know where to seek help, think they could manage on their own, or are worried about the reaction of the local community if it becomes apparent that a family member is seeking psychological assistance.

Muslims are also apprehensive about accessing mental health support from mainstream service providers out of fear of being misunderstood. The increased Islamophobia and political rhetoric has added an additional burden to Muslims, who in addition to living, working, socialising and contributing also need to process and deal with negative Muslim stereotypes and outright discrimination. The consultation revealed that many Muslims seek the support of a psychologist who is culturally or religiously aligned with themselves because they perceive them to be more trustworthy and feel they will be better understood because they do not have to spend time explaining their cultural and faith sensitivities.

Improving understanding of mental illness

The community consultation revealed mental health awareness and education was by far the most prominent issue raised at community consultations, by community leaders and religious figures. The following suggestions were made to address this need.

Mental Health Awareness Workshops

By talking about mental health, we are able to:

- Facilitate an openness about mental health and adoption of more positive and hopeful attitudes towards mental health
- Build awareness and understanding of mental health
- Normalize mental health concerns
- Challenge and dispel the myths around mental health issues within and beyond the Muslim community

- Stand up to the stigma
- Minimize self-reliance
- Promote faith-based perspectives of mental health and wellbeing
- Promote help-seeking behaviours, quicker recovery and better quality of life

This initiative in particular is critical in helping us to improve the mental health literacy of the Muslim community, which includes:

- The ability to recognize key mental health issues such as depression and anxiety
- Knowing how to seek mental health information
- Understanding risk factors and causes of mental illness
- Knowing where to go for professional help

"We need presentations and workshops in every single Muslim community in Victoria, including in mosques and centres so Muslims can understand that even the most religious people can have mental health problems. As the official Imam of the oldest mosque in Melbourne and one of the most qualified in Islamic Law and Human Rights, I always wanted to have some sort of training in counselling and understanding mental illness"- Imam (religious leader)

CMW has received seed funding to deliver mental health awareness workshops to the Muslim community over the next 12 months. Our strategy is to be inclusive and reach a diverse range of Muslim communities including at-risk groups. We will be targeting different ethnicities, Muslim youth, the Shia community, LGBTIQ+ communities, ATSI Muslims and Muslims living in rural Victoria to ensure we have a good spread of ages, ethnicities and minority groups.

We understand that this change in mindset and infrastructure cannot be achieved immediately and will require long-term planning and implementation.

Increasing visibility of mental health

The community consultations identified numerous strategies to help make mental health issues more visible, therefore destigmatizing the taboo surrounding mental illness and allowing more people in the future to come forward to access prompt treatment. These included:

- Having a national Muslim mental health day where Imams speak about mental wellbeing at the mosque
- Identifying Muslim mental health ambassadors who are prepared to speak about their personal experiences of mental health issues and convey relatable stories
- Promoting mental health services via generic community advertising streams such as on prayer calendars, notice boards at mosques and local community centres

Social media campaign

In the community consultations, there was a significant emphasis on promoting mental health awareness amongst Muslim youth. Taking into consideration the technology preferences of this age group, social media was highlighted as an important platform for a mass awareness campaign targeting youth.

Working with Imams

The consultations revealed that Muslims turn to their local Imam as a trusted advisor in times of challenge and adversity. International literature indicates that Imams play central roles in shaping family and community attitudes and responses to illness (Padela et al., 2012). For example, Abu-Ras and colleagues (2008) interviewed 22 imams and 102 worshippers from 22 mosques in New York after the September 11 attacks and found that imams had a critical role in promoting health mental health. In a separate study of 62 imams from across the U.S.A, Ali, Milstein and Marzuk (2005) found that 95% reported spending significant time each week providing counselling to their congregants.

The community consultations indicated that Imams are likely to be sought by Muslims to provide mental health care, especially in marriage related issues, but they do not have the support, training or resources to manage the growing mental health counselling needs of their communities. It was noted that Imams would benefit from further training to strengthen and improve their:

- Attitudes towards causes and solutions to mental health related problems
- Ability to recognize serious mental illness
- Counselling skills
- Willingness to refer to mental health professionals

"Religious and community leaders must have a better relationship with all the services that deal with mental health so if anyone goes to them with mental problems they will be able to point them in the right direction" - Imam

Working collaboratively with Imams to help dispel misconceptions and myths surrounding mental illness was also identified as an important priority. Although faith and prayer helps in calming and soothing individuals, it does not treat the underlying pathology. Therefore, Imams play an important role in informing the Muslim community that mental illness, just like physical illness, requires medical treatment.

Recommendations

- We recommend support for the delivery of mental health awareness workshops designed to improve the mental health literacy of the Muslim community.
- We recommend support for strategies that help make mental health issues more visible within the Muslim community, therefore destigmatizing the taboo surrounding mental illness and allowing more people in the future to come forward to access prompt treatment.
- We recommend support for the development of media campaigns promoting mental health awareness amongst Muslim youth.

- We recommend support for programs that strengthen the mental health literacy of Imams.
- We recommend that this support is on going and that a long term investment is made to the sizable positive impact it will make.
- Further research is needed to better understand the role and the impact Imams make when community members seek out their assistance for personal and mental health problems.

Preventing Mental Illness

Early intervention is required to prevent the progression of mental health concerns and minimise collateral damage to social, educational, and vocational functioning. For example, self-limiting disorders and milder, yet potentially serious disorders in an early stage may respond to simple measures such as psychosocial support, self-help strategies and education. Effective support during the early stages of a problem can mean that mental health issues are resolved before they become worse or entrenched, improving the quality of life for an individual and their family. Furthermore, research indicates that early intervention and prevention is a crucial determinant in minimising the potential impact of such illnesses.

What's working?

The community consultations revealed that Muslims often align themselves with one or many communities based on their location or cultural background. Being part of a community provides Muslims with a sense of belonging and social connectedness, which the research shows protects and promotes mental health and emotional wellbeing (Kawachi and Berkman, 2001; Perkins et al., 2015). A sense of belonging can also prevent and reduce feelings of isolation, depression and psychosocial distress (Sargent et al. 2002). It was noted that Muslims draw on tenants of their faith which promote a balanced life, prayer and a focus on family. These factors were identified as being helpful in dealing with challenges and adversity.

Sports programs such as the Bachar Houli Academy were also identified as working well to engage young people and facilitate a space where a range of issues, including mental health, could be talked about. Islamic schools were also noted to be placing a greater emphasis on the mental health and wellbeing of students by ensuring there was a school counsellor or psychologist on staff to deal with and address problems as they arise.

Barriers to accessing health care

Timely and effective access to mental health care is deemed as being essential to reducing the burden of illness. Navigating the mental health care system is particularly challenging for people from CALD backgrounds where language barriers predominate and for people with low mental health literacy.

Community leaders and consumers of mental health services expressed that they did not know where to go to find culturally, religiously and language appropriate psychology and psychiatry services. The need for a centralized directory of mental health professionals with cultural competency was identified to make it easier for gatekeepers such as GP's, Imams, community leaders, social welfare workers and teachers to access information and make referrals.

Finding a bi-lingual / bi-cultural or faith appropriate mental health practitioner

There is a huge gap in the system when it comes to CALD consumers or consumers seeking to find a faith similar psychologist, psychiatrist, social worker or counsellor. Whilst many online directories exist, the only specifier that assists consumers is sorting professional by language. If you just wanted to find a Muslim psychologist or a Jewish psychologist who spoke English, no mainstream directory exists. Important bi-lingual directories that could be modified to include more categories to suit the consumer to find the most appropriate practitioner are:

Australian Psychological Society
Victorian Transcultural mental health
The Royal Australian & New Zealand College of Psychiatrists

Recommendations

- We recommend support for the development of programs that provide Muslims with meaningful opportunities for community participation.
- We recommend support for the development of a centralized directory of mental health professionals with cultural competency who are able to meet the needs of CALD and faith diverse communities.
- We recommend that all mental health directories have listing of not only bi-lingual counsellors and psychologists but also bi-cultural and faith-based psychologists.

Suicide Prevention

In 2012 suicide accounted for 1.4% of all deaths worldwide, making it the 15th leading cause of death and resulting in significant economic, social and psychological burden for individuals, families and communities (WHO, 2014). The foundation of any effective response in the prevention of suicide requires an identification of risk factors and appropriate alleviation of these risk factors through the implementation of interventions. Research indicates that systemic, societal, community, relationship (social connectedness to immediate family and friends) and individual risk factors act cumulatively to increase an individual's vulnerability to suicidal behaviour (WHO, 2014).

Stigma associated with suicidal behaviours

The topic of suicide has been identified by community members as being a taboo subject that is not openly discussed in families or at the community level. Given it is not talked about, there is a predominating belief that Muslims are somehow immune to suicide. The need for discussing and disseminating information about suicide and self-harming behaviours within mosques and Islamic schools was identified. The lecture before Friday prayers was noted as being a good opportunity to start having some of these conversations and highlighting the importance of how seeking professional help can save lives. Community leaders noted that culturally

appropriate approaches are required to draw engagement from the Muslim community. For example, holding a seminar on "overcoming mental health challenges and suicidal ideation" would be deemed too overt and confronting as a first port of call. Rather, calling the seminar "flourishing families" and covering suicide as part of a broader discussion would have a much greater level of appeal and engagement.

"It would be beneficial for imams to deliver sermons about mental illness so that it becomes more mainstream and legitimate in the community"
– Consumer of mental health services

Stigma against seeking help for suicidal ideation and intent continues to exist in many Muslim communities and is a substantial barrier for accessing treatment. Several Imams noted receiving anonymous phone calls from community members where thoughts of suicide were disclosed and spoke about not knowing how to manage and direct such disclosures. Stigma was noted to also discourage the friends and families of vulnerable individuals from acknowledging and providing support. Implementing mental health literacy training designed to develop the knowledge, attitudes and skills required for identifying individuals at risk, determining the level of risk and then referring at-risk individuals to treatment was identified as a core need of the Muslim community. Such training was noted to be crucial for gatekeepers and young people in order to promote recognition and appropriate help-seeking behaviours.

"I just met a Muslim last Friday who had severe depression and as a result he hung himself in the hospital on Saturday. The nurses found him after 20 minutes and revived his heart but it was too late for his brain and he died on Sunday. Even hospitals should have someone from a Muslim faith that can provide support to patients who are Muslim" - Imam

The consultation also revealed that there is stigma associated with having a family member attempt or commit suicide. There is often a great deal of shame and guilt that comes with such bereavement and leads to families hiding the case of death in such cases of suicide and drug overdose. There is some anecdotal evidence of families being ostracised and Imams refusing to perform burial rituals or bury people who have committed suicide. Muslim families who have been bereaved by suicide therefore require additional support to overcome cultural and faith-based implications of suicide and associated grief.

Suicide in Islam and in the Victorian Muslim Community

Taking one's own life is largely considered unacceptable in the Islamic faith. This however has and continues to be a protective factor to Muslims experiencing some mental health issues such as Depression. Many Muslims will evidence many of the symptoms of depression, but will strongly articulate that because they believe that suicide is forbidden, that they would never take their own life, that suicide is not an option for them. However Muslims like people of other faiths have differing levels of Islamic knowledge and religiosity and may not draw from their faith in times of adversity. In addition the severity of the mental illness can also impact a person's cognitive and emotional functioning, which impairs their ability to reason and draw from religious or social coping mechanisms that they might be able to do when they are less impaired by the mental health issue.

In multiple community consultations with Muslim community members, not one single Muslim had ever heard the topic of suicide mentioned in a community setting, such as during a Friday Khutbah (sermon), religious lecture, conference, workshop. The resounding conclusion is that there is silence around the topic of suicide in the Muslim community in public spaces. Reasons for this include false beliefs that Muslims don't commit suicide because it is against their religion and a fear that speaking about suicide will influence someone to commit suicide. Another primary reason for the lack of discussion about suicide is a pervasive lack of mental health training of Muslims in positions of religious or community leadership and a lack of

integration between Muslim community organisations and psych-social service providers.

Community and relationship risk factors

The stresses of acculturation and dislocation represent a significant suicide risk that has an impact on a number of vulnerable groups, including indigenous peoples, asylum-seekers, refugees, persons in detention centres, internally displaced people and newly arrived migrants. Community leaders have identified International students as being at risk for suicidal ideation due to the lack of social support and sense of isolation. Relationship conflict, discord or loss is also noted to increase the risk of suicide, with community leaders also noting a rising trend of suicidal ideation amongst Muslim men in their 40's after family or marital breakdown.

In addition, young people who have experienced childhood and family adversity (physical violence, sexual or emotional abuse, neglect, maltreatment, family violence, parental separation or divorce) have been shown to have a much higher risk of suicide than others (Johnson et al., 2002). The effects of adverse childhood factors tend to be interrelated and correlated and act cumulatively to increase risks of mental health disorder and suicide. The community consultations revealed that parents need to build stronger relationships with their children's schools so they can collaborate to better navigate challenges before or as they arise. Youth programs aimed at building intracommunity connections, facilitating strong identity development and a sense of belonging were also identified as being an area of priority.

Recommendations

- We recommend a focus on promoting wellbeing and preventing suicide in vulnerable and at risk Muslim populations, including indigenous peoples, asylum-seeks, refugees, newly arrived migrants and international students.
- We recommend the development of a framework that assists organisations and individual practitioners to provide culturally appropriate mental health

services for Muslim families who have been bereaved by suicide.

- We recommend the development of youth programs aimed at building intracommunity connections, facilitating strong identity development and a sense of belonging.
- We recommend investment of resources into CALD qualified professionals that have extensive links to their community to build networks with public mental health services, hospital triage units, and people in government responsible for better mental health outcomes at State and Federal level to follow up on these recommendations.

Community resilience: Good mental health

Factors cited in community consultations to be protective factors towards positive mental health and wellbeing included:

- Strong familial ties
- Intra-community informal networks that support individuals and families in need
- Reliance on psycho-spiritual support, drawn from authoritative religious texts, religious teachers, supportive religious study circles.
- Practicing the tenants of Islam was regularly cited to promote a balanced mind-set and cultivate positive emotions such as hope, contentment, and inner peace.

Accessing support of Imams was largely cited as the most common help seeking mechanism to deal with personal problems including mental health problems, however it was as noted that this has not been effective and at times the Imams lack of knowledge of mental health issues has been detrimental. It was acknowledged Imams need training in mental health and that they need to facilitate referrals to qualified mental health practitioners and also broad community services, rather than trying to be the one-stop-shop for community members. Their efforts and their risk of mental burnout themselves was also highlighted.

The Muslim communities' uptake of mental health services, including psychotherapy and accessing other wellbeing programs has significantly increased over the past 2 decades, assisted by advocates of mental health and wellbeing within the Muslim community. Attendance of well-known Australian Muslim Psychologists at events, conferences, in the media, on social media platforms such as Facebook have secured excellent traction and engagement of the Muslim community, but there is so much more to be done.

Muslims are able to access services that support their wellbeing from Child and maternal health services, hospitals, Primary and secondary schools, in workplaces. They are also able to access referrals by GPs via the Medicare funded Better Access to Mental Health services in private practice with a Psychologist of their choice. This has been a game-changer as Muslims like other Australians can choose a private provider that they believe will meet their needs. However this choice is only made possible by on-going Federal support for a broad spectrum of Psychologists under the Medicare. Proposals by professional bodies such as the Australian Psychological Society (APS) that continue to support an evidence-less 2-tier or 3 tier model, relegating care of people with moderate to severe cases of mental illness currently offered by all Psychologists to ONLY Clinical psychologists will directly and negatively impact clients from culturally and linguistically diverse backgrounds. Imposing any restrictions on qualified psychologists to treat people with mental illness will reduce access and quality of care of CALD clients.

To promote choice of Psychologists, many psychologists who themselves are members of diverse cultural backgrounds and who are bi-lingual have been successfully filling a gap the current public mental health system, including models of care offered by Headspace youth mental health cannot offer and that is diversity of treating clinician. Clinician cultural diversity is a key factor in the delivery of culturally appropriate mental health care for CALD and

faith-diverse communities. Clinicians from CALD backgrounds are entering professions such as psychology and psychiatry and responding to needs of CALD clients faster than the tertiary system in embedding cultural competence models across the very curriculum intended to train and skills Australian clinicians. If we want to make significant gains in reducing mental health disparities that exist between Anglo-Australian and CALD and ATSI communities in mental health, then we must recognise and support the cultural diversity of the professionals treating diverse clients.

Proposals by professional bodies such as the Australian Psychological Society (APS) that continue to support an evidence-less 2-tier or 3 tier model, relegating care of people with moderate to severe mental illness currently offered by all Psychologists to ONLY Clinical psychologists will directly and negatively impact clients from culturally and linguistically diverse backgrounds.

Carers & families

The supports needed by carers and family members who have a loved one with a mental health issue are not any different to those of other Victorians, however it was noted that Muslim families may not understand what symptoms comprise a mental health issue, lack the understanding of how to intervene and lack the understanding of the supports available to them.

Often religious leaders or community influencers are consulted or brought in to family homes to provide spiritual advice or perform rituals to rid the person of the symptom. Families are sometimes advised by religious or community leaders to seek out qualified mental health practitioners such as a psychologist but this is very much dependent on the mental health literacy of the religious leader.

There is very little awareness of support groups or support workers for families with a loved one across the lifespan (child, adolescent, young adult, sibling, parent or elderly parent) experiencing a mental illness.

Support groups for carers may not get the uptake by Muslim community members due to shame/stigma in revealing that their son/daughter/spouse has a mental health issue. In-home family outreach support is likely to be much more effective and act as an influential bridge into other mental health supports for carers.

We know many Muslim parents refer children exhibiting symptoms of social, emotional, behavioural and developmental disorders by schools (in the public and independent education sectors) to access psychological supports from psychologists in private practice, psychological supports offered by The Children's Hospital (RCH) and Orygen youth mental health and Headspace centres, but the quality of that care is undocumented. We don't know how pervasive these referrals are across independent schools, such as Islamic schools where some schools are well resourced with teams of psychologists, school counsellors and student welfare, but some newer schools are not well resourced, and referrals are left to teachers and management. Schools do play a vital role in enhancing the mental health literacy of students and their parent communities. Through the delivery of parent workshops and information in school newsletters, mental health awareness and awareness of local services can be enhanced.

NDIS

Many community members are unaware as to whether they are eligible for NDIS and how NDIS will be able to support their children, adult children or a parent who has a mental health disability.

We have had feedback that many Commonwealth funded community based mental health support services, such as recovery and wellbeing programs and group therapy were defunded to support people with diagnosed mental illness and disability under the NDIS. Some client groups are more likely to access community based support

programs rather than see a psychologist, due to the cost and the stigma. It is short sighted to defund programs for people with mild to moderate mental illness in favour of people who are diagnosed with severe mental illness. Those very programs maintain good mental health and keep them out of the crisis end of the system.

Psychopharmocological treatment

There is a pervasive stigma across the Muslim community in using medication to treat mental illnesses. When medication is prescribed by a GP, many Muslims will resist taking it for as long as possible, even when symptoms of anxiety and depression are severe and impair their daily functioning. Some Muslims feel and are made to feel as if they are doing something wrong by their faith by some members of their families and some religious leaders, despite there being no religious prohibitions to taking such medication. The delay in accessing psychological treatment and when required psychopharmacological treatment does result in a deterioration of mental wellness and more intensive forms of treatment when people find themselves in crisis.

Psychopharmocological treatment might also be a preferred option for some members of culturally and linguistically diverse communities over accessing psychological treatment due to the stigma in seeing a psychological or a psychiatrist. Reliance on family members, religious leaders and self reliance are all factors that influence Muslims and other Victorians in delaying treatment of mental health conditions.

Substance Abuse

It is also noted that some community members use illicit substances. They are sometimes the cause of mental illnesses such as psychotic disorders and sometimes they are used inadvertently to self medicate existing mental illnesses such as anxiety and depression. In some social circles, particularly for young people, it is more socially acceptable to self medicate using an illicit substance rather than seeking out prescription Psychopharmocological medication (anti-depressants & mood

stabilisers, anti-anxiety medication, anti-psychotics) or professional psychological care.

Muslim carers and family members of someone with a substance abuse disorder will often reach out to an Imam for support, but the Imam is not a qualified drug and alcohol counsellor or family therapist. Many Muslim community groups acknowledge the impact of the ICE epidemic and the infiltration of other illicit substances with some community members and the devastating impact it has on families. A good initiative in Melbourne's north is the My Centre Support services model. A pilot project between 7 different organisations, some with expertise in delivering drug and alcohol counselling, detox and rehabilitation support, others with cultural and religious expertise working together to deliver a grant aimed at supporting Muslim community members and family members afflicted by substance abuse. The services offered include drug and alcohol counselling, youth outreach, family support groups, assessments, referrals to detox and rehab and community education.

Recommendations

- Mental health awareness and substance abuse awareness workshops delivered in different languages to different communities that provide information on not only what symptoms constitute mental illness and addiction, but improved literacy of the available supports and service system.
- That the above training be regularly held in mosques, community centres
- That religious and community leaders receive training in these areas every year. Some of this training will need to be conducted in languages other than English, e.g. Arabic, Persian, Farsi, Malay, Somali, Oromo, Eritrean. The government should support the provision of culturally appropriate group counselling programs for Muslims with suitably qualified and experienced therapists.

CONCLUSION

This submission provides valuable evidence into the mental health needs and experiences of the Victorian Muslim community.

The Centre for Muslim Wellbeing is of the view that adopting the recommendations throughout this report would enable the government to implement a coordinated strategy to greatly reduce the risk of Victorian Muslims showing up at crisis points in the service system and to improve the markers of wellbeing.

The Centre for Muslim Wellbeing urges the government to use the valuable opportunity afforded by the Royal Commission to prevent and address mental illness within not only the Victorian Muslim community but to support all Victorians to access early treatment and support.

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