multicultural
MENTAL HEALTH AUSTRALIA

Senate Select Committee of Inquiry into Mental Health Services

Additional recommendations in response to the
Report of the Inquiry into the
Circumstances of the Immigration Detention of Cornelia Rau

Multicultural Mental Health Australia

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CONTENTS

Additional Recommendations in response to the Report of the Inquiry into the Circumstances of the Immigration Detention of Cornelia Rau

This document is additional to Multicultural Mental Health Australia's submission initial submission to the Senate Select Committee of Inquiry into Mental Health Services.

It relates to the section headed **People from diverse background with mental health problems in criminal and immigration detention**, on page 18 of that submission.

It contains additional recommendations developed in response to the Report of the Inquiry into the Circumstances of the Immigration Detention of Cornelia Rau.

Summary of additional recommendations

Additional Recommendation 1:

That DIMIA management review its primary mental health care strategy for Immigration Detention Facilities (IDFs) placing emphasis individuals whose risk of developing mental health problems or mental illness is significantly higher than average.

Additional Recommendation 2:

That DIMIA reviews its relationship with relevant State and Territory Drug and Alcohol Services and Multicultural Mental Health Specialists to examine how clients in Immigration Detention Facilities (IDFs) with dual diagnosis can be better managed.

Additional Recommendation 3:

That managers build and model effective communication practices between stakeholder agencies and formal policy for resolving interagency conflict is agreed upon with the aim of avoiding deadlock, improving trust networks, ensuring fairness and equity of points of view with regard to individual roles and responsibilities.

Additional Recommendation 4:

That a dedicated team should orientate their psychiatric assessment and therapeutic endeavours toward a mutually interpretable explanation for the clients presenting problems, including

- Implementing evidence based interventions such as psychosocial (broadly defined) supports and medication to reduce symptoms[1];
- Supporting and encouraging specialist mental health services and general practitioners to initiate and participate in education and guidance of people with regard to their drug therapy, in order to promote a sense of partnership towards adherence and the achievement of therapeutic outcomes;
- Helping to reduce, or remove the need for drug therapy – particularly in children;
- Supporting and encouraging specialist mental health services, primary care services and general health services to respond to risk and protective factors and to early warning signs and symptoms in their regional settings. (This will need to be done in collaboration with non-health services [volunteer groups] that provide a strong support and friendship network to the men).

1 Clinicians should seek to identify and address the causes of an individual's distress, allowing that causes may be biological, psychological and/or social (see G. Parker, Depressions black and blue: changing the Zeitgeist. Medical Journal of Australia 2003; 179 (7): 335-336.

Additional Recommendation 5:	That senior management review its relationships with tertiary educational institutions, clinical schools, to encourage the establishment of education and training for mental health and non-mental health staff.
Additional Recommendation 6:	That in conjunction with the Australian Mental Health Consumer Network, relevant State and Territory Departments of Health (Mental Health) and Drug and Alcohol Services, Regional Division of General Practice, Australian and New Zealand College of Psychiatrists, Australian and New Zealand College of Mental Health Nurses, specific training regarding the assessment, recognition and management of suicidal clients should be provided to all relevant staff.

People from diverse backgrounds with mental health problems in immigration detention

(TOR J)

The following recommendations were developed in response to the Report of the Inquiry into the Circumstances of the Immigration Detention of Cornelia Rau (the Palmer Report) which was release after the initial Multicultural Mental Health Australia Submission was complete.

The provision of mental health services in Immigration Detention Facilities (IDFs)

Additional Recommendation 1: That DIMIA management review its primary mental health care strategy for Immigration Detention Facilities (IDFs) placing emphasis individuals whose risk of developing mental health problems or mental illness is significantly higher than average.

Rationale: International evidence points to the immigration detention environment being injurious to mental health. The universal targeting of preventative interventions at individuals whose risk of developing mental health problems or mental illness is significantly higher than average, or as indicated by the needs of high-risk individuals, is a key element of *Australia's National Mental Health Plan 2003-2008.*

Outcome indicator: A strategic approach to mental health provides is developed to address identified problems and unmet needs. The approach taken encompasses the whole of the lifespan from infancy to old age.

Additional Recommendation 2: That DIMIA reviews its relationship with relevant State and Territory Drug and Alcohol Services and Multicultural Mental Health Specialists to examine how clients in Immigration Detention Facilities (IDFs) with dual diagnosis can be better managed.

Rationale: Clients from a CALD background with a dual diagnosis are those with a mental illness and a coexisting alcohol and other drug disorder. There is considerable likelihood that clients with dual diagnosis may receive less than optimal treatment in an IDF in part because:

1. People with a coexisting mental illness, alcohol or other drug disorders often present as a diagnostic challenge as each disorder may complicate the other;
2. The separation of Drug and Alcohol and Mental Health Services which may allow clients to 'fall between the gaps".

Lack of early identification and treatment increases the cost for the clients, health care systems and the community. As clients with dual diagnosis are often seen in Emergency Departments, it is important to ensure coordination of services for this population group. Access would have to be ensured by DIMIA and GSL to drug and alcohol agencies either by

the location of a dual diagnosis clinician in the service, or the availability of a designated worker within the attending mental health service. It is anticipated that this recommendation will be the subject of a working party facilitated by the Immigration Detention Review Committee.

Outcome Indicators:

- Improved alliances between State and Territory Drug and Alcohol Services, Multicultural Health Agencies (including NGO's) and DIMIA bring coordination of all matters pertaining to drug (including alcohol) issues including prevention, treatment, health promotion, education and evaluation into a coherent framework for action.
- Seriously mentally ill clients are treated by psychiatric services, with the drug and alcohol services using their allocated worker for those who do not meet the criteria for case management in the psychiatric service[2].
- The combined effect of the above is improved connectedness with cultural awareness and understanding, client preferences[3], stigma reduction and improved teamwork and collaboration across disciplines.

Additional Recommendation 3: That managers build and model effective communication practices between stakeholder agencies and formal policy for resolving interagency conflict is agreed upon with the aim of avoiding deadlock, improving trust networks, ensuring fairness and equity of points of view with regard to individual roles and responsibilities.

Rationale: The Palmer Report calls for collaboration between State Health Services, DIMIA, GSL and its contractors. Service provision can be hindered due to a fundamental clash of beliefs surrounding assessment, treatment and care for people inside IDF. The IDF is not a treatment or therapeutic environment and has been known to be injurious to mental health making breakdown of communication and deadlock between people and organisations a very real possibility. The solution to these problems is a commitment by managers – codified in formal policy – to deal with escalated conflict directly with their counterparts.

It is acknowledged that a formal policy and process may seem cumbersome, especially when the issue (eg client admission to hospital) is time-sensitive. But resolving the problem early on is ultimately more desirable in a health service where many issues have significant implications for numerous parts of the service. Unilateral responses to unilateral escalations of conflict are a recipe for inefficiency, ill feeling and a sense of "we'll win next time", taking hold, making future conflict even more difficult to resolve[4].

When people collaborate more freely they are more likely to trust each other. When people trust their organisations, they are more likely to give of themselves now in anticipation of future change and reward

Outcome Indicators:

- Conflict is resolved constructively and efficiently – and in ways that promote interagency collaboration and models desired behaviours.
- Commitment to resolve conflict and prevent deadlock is embedded in formal policy.

2 Deans, C. (2005) Caring for clients with dual diagnosis in rural communities in Australia: the experience of mental health professionals, *Journal of Psychiatric & Mental Health Nursing* 12 (3), 268-274

3 Tinerri, M.E., Bogardus, S.T., Agostini, J.V. (2004) Potential pitfalls of disease-specific guidelines for clients with multiple conditions, *New England Journal of Medicine*, 351 (27), 2870-2874.

4 Weiss, J. and Hughes, J. (2005) Want collaboration? Accept-and actively manage-conflict. *Harvard Business Review*, March, pp. 92-101

- Conflict resolution reduces individual and organisational ambiguity, and increases transparency and efficiency of mental healthcare.
- New lines of communication and professional relationships facilitate timely access to appropriate resources and supports.
- There is a decrease in the number of problems that are pushed up the management chain.

People released from Immigration Detention into the Community

Non-government, volunteer and community health organisations have performed a key role in providing support services for refugees and asylum seekers with mental health problems and mental illness, in advocating for services to be more responsive and in providing important trust networks to overcome specific access challenges due to cultural, linguistic and geographical barriers. This however cannot be sustained over an indefinite period and on the ground support and leadership in a systematic and coherent way is required without delay.

Action without delay requires an **adequate level of resources**, essential support, education and clinical consultation as an adjunct to mainstream community and mental health services. This will enable the energies of local employees and organisation imperatives to be pooled for mutual advantage. In rural and regional centres this will involve continuity across the geography of the region, course of individual suffering and distress recognising that asylum seekers will have different needs at different points of time.

A dedicated mental health promotion and building resilience program should involve an integrated community health, specialist mental health system with appropriate inpatient-community, NGO and volunteer group linkages. It should involve linkages between the specialist mental health service sector and primary care, between the mental health sector and the wider health system, and strong relationships with systems outside the health sector that provide social support and employment for this population group. More than this it requires appropriate and timely information transfer, with careful consideration being given to privacy principals.

Continuity of care for refugees and asylum seekers living in the community is not necessarily synonymous with continuous care, and may sometimes be episodic, involving good exit planning and contingency arrangements.
If a dedicated mental health program is initiated it should be designed to address two key barriers to understanding:

1. Fear and stigma of seeking help outside their own community lest their emotional problems label them “of unsound mind” and they place at risk any outstanding Government decisions about their future.
2. Fear a loss of control, such as being involuntarily hospitalised for mental illness.

Additional Recommendation 4: That a dedicated team should orientate their psychiatric assessment and therapeutic endeavours toward a mutually interpretable explanation for the clients presenting problems, including

- Implementing evidence based interventions such as psychosocial (broadly defined) supports and medication to reduce symptoms[5];

5 Clinicians should seek to identify and address the causes of an individual’s distress, allowing that causes may be biological, psychological and/or social (see G. Parker, Depressions black and blue: changing the Zeitgeist. Medical Journal of Australia 2003; 179 (7): 335-336.

- Supporting and encouraging specialist mental health services and general practitioners to initiate and participate in education and guidance of people with regard to their drug therapy, in order to promote a sense of partnership towards adherence and the achievement of therapeutic outcomes;
- Helping to reduce, or remove the need for drug therapy – particularly in children;
- Supporting and encouraging specialist mental health services, primary care services and general health services to respond to risk and protective factors and to early warning signs and symptoms in their regional settings. (This will need to be done in collaboration with non-health services [volunteer groups] that provide a strong support and friendship network to people across the lifespan).

Action Required for Palmer Recommendation 6.13 Education and Professional Development

Additional Recommendation 5: That senior management review its relationships with tertiary educational institutions, clinical schools, to encourage the establishment of education and training for mental health and non-mental health staff.

Rationale: The recognition, assessment and management of clients with mental illness across the care continuum requires specific skills which can best be acquired by coupling in-situ exposure with academic learning. Practical education in the recognition, assessment and management of people with mental illness, assessment of risk and protective factors enables timely interventions to be targeted. Education should cover mental health and risk assessment, rapid tranquillisation and physical restraint guidelines for use in clients with disturbed or violent behaviour.

It is recommended that all non-mental health staff who might have to manage clients with disturbed or violent behaviour should receive ongoing competency training to recognise anger, potential aggression, antecedents, and risk factors of disturbed and violent behaviour and to monitor their own verbal and non-verbal behaviour.

This training should include methods of anticipating, calming, de-escalating, or coping with disturbed or violent behaviour.

Additional Recommendation 6: That in conjunction with the Australian Mental Health Consumer Network, relevant State and Territory Departments of Health (Mental Health) and Drug and Alcohol Services, Regional Division of General Practice, Australian and New Zealand College of Psychiatrists, Australian and New Zealand College of Mental Health Nurses, specific training regarding the assessment, recognition and management of suicidal clients should be provided to all relevant staff.

Rationale: Increased efforts are being made nationally on reducing the tragic incidence of self harm and attempted suicide. IDF staff will, for many reasons, be central to any coordinated strategy for reducing incidence, particularly as a key predictor of eventual suicide is a history of depression and a previous suicide attempt[6]. These clients are frequently seen in IDF infirmary, and it is hoped that opportune intervention at this point may

6 Beautrais, A.L. (2005) National strategies for the reduction and prevention of suicide. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 26 (1):1-3

prevent some suicide attempts. To this end training specifically aimed at recognising, assessing and managing clients with suicidal ideation is needed.

Outcome Indicators:

- DIMIA establishes a program of education and training for all staff across the continuum.
- A whole of sector interdisciplinary approach to educational resources is developed to help minimise duplication of effort.
- There is easy dissemination of innovative and effective educational programs.
- Non-mental health staff report feeling more confident to manage clients with depressed, withdrawn, disturbed or violent behaviour, are able to better recognise anger, potential aggression, antecedents, and risk factors of depression, disturbed and violent behaviour and monitor their own verbal and non-verbal behaviour.
- Staff are able to more readily recognise, assess and managing clients with suicidal ideation.

Selected References

Procter, N.G. (2005) “They first killed his heart (then) he took his own life”, part 1: Review of context and literature on mental health issues for refugees and asylum seekers. *International Journal of Nursing Practice*, (in press)

Procter, N.G. (2005) “They first killed his heart (then) he took his own life”, part 2: Practice implications. *International Journal of Nursing Practice,* (in press)

Procter, N.G. (2005) A call for deeper scrutiny of mental health care for people in immigration detention centres [Guest Editorial] *International Journal of Mental Health Nursing* 14(2): 70-71

Procter, N.G. (2005) Providing emergency mental health care to asylum seekers at a time when claims for permanent protection have been rejected. *International Journal of Mental Health Nursing,* 14(1): 2-6

Procter, N.G. (2005) Emergency mental health nursing for self harming refugees and asylum seekers. *International Journal of Mental Health Nursing*, 14(3): 205-210

Procter, N.G. (2004) The mental health of moving asylum seekers from ‘temporary’ to ‘permanent’ protection visas: It’s much more than a quick political fix [Guest Editorial] *Contemporary Nurse* 17(3): 179-182

Procter, N.G. (2004) Re-traumatisation, fear and suicidal thinking: a case study of 'boatpeople' to Australia. *Migration Letters: An International Journal of Migration,* 1(1): 42-49.

Procter, N.G. (2004) Support for Temporary Protection Visa holders: Partnering individual mental health support and migration law consultation. *Psychiatry, Psychology and Law,* 11(1): 110-112.