Dietitians Australia

Nutrition and Mental Health in the Culturally and Linguistically Diverse (CALD) Population

Background

CALD stand for 'Culturally And Linguistically Diverse' populations who have been in non-English speaking countries and identify with a specific religion and/or culture.[2]

Data from 2011 estimates that almost half of the Australian population were either born overseas or had at least one overseas-born parent.[1] Regardless of their country of origin, new arrivals to Australia come from a range of socioeconomic backgrounds and have a wide range of experiences that may affect their mental health.[2]

The 2007 National Survey of Mental Health and Wellbeing estimated that over one third of 4.3 million first-generation adult Australians from CALD backgrounds experienced some form of mental disorder in a 12-month period.[3] Anxiety disorders including post-traumatic stress disorder (PTSD) were identified as the most prevalent, followed by affective disorders such as depression and substance use disorders.[3] A study in 2009 identified that 30 percent of people displaced from their countries experience PTSD and depression with exposure to torture and experienced trauma being the strongest predictors.[4]

Factors associated with increased risk of mental disorders in CALD populations in Australia include:[3, 6, 7]

- Isolation due to loss of family and community social support
- Dealing with past experiences of flight, torture, trauma, grief and abuse
- Racism and discrimination in the host community
- Loss of social status including unemployment
- Difficulties in communication
- Pressures from children or family to culturally assimilate / changes in family roles

CALD population access to mental health services

There is inadequate population epidemiological data regarding the use of health services by CALD populations; hence, immigrants may be an under-representative population in utilising general health services. Cultural beliefs about what constitutes mental illness and how to respond to it can affect how people explain symptoms, seek help, and access health services.[5] Research consistently demonstrates that immigrants and refugees are less likely to access and use mental health services when compared to their Australian-born counterparts, placing them at greater risk of mental health deterioration.[4] Cultural and language barriers are likely to have a greater impact on access for the elderly.[8] Despite efforts to address barriers to access, mental health services continue to be inadequate in meeting the specific needs of CALD communities.[9]

Barriers to access appropriate mental health services within CALD populations:[3, 6, 10]

- Stigma and shame associated with mental health
- Poor knowledge of mental health and available services
- Lack of availability of or reluctance to utilise bilingual practitioners and/or interpreters
- Distrust of service providers
- Limited access or lack of culturally competent services

This fact sheet was developed by MHANDi, a Dietitians Australia Mental Health Interest Group initiative.

- Financially unaffordable and lack of private health insurance
- Fear of hospitalization
- Concerns regarding deportation and poor knowledge about legal rights and entitlements

Mental health issues combined with the competing stress of settling in a new country may mean that nutritional needs are neglected, which can impair health, especially among refugees and asylum seekers living in Australia.[11] People who have newly arrived from multiple ethnic groups require health practitioners to maintain cultural appropriateness in order to reduce gaps and barriers in service delivery.[12]

Nutrition issues that have been identified in some CALD communities to be associated with migration and mental health include:[13–15]

- Undetected or poorly managed chronic diseases, including hypertension and diabetes
- Nutrient deficiencies: iron, vitamin D and folate
- Growth and development issues in children, often compounded by misconceptions, for example milk being provided to children as a complete meal
- Changing food habits
- Poor dental health and hygiene
- Food security, including a lack of knowledge of how to prepare unfamiliar foods, especially vegetables
- Poor appetite
- Weight gain, often due to ready availability and relative affordability of energy dense snack foods, take away and high sugar drinks
- Poor access to traditional foods, or inability to eating according to religious considerations

For migrants and refugees alike, access to culturally appropriate food, learning how to obtain food in a new environment and becoming familiar with new foods is imperative to successfully settlement in Australia.[11,13]

Healthier food choices to propose when providing nutrition education at individual or group level

- Maintain a key focus on the cultural and nutritional value of their cuisine
- Emphasise vegetable and pulse dishes in traditional recipes over fatty meat-based dishes
- Identify portions sizes, especially in meals that are based on protein and/or carbohydrates (particularly maize, cassava, sweet potato, taro, rice, bread, potato); focus on increasing proportions of vegetables and/or cooked or fresh (salads) in the meal
- Focus on carbohydrate quality, including whole grains and low GI options in moderation
- Identify which fats are used in cooking and cooking techniques to lower saturated fat intake.
- Encourage the use of monounsaturated fats and oils
- Emphasise nutrient quality in foods and a regular eating pattern within their cultural custom
- Encourage consumption of key nutrients for mental health including foods rich in iron and omega-3 fats

Additionally, encourage awareness of 'non-core' foods and the need to limit intake of foods in Australia that are high in sugar, salt and fat.[16] For example:

- Reducation of added sugar in drinks such as tea/ coffee and soft drink;
- Substitution of energy dense snack foods such as biscuits, cakes, and chips, while offering healthier alternatives
- Better choices for take away and restaurant meals

Practical tips when working with CALD populations

- Every person and community is unique, and hence it is necessary for practitioners to be familiar with and have a good understanding of the culture and customs specific to each CALD community prior to engaging with each person.[15]
- The Queensland Government has developed accessible food and cultural profile resources, which may be useful in assisting dietitians working with CALD individuals or communities, and have developed guides to assist health professionals to develop food and cultural profiles for any ethnic group.[17]
- Be aware of dietary considerations that exist within different religious practises. For example, dietary restrictions are part of Hindu, Islam, Sikh, Jewish, Buddhist, Christian, Hare Krishna, and Sufi religions. Explore how an individual practices these within their own lives, and offer culturally appropriate education based on this as well as suggestions on where to source appropriate food e.g. Halal butchers.
- As dietitians, it is important to develop trust and rapport with each patient and to refer to other service providers if required for improved access. Interpreters (phone or in person) should be used appropriately to ensure the person is comfortable throughout the session. In addition, interpreters are often culturally competent and provide additional support to assist with the care of the person.[16] However, exceptions may be made in using interpreters in a mental health context when the person prefers a relative or carer who speaks English, as in many cultures, a mental illness is highly

stigmatising. Nutrition education and mental illness can be difficult to address if an interpreter belongs to the patient's home community, due to fear of being 'exposed' to the whole community. A carer's participation is acknowledged when liaising with the practitioner having the potential of a better outcome in the management of the person's health condition.[18]

- Patients may also feel more comfortable if their family is involved in their treatment, and may prefer to have them sit in each consult. If this is the case, ensure the consult room is large enough so that the patient and dietitian are comfortable to complete the session. It is important that the patient's acceptance for a relative or carer to be present during the session is sought, and also that the client understands they are welcome to bring family members to consults. During assessment, it is helpful to observe the patients verbal and non-verbal cues, as this may assist with their treatment.[11]

Links to Recommended Resources and Readings:

- Mental Health in Multicultural Australia: Cultural awareness tool: Understanding cultural diversity in mental health
- Flinders University HELPP 2012: Useful CALD resources
- Mental Health Professionals Network: Collaborative Mental Health Care to Support a Young Person from a Refugee Background
- Mental Health Professionals Network: Mental Health Services for CALD Communities
- Nutrition Education Materials Online (NEMO): Cultural competence resources for clinicians and their work units
- Queensland Government: Multicultural Nutrition Resources for consumers
- Queensland Government: Multicultural Nutrition Resources for Dietitians
- Australian Government: Translating and Interpreting Service
- Please also refer to the MHANDi document '5.0 Links to Mental Health Resources' for a list of web links to key organisations offering CALD population services and resources
- Agency for Clinical Innovation: Nutrition Standards for Consumers of Inpatient Mental Health Services

Disclaimer: The aim of this document is to both provide an introduction and highlight the key nutrition issues in mental health. This resource has been reviewed to ensure the information is current and up to date, however it is not an in-depth literature review. References, recommended reading and resource lists are included for further research.

References:

1. Australian Bureau of Statistics. 4326.0- National Survey of Mental Health and Wellbeing: Summary of Results. Canberra: Australian Bureau of Statistics, 2008.
2. Australian Bureau of Statistics. Cultural Diversity in Australia: Reflecting a Nation: Stories from the 2011 Census. Canberra: Australian Bureau of Statistics, 2012.
3. Steel Z, Chey T, Silove D, et al. Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. Jama 2009; 302: 537-549. 2009/08/06. DOI: 10.1001/jama.2009.1132.
4. Silove D, Steel Z and Watters C. Policies of Deterrence and the Mental Health of Asylum Seekers. JAMA 2000; 284: 604-611. DOI: 10.1001/jama.284.5.604.
5. Embrace Multicultural Mental Health. Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery, https://embracementalhealth.org.au/service-providers/framework (2020).
6. Minas H, Kakuma R, Too LS, et al. Mental health research and evaluation in multicultural Australia: Developing a culture of inclusion. In: Australia MHiM, (ed.). National Mental Health Commission 2013.
7. Chen W, Hall BJ, Ling L, et al. Pre-migration and post-migration factors associated with mental health in humanitarian migrants in Australia and the moderation effect of post-migration stressors: findings from the first wave data of the BNLA cohort study. The Lancet Psychiatry 2017; 4: 218-229. DOI: 10.1016/S2215-0366(17)30032-9.
8. Rao DV, Warburton J and Bartlett H. Health and social needs of older Australians from culturally and linguistically diverse backgrounds: issues and implications. Australasian Journal on Ageing 2006; 25: 174-179. DOI: 10.1111/j.1741-6612.2006.00181.x.
9. Cross W and Singh C. Dual vulnerabilities: Mental illness in a culturally and linguistically diverse society. Contemporary Nurse 2012; 42: 156-166. DOI: 10.5172/conu.2012.42.2.156.
10. Wohler Y and Dantas JAR. Barriers Accessing Mental Health Services Among Culturally and Linguistically Diverse (CALD) Immigrant Women in Australia: Policy Implications. Journal of Immigrant and Minority Health 2017; 19: 697-701. DOI: 10.1007/s10903-016-0402-6.
11. The Victorian Foundation for Survivors of Torture Inc. Promoting Refugee Health: A guide for doctors, nurses and other health care providers caring for people from refugee backgrounds. 3rd ed. Online Foundation House, 2012.
12. Poropat M, Qadeer MT and Gooding B. Latrobe City CALD Communities' Access to Mental Health Service Mapping and Scoping Project. In: Region DoHG, (ed.). Gippsland Multicultural Services, 2014.
13. Centre for Culture Ethnicity and Health. New arrivals, nutrition and food security: literature review VicHealth, 2008.
14. Association for Services to Torture and Trauma Survivors. Good Food for New Arrivals: Nutrition issues for refugees in Australia. Refugee Health Network, 2004.
15. Metro South Health Access and Capacity-building Team. Providing culturally responsive dietetic services: a short organisational assessment tool. In: Health QDo, (ed.). Queensland Department of Health, 2016.
16. Mental Health Professionals' Network. Webinar: Collaborative Mental Health Care to Support a Young Person from a Refugee Background, https://www.mhpn.org.au/ (2013).
17. Queensland Government. Multicultural nutrition resources, https://metrosouth.health.qld.gov.au/multicultural-nutrition-resources (2020).
18. Rooney R, Wright B and O'Neil K. Issues faced by carers of people with a mental illness from culturally and linguistically diverse backgrounds: Carers' and practitioners' perceptions. Australian e-Journal for the Advancement of Mental Health 2006; 5: 132-144. DOI: 10.5172/jamh.5.2.132.