



Compulsory community treatment and ethnicity: Findings from a culturally and linguistically diverse area of Queensland



Katherine Moss^{a,b,*}, Marianne Wyder^a, Vivienne Braddock^a, David Arroyo^b, Steve Kisely^{a,b}

^a Metro South Addiction and Mental Health Services, University of Queensland, Brisbane, QLD, Australia

^b School of Medicine, University of Queensland, Brisbane, QLD, Australia

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ABSTRACT

Objective: To compare the use of community treatment orders (CTOs) and forensic orders (FOs) in a culturally and linguistically diverse (CALD) population to that in a non-CALD population.

Methods: We analysed the relationship between coming from a CALD background and the use of CTOs and FOs on discharge from hospital using merged data from the Metro South Addiction and Mental Health Service's Transitions of Care (ToC) and Consumer Integrated Mental Health Application (CIMHA) databases.

Results: Nine hundred and seventy-six individual records were included in the data set, of whom eighty-six were from a CALD background (8.8%). Three hundred and eleven patients were on compulsory community treatment. Use of compulsory community treatment (CTOs and FOs) was similar for those born in Australasia, British Isles, North America and Europe but significantly higher for those born elsewhere even after adjusting for socio-demographic and clinical variables (Adj OR 2.19, 95% CI 1.36–3.52). The use of an interpreter significantly increased the likelihood of compulsory community treatment (Adj OR 2.76, 95% CI 1.20–6.35). Restricting the analyses to CTOs only did not alter these results.

Conclusions: Metro South residents from a CALD background outside of Europe were over-represented on compulsory community treatment orders. This could reflect the difficulties in accessing voluntary services, communication barriers, stigma associated with mental illness, discrimination, or issues related to accurately diagnosing mental illness cross-culturally. Clinicians need to be aware of the complexity of working with people from diverse cultures and apply these orders judiciously.

1. Introduction

People from culturally and linguistically diverse (CALD) backgrounds are generally defined as those born overseas, originating from non-English speaking backgrounds (NESB). Australia is a nation with a significant CALD population, encompassing both migrant and refugee populations. The Australian Bureau of Statistics (2016) reported a high proportion of overseas-born people in Australia (26%) coming from over 300 different ancestries. Despite the availability of universal healthcare in Australia (Straiton, Grant, Winefield, & Taylor, 2014) there remain significant challenges around the support and treatment of people from CALD backgrounds experiencing serious mental illness. For instance, studies from Australia and abroad suggest they have difficulties with access to mental health services, as well as more complex pathways to specialist care (Mfofo-M'Carthy, 2014; Stolk, Minas, & Klimidis, 2008).

In Britain, a study by Bhui et al. (2003) reported that people from a

CALD background took longer to reach services and were more likely to be admitted following home visits. CALD individuals were also less likely to be referred to specialists by their general practitioners. Furthermore, police were also more likely to be involved in the admission or readmission process. In Australia, people from a CALD background have consistently lower rates of access to public community and in-patient mental health services, a higher proportion of involuntary admissions, a higher proportion of a diagnosis of psychosis and an increased risk of involuntary admissions (Klimidis & Victorian Transcultural Psychiatry Unit, 1999; Stuart, Klimidis, & Minas, 1998).

There are also differences in health service use within culturally diverse populations in Australia. For instance, the rate of psychiatric admissions of European migrants in Western Australia approached the rate of Australian-born individuals over time (Bruxner, Burvill, Fazio, & Febbo, 1997). By contrast, this study found that admissions for South-east Asian migrants, predominantly those from Vietnam and Malaysia remained lower than in the general population. When only compulsory

* Corresponding author at: Metro South Addiction and Mental Health Services, Princess Alexandra Hospital, 199 Ipswich Road, Brisbane, QLD 4102, Australia.
E-mail address: katherine.moss@health.qld.gov.au (K. Moss).

admissions were considered, rates were increased two-fold for those born in Yugoslavia, Poland, Malaysia and Vietnam.

Clinician-initiated community treatment orders (CTOs) have been implemented across a number of Western nations and their use has significantly increased in Australia (Light, Kerridge, Ryan, & Robertson, 2012). In spite of their widespread use, there have been concerns regarding their use and effectiveness. The largest systematic review to date by Churchill, Owen, Singh, and Hotopf (2007) found no evidence for CTO effectiveness on social functioning, arrests, homelessness, general mental state, psychopathology, quality of life, carer satisfaction, or perceived coercion. Similarly, a systematic review by Maughan, Molodynski, Rugkasa, and Burns (2014) did not find any significant effects for CTOs on hospitalisation and other service use outcomes.

There is particular concern that individuals from CALD backgrounds may be disproportionately placed on CTOs. Of particular concern refugees have often experienced trauma, poverty, lack of housing, exploitation, racism, discrimination, sexual violence, famine, drought, civil wars and other forms of deprivation. These factors play a role in the social determinants of health and undoubtedly contribute to a myriad of mental health conditions that require thorough evaluation and treatment. However, there is relatively little information on whether culturally diverse patients are at greater risk of clinician-initiated involuntary treatment in the community. A study from Scotland reported that African individuals had a fourfold risk of being treated under a CTO while those of Chinese heritage had an almost twofold risk to be placed under a CTO (Bansal et al., 2014).

A West Australian study found that while people who were born in Australia, New Zealand, the United Kingdom or Ireland had very similar rates of CTO placement, those who were born elsewhere were at greater risk of a CTO (Kisely & Xiao, 2017). However, there were several limitations to this study. Firstly, the data was between 10 and 20 years old, and the rate of CTO use in Australia has increased markedly over the subsequent years (Light et al., 2012). Secondly, although Western Australia has the highest proportion of residents who are born overseas, the vast majority come from English speaking countries. As a result, the state has a much lower proportion from non-English speaking backgrounds than Australia's East Coast (Australian Bureau of Statistics, 2017). Both these factors may limit generalisability to both the present day and elsewhere in Australia.

The importance of understanding the role of culture in mental health presentations has led to an attempt to draw clinician's attention to cultural factors (e.g. the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Cultural Formulation Interview). The Cultural Formulation Interview is recommended based on the growing body of literature that describes how culture shapes psychiatric care, influences patient's experiences of illness and distress, gives rise to particular patterns of symptoms and influences the way clinicians interpret symptoms (Desilva, Aggarwal, & Lewis-Fernandez, 2018). The Royal Australian and New Zealand College of Psychiatry (RANZCP) also supports the education and training of psychiatrists in cultural diversity and currently provides over twenty on-line modules covering various aspects of culture for continuing professional development for its trainees and fellows.

In this study we aim to determine whether patients from CALD backgrounds in one of the most culturally and linguistically diverse populations in Brisbane, Queensland (Metro South Health area) are more likely to be treated on CTOs and forensic orders (FOs) than those from non-CALD backgrounds between 2016 and 2017.

2. Methods

2.1. The setting

The data was drawn from The Metro South Health Area. Metro South Health, as the most populated hospital and health service in Brisbane, Queensland, provides health care to approximately 23% of

Queensland's population (Metro South Hospital and Health Service, 2017). The Metro South Health area contains one of the most culturally and linguistically diverse populations in Queensland, Australia, with around 32% of the total population of 1,101,386 born overseas. In 2011 around 300,000 residents in the area reported being born overseas, 59% of which reported that they were from non-English speaking countries. In addition, 18% reported that they did not speak English well, if at all.

2.2. Population studied

We included all patients who were under involuntary community treatment, previously termed CTOs and now called treatment authorities (TAs), or other compulsory community treatment such as FOs or forensic disability orders (FDOs) between 6th December 2016 and 30th June 2017 within the Metro South Health district. Information from two data sets, the Transitions of Care (ToC) and the Patient Integrated Mental Health Application (CIMHA) were merged to gain the information required for the study. This study was approved by the Metro South Health Human Research Ethics Committee.

2.3. Databases

The ToC online platform is a digital system unique to Metro South Health that is used for all patients in the service as they transition between services, in this case from inpatient to community mental health treatment. The ToC makes it clear when care has been transferred from one team to another and shows who is responsible for patient care at all times. The ToC platform is a secured website application managed locally by Metro South Health, administered by the Adult Mental Health Service. Using this dataset, we were able to ascertain the number of patients currently treated voluntarily and involuntarily. Other information recorded on the ToC included country of birth, language spoken, interpreter requirements, cultural requirements and diagnosis.

CIMHA is the clinical information system that is designed to support mental health services within Queensland. CIMHA delivers functions required to meet the statutory obligations under the *Mental Health Act 2016*, including being a register of patient records. Information collected from CIMHA included country of birth, type of mental health order, language spoken, gender, marital status, living situation (living with others or alone, as well as type of residence), employment/study, diagnosis and need for an interpreter.

2.4. CALD status

CALD status was determined by country of birth, whether individuals came from an English-speaking background (ESB) or a non-English speaking background (NESB) and the need for an interpreter, as captured in CIMHA. The Australian Bureau of Statistics (1999) has published the Standards for Statistics on Cultural and Language Diversity to identify, define and classify the particular attributes that relate to a CALD background. The minimum data set recommends four variables to capture cultural and linguistic diversity including country of birth, main language other than English spoken at home, proficiency in spoken English and Indigenous status. However, neither of our two databases captured proficiency in spoken English.

2.5. Country of birth categories

In order to aggregate individuals into country of birth categories we determined that English speaking included English-speaking nations with similar cultural roots and close ties. Included in this group were Australia, New Zealand, United Kingdom, Ireland, Canada and the United States of America. People from non-English speaking backgrounds were divided into those born in Continental Europe and those born elsewhere.

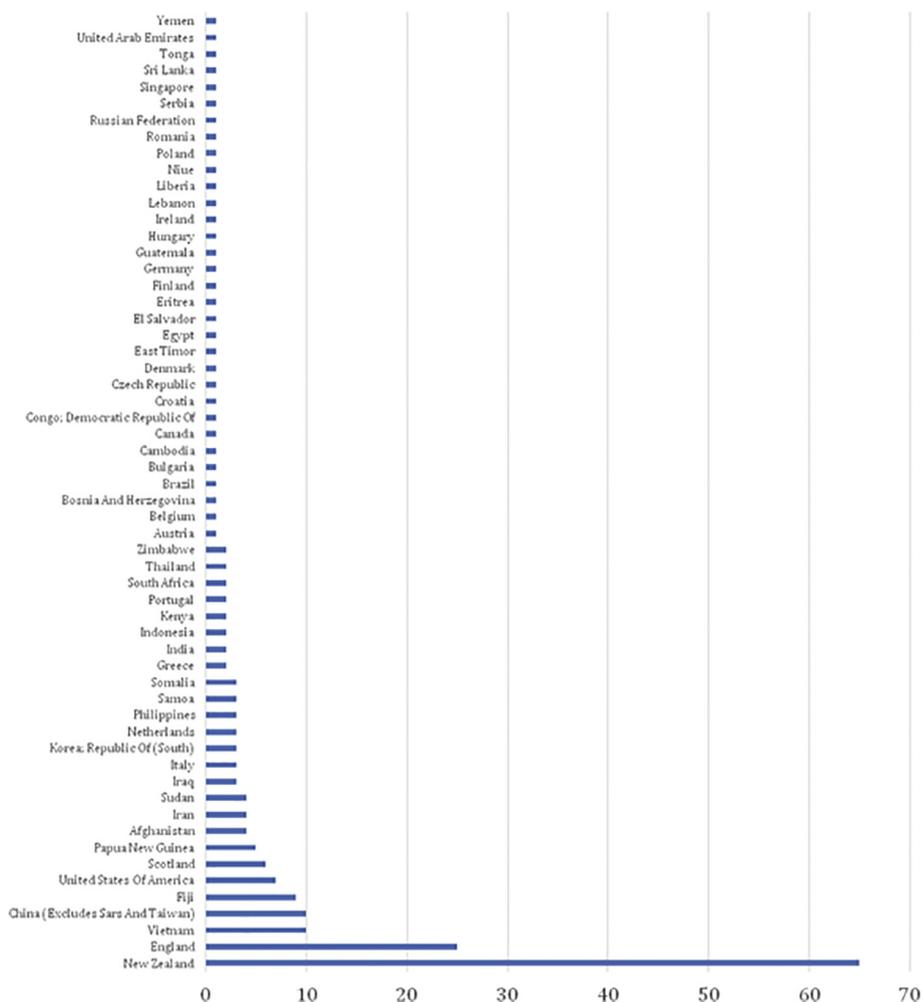


Fig. 1. Overseas country of birth.

We analysed the relationship between coming from a CALD background and being placed under involuntary treatment using unadjusted odds ratios. Further statistical analyses were performed to calculate adjusted odd ratios to determine the contribution of different variables to involuntary treatment. These variables included age, gender, marital status, living alone, accommodation, employment, diagnosis, Aboriginal or Torres Strait Islander status, use of an interpreter and country of birth.

3. Results

The data set included 976 patients. New Zealand, England and Vietnam were the most common countries of birth after Australia (Fig. 1). Eighty-six (8.8%) came from a CALD background as determined by country of birth, language spoken or use of an interpreter. Twenty-eight patients from eighteen different countries required interpreters. The most common languages requiring an interpreter were Vietnamese, Mandarin, Arabic and Farsi (Fig. 2).

In terms of legal status, 665 were voluntary patients, and 311 were discharged to some form of involuntary treatment in the community, most commonly a CTO (n = 280) or a FO (n = 31).

Table 1 shows the characteristics of the sample divided into those from English and non-English speaking backgrounds. There were no significant differences with regards to age, gender, marital status, living alone, accommodation, work/study or diagnosis.

Table 2 demonstrates that CTO use was similar for those born in Australasia (31.0%), the British Isles or North America (20.5%) and

Europe (15.0%) but was significantly higher for those born elsewhere (48.8%).

Given the similarity in results for people from English-speaking backgrounds and Continental Europe, we grouped them together and compared their experience with those from a non-English speaking background outside of Europe. Factors that were associated with CTO placement included younger age (p = 0.01), living alone (p < 0.001), unemployment (p = 0.03) and a diagnosis of schizophrenia (p < 0.001). After adjusting for these variables, being from a non-European CALD background still increased the risk of involuntary community treatment (Table 3). There were similar findings for patients who required an interpreter, which almost tripled the likelihood of involuntary community treatment (Table 4).

We found similar results when we restricted the analyses to just those patients on CTOs (n = 280) for both coming from a CALD background (Adj OR 2.30, 95% CI 1.42–3.72), and needing to use an interpreter (Adj OR 3.01, 95% CI 1.31–6.89).

4. Discussion

Our study highlights that nearly half (48.8%) of the CALD patients from outside of Europe were treated under involuntary community treatment compared to a third (33.4%) of individuals from English-speaking or European backgrounds. These patients were twice as likely to be placed on involuntary community treatment. We found similar results when we considered only the 280 patients on CTOs.

The different rates reported in this study raise questions regarding

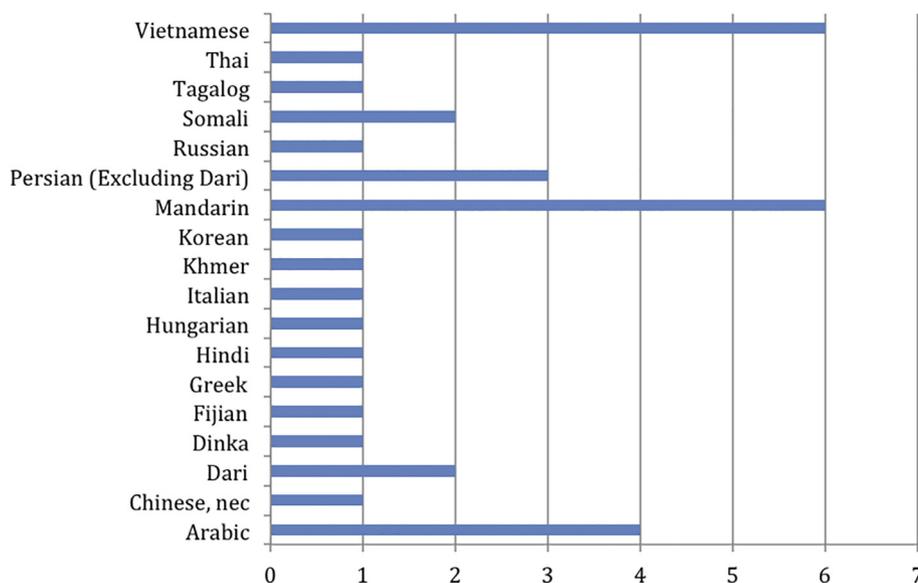


Fig. 2. Languages spoken.

the factors that influence the use of CTOs and whether they may be over or under utilised in certain populations. It is possible that certain groups may experience inappropriate levels of coercion with potential negative impacts on their recovery and potentially exacerbating their pre-existing trauma symptoms. For instance, involuntary patients are more reluctant to seek psychiatric care in the future and therefore are more likely to have subsequent involuntary admissions (Priebe et al., 2009). They are also significantly less satisfied with their relationship with the treating health care professionals (Kallert, Glockner, & Schutzwahl, 2008; Priebe et al., 2009). Conversely if CTOs are under-used for certain groups, this could lead to some people not gaining access to services.

One of the more significant findings of this study was that patients who required an interpreter were almost three times more likely to be treated on a CTO than those who did not require the use of an interpreter. It is possible that clinicians may unknowingly discriminate against those requiring interpreters by virtue of the difficulties in communication that ensue. Assessments with interpreters rely on the interpreter relaying information correctly as well as making judgements on aspects of the consultation such as thought disorder and defining cultural concepts and language. These interactions are complex with confounding problems when the interpreter is from a different culture or sub-culture with which the individual identifies. Alternatively, the increased use of interpreters for patients on CTOs could be as a result of limited use of interpreters for CALD patients being treated voluntarily

raising questions about the effectiveness of voluntary treatment of CALD patients.

In a naturalistic study it was noted that language differences can be viewed as a social marker to classify and categorise patients as well as staff. There is some indication that those with limited proficiency in English are at risk of being evaluated negatively and seen as a threat to scarce healthcare resources. The authors also noted that patients were obstructed from getting access to qualified health interpreters in a timely manner, or at all (Johnstone & Kanitsaki, 2007).

Patients from CALD backgrounds can have difficulties accessing mental health services along with more complex pathways to specialist care (Mfoafo-M'Carthy, 2014; Stolk et al., 2008). These studies report that CALD patients generally see more carers before contact, admissions are more likely to follow home visits, they are less likely to be referred to specialists by their general practitioner and police are more likely to be involved in the admission or re-admission process. There may be an underlying lack of knowledge of psychiatric services or how to access them. Patients may come from counties that have poorly-developed psychiatric services or no services at all. In addition, mental illness may be conceptualised differently and incorporate spiritual or religious understandings. Thus, patients may not know why or how to seek help from established services.

Research suggests that the experiences of those from a CALD background with the mental health services are diverse. An Australian

Table 1
Characteristics of the sample.

Country of birth		English-speaking: Australia, New Zealand, United Kingdom, Ireland, Canada, USA		Non-English-speaking: Europe and the Rest of the World		OR	95% CI
Count	Column N %	Count	Column N %				
> 38	463	52.0%	47	55.3%	1.19	0.76–1.84	
Male	489	54.9%	42	48.8%	0.75	0.48–1.14	
Single	538	60.4%	48	55.8%	0.79	0.51–1.22	
Lives alone	224	25.2%	18	20.9%	0.75	0.44–1.29	
Institutional care or homeless	170	19.1%	14	16.3%	0.81	0.45–1.47	
Work or study	158	17.8%	18	20.9%	1.17	0.68–2.02	
Schizophrenia & other psychoses	340	38.2%	41	47.7%	1.44	0.93–2.22	
Other disorders/not specified	409	46.0%	34	39.5%	1.00	-	
Affective disorders	141	15.8%	11	12.8%	1.12	0.55–2.25	
Schizophrenia & other psychoses	340	38.2%	41	47.7%	1.57	0.78–3.13	

Table 2
Effect of country of birth and preferred language on placement.

		Treated under the MHA				OR	95% CI for OR		Sig.
		No		Yes			Lower	Upper	
		Count	Row %	Count	Row %				
Region	Australia & New Zealand	573	69.0%	258	31.0%	1.00			
	United Kingdom, Ireland, Canada, USA	31	79.5%	8	20.5%	0.57	0.26	1.26	0.17
	Continental Europe	17	85.0%	3	15.0%	0.39	0.11	1.35	0.14
	Rest of the World	44	51.2%	42	48.8%	2.12	1.35	3.32	0.00
Interpreter Required	No	652	68.6%	298	31.4%	1.00			
	Yes	13	50.0%	13	50.0%	2.19	1.002	4.78	0.04

study reported a number of difficulties including an inability to communicate with service providers, poor attitudes by staff and lack of respect, not being able to have their families present, not being listened to, not being given clear explanations, being forced to comply with unfamiliar forms of care and the overall inflexibility of the system (Johnstone & Kanitsaki, 2007). Positive experiences were reported in another study by Mfoafo-M'Carthy (2014). In this study, CALD individuals reported that the CTO had improved their rapport with the case management and clinical team, increased medication compliance and feelings of empowerment. Participants also felt that the CTOs enabled them to access treatment resources that would otherwise have not been available to them. By contrast, negative experiences of CTOs included issues of racism and discrimination, stigma and a feeling of coercion with regards to their treatment.

The issue of discrimination has been identified as a neglected but central societal force that can adversely affect the health of CALD populations. The 2014 Scanlon Foundation survey reported that discrimination was suffered by 16% of those born in Australia, 11% of those born overseas of an English-speaking background and 26% of those born overseas and of a non-English speaking background (Markus, 2014). Similarly, it has been reported that around a third of young people aged between fifteen and nineteen experiences either unfair treatment or discrimination based on their race (Ford & Hunjan, 2016). Racial discrimination can be a significant determinant of both physical and mental health and can impact behaviours that have a detrimental effect on health (Paradies, 2006). There is also some indication that poorer mental health is associated with the volume of discrimination experienced, rather than the type of experience (Ferdinand, Paradies, & Kelaher, 2015).

Stigma associated with mental illness varies across cultures as understandings and explanations vary. For some communities there is

Table 3
Demographic and health service factors associated with CTO placement.

	Controls (n = 665)		CTO cases (n = 311)		OR	95% CI	Adj OR ^a	95% CI	Sig.
	N/mean	%/SD	N/mean	%/SD					
Age	42.1	17.3	38.7	13.2	0.98	0.97–0.99	0.99	0.98–1.00	0.01
Male	338	50.8%	193	62.1%	1.58	1.20–2.08	1.34	0.99–1.81	0.06
Single	378	56.8%	208	66.9%	1.53	1.15–2.03	0.93	0.65–1.32	0.67
Lives alone	147	22.1%	95	30.5%	1.55	1.14–2.10	1.62	1.16–2.25	0.00
Institutional care or homeless	118	17.7%	66	21.2%	1.25	0.89–1.75	1.17	0.81–1.68	0.40
Work or study	134	20.2%	42	13.5%	0.62	0.43–0.90	0.67	0.45–0.99	0.05
Other disorders/not specified	343	51.6%	100	32.2%	1.00				
Affective disorders	121	18.2%	31	10.0%	1.14	0.72–1.79	1.11	0.70–1.77	0.62
Schizophrenia & other psychoses	201	30.2%	180	57.9%	3.50	2.24–5.44	2.16	1.86–4.70	< 0.0001
Aboriginal or Torres Strait	58	8.7%	23	7.4%	0.84	0.51–1.34	0.81	0.48–1.39	0.45
Australia, NZ, UK, US, Can, Europe ^b	621	93.4%	269	86.5%	1.00		1.00		
Rest of the World	44	6.6%	42	13.5%	2.20	1.41–3.44	2.19	1.36–3.52	< 0.0001

OR = odds ratio; CI = confidence interval.

^a Adjusted for all variables in the table.

^b Australia, NZ, British Isles, Canada, the USA & Continental Europe as a reference group for the Rest of the World.

Table 4
Need for an interpreter and CTO placement.

	Adj OR	95% CI for OR		Sig.
		Lower	Upper	
Age	0.99	0.97	1.00	0.01
Single	0.99	0.70	1.39	0.93
Lives alone	1.62	1.16	2.25	0.00
Institutional care or homeless	1.21	0.84	1.72	0.31
Work or study	0.71	0.48	1.06	0.09
Other disorders/ not specified	1.00			
Affective disorders	1.13	0.71	1.80	0.59
Schizophrenia & other psychoses	3.19	2.01	5.05	0.00
Aboriginal or Torres Strait	0.78	0.46	1.33	0.36

significant stigma and shame associated in having a mental illness and seeking mental health treatment. As a result, many families will attempt to care for their relative and avoid seeking mental health care for fear of negative community responses (Wynaden et al., 2005). Harmful effects of stigma include feelings of shame, hopelessness and isolation, a reluctance to seek help for mental health difficulties, lack of understanding by others, fewer opportunities for social interaction, and self-doubt. Turnbull and Stokes (2011) found resistance to counselling in a CALD population because of stigma. Measures proposed to counter stigma include broader community education and outreach programs, with a particular focus on those most vulnerable including the newly-arrived, youth, homeless and those with a trauma history.

Our study was limited to the Metro South Health area in Brisbane, Queensland, and our findings may not be generalisable to other health areas. In addition, we relied on proxy indicators such as place of birth and the need for an interpreter to determine CALD status. As a result, second and third generation immigrants who still may identify as

culturally and linguistically diverse may not have been identified. In the case of people from New Zealand, country of birth may disguise differences in the Maori and non-Maori population. However, given that it is known that Maori people in New Zealand are over-represented in being placed on CTOs (Churchill et al., 2007), this would have had the effect of reducing any difference between the CALD and non-CALD groups. Recent data from New Zealand reports that the Maori population are 3.6 times more likely than non-Maori to be subject to a CTO (Ministry of Health, 2017). This occurs even though many Maori people speak English as their first language. Hence, cultural factors such as the manifestation of symptoms, stigma, health seeking behaviours and support systems may be more at play in these cases.

Due to limited numbers, we had to group disparate countries together, especially in the case of the “rest of the world”. This may have obscured important differences. We have no information on the date of arrival in Australia for people born outside of the country or information on proficiency of English. It is possible that the results for people from Europe may have reflected longer Australian residence. We were also unable to adjust for other possible confounders such as socioeconomic status and personal trauma.

There is scope for more research into the access and use of psychiatric services available to vulnerable populations, such as refugee claimants and very new immigrants to Australia. It is important to understand the barriers that exist in order to overcome the difficulties instead of resorting to involuntary treatment if it is not indicated or required. In addition, legislation for detaining and treating CALD individuals should also be the subject of further research and consideration. It may be that re-framing current legislation may lessen the likelihood of inappropriate or unfair use of compulsory measures for CALD individuals and other marginalised populations.

5. Conclusion

In our study, CALD individuals were twice as likely to be treated under involuntary community treatment. This provides further evidence to current literature, that patients from CALD backgrounds are significantly more likely to be placed on involuntary community treatment orders than their non-CALD counterparts. This suggests that there could be a bias towards treating patient with mental illness from a CALD background, particularly from outside of Europe, under involuntary community treatment. Furthermore, our study also demonstrated that the use of an interpreter tripled the likelihood of treatment on an involuntary community order for CALD individuals. It is important that clinicians assessing CALD individuals are aware of this potential bias. Further training focusing on cultural understandings of causes and management of mental illnesses and training in the use of interpreters could also assist in reducing this bias. Acknowledgement of and reduction of discrimination and stigma, as well as addressing other concerns that individuals from a CALD background have may also help to reduce the disparity in mental health care in Australia.

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