EASTERN AND CENTRAL AFRICA COMMUNITIES OF VICTORIA INC.

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To Committee Secretary
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
Canberra Act 2600
Australia
Email: mental.health@aph.gov.au

Dear Sir/Madam,

Subject: **Eastern and Central Africa Communities of Victoria Inc, (EACACOV) Submissions to Senate Select Committee on Mental Health May 2005**

Organisation Background

The Eastern and Central Africa Communities of Victoria Inc. (EACACOV) is a state-wide emerging and inclusive organisation that aims to bring together African-Australians in Victoria, who mainly traces their genealogy from various African countries and those who feel connected to Africa. One of the main objectives of coming together is to address issues that impact on their settlement in Australia.

EACACOV manages the *"African Holistic Settlement Service in Victoria"* on behalf of the Department of Immigration, Multicultural and Indigenous Affairs (DIMIA), under the Community Settlement Services Scheme (CSSS). This service was established in 2001 to provide holistic and culturally appropriate sensitive settlement services to all African-Australians who require an alternative option to mainstream, ethno-specific or local services, with an emphasis on assisting families and youth, refugee and humanitarian entrants, as well as individual men and women.

Sub-Saharan Africa: Pre-Migration and Health Issues

The recent history of Africa has seen war, famine and political upheavals. This has led to a high influx of refugees and migrants from this part of the world. Australia like many other countries has become a recipient in recent years of a number of refugees, many of who have experienced torture and trauma. They have left their countries because they have been in direct danger due to political, racial or religious persecution. In many cases they have been tortured and have witnessed the horrors of war, repression and have spent many years in refugee camps.

Settlement experiences in Australia—multiple health issues

There are a substantial number of people within the African communities who in the process of flight, asylum seeking in other countries and arrival in Australia as refugees, experience profound emotional, mental and physical distress and severe disruptions to their family relationships, schooling; work employment, loss of status, roles and local communities.

Pre-migration experiences together with grief and loss can have serious effects on the Africans and their families, often resulting in family break down, domestic violence, isolation, and mental health problems, especially if culturally appropriate support is not provided. Torture and trauma have a profound, immediate and long-term impact on their physical and psychological health.

It is becoming apparent that many services including mental health services do not know how to cope with the complex needs of these new citizens.

In response to the Senate Select Committee on Mental Health inquiry points of the terms of reference item B, C, D, E, F, G, H, I, J we would like to bring the following concern to your attention.

B & H). The adequacy of various modes of care for people with mental illness in particular, prevention, early intervention/detection, acute care, community care, after hours crisis mental services are non existence in regards to African affected persons or African communities.

Prevention, detection and early intervention strategies

Service providers

- It is our experience as African, social and community support workers in the field that when we have clients who display psychotic disorders symptoms/behaviour or suffering from psychological disorders; mental disorder/illness, on a number of times we have contacted many mental health services providers and we have found that there are no strategies for prevention or early intervention.
- On a number of times we have been asked if the person is harming him/herself or others. If the answer in no, the person is not regarded as in need of either prevention or earlier intervention and there is no service to assist them.
- Most mental health services are more concerned of people, especially from culturally and linguistic diverse (CALD) background not accessing their services, of course at crisis point, but are not interested in prevention or early intervention and have no strategies in place.
- Cultural distances of the African groups from mainstream often results in inappropriate referrals and follow up.
- Mainstream service providers lack awareness about pre and post migration experiences, such as: torture and trauma, vast differences in cultural, religious and gender issues between countries of origin and Australia and their impact on family relationships and mental well-being.

African communities

- Due to fear of stigma and lack of knowledge of symptoms of mental illness, families keep people at home until crisis point.
- African communities lack information about preventative as well as treatment services
- Furthermore, little awareness within the African communities early symptoms which might result in serious mental health problems if left unaddressed as a result, clients access services only when they reach a crisis point and in most cases African clients are taken by police and are admitted as involuntary clients to mental health institutions or clinics

Acute care, community care and after hours crisis services.

- Acute care and community care are not accessible by the African clients as there are barriers. Community care is only on voluntarily basis from the communities which is unreliable. Some of our clients have ended up in custody, immigration detention centres, rooming houses (which are inappropriate) because there was no appropriate respite care, nor after hour's crisis services.
- For example, in January 2005, one of our clients with a mental disorder was locked up in Villa Wood Detention centre Sydney, because he had no identification or travel documents with him, he had not been taking his medication, he was confused and he had lost all his documents, plus his mobile phone. He was released from the detention centre and admitted to Banksia Mental Health Hospital/Psychiatrist Unit when an inmate from Sudan contacted EACACOV's workers on the client's behalf. The staff faxed a copy of his travel document which was on his client file to the case worker/officer. For further details (**see case study bellow).**

(D) The appropriate role of the private and non-government sectors is not appropriately responding to the needs of our clients.

Barriers to services

- Through ECACOV's African Holistic Settlement Service Victoria, it is evident that African families and individuals do not adequately access mainstream services which could assist them. The different culture of assistance within the Australian community and the absence of a welfare state in most African countries leads to a lack of understanding by Africans new to this country of the services and institutions that can be utilised and their possible benefits.
- A service such as The Victoria Foundation for Survivors of Torture (VFST) has long waiting list/period, before one can access services. Furthermore, Africans do not consider their services/counselling to be appropriate to their needs.

Communication – interpreters

- Unlike other ethnic groups with a large representation in Australia, it is often difficult to find interpreters who speak the appropriate language or dialect to assist them to access services. Most mental health organisations or community health centre, except some in large cities, are not equipped to deal with refugees with limited English/communications skills.
- Also, in some cases there are no English words that mean the same as what is being said in the customer's language.
- Bilingual mental health or social workers are in short supply. Community members who have been in Australia for longer periods are under enormous pressure to provide support and face high levels of responsibility with limited resources.
- Taken together, these factors act as a barrier between the Africans refugees, new migrants and the mental health system.

(E) The extent to which unmet need in supported accommodation, employment, family and social support services is a barrier to better mental health outcomes.

Supported accommodation

- There is no strategy for supported accommodation for people of CALD background, especially people from African background clients with mental health illness. The services providers fear to accommodate the mentally ill person on the ground that he/she will damage the property or harm him/her, knowing that the ill person will not have a support worker or family support.
- There are also shortages of hospital beds which results in early discharge before clients are well and homeless. When people are discharged before they are well because of shortages of hospital beds, sometimes they are forced to be transferred/moved to different regions, were sometimes rooming houses or lodge accommodation is available. Rooming houses accommodation is seen by African as culturally inappropriate, not suitable for Africans with mental disorders.
- Furthermore, lack of respite care and supported accommodation results in clients being sent to live in different regions, removed from their social support networks and familiar workers, case managers and this adds to their anxiety.
- Due to this overall lack of resources, friends and families who may not be coping well themselves, are forced to provide accommodation and support.

Social support services.

- Services which are available, such as support groups, are not accessed by Africans because they are not considered to be culturally appropriate or acceptable, and are conducted in English.

Employment and underemployment

- Levels of unemployment are high for African communities and many are underemployed, undertaking menial work despite most people having tertiary qualifications and overseas skills. The need to feel productive, contribute to the family functioning and to be an active member of society is particularly strong for some people and has the potential to affect their mental health significantly if are unproductive or unemployed..
- Barriers to employment include: lack of networks, lack of Australian work experience, lack of recognition of overseas work experience, qualification and some people have English language communication problems.
- There is a need to recognise the importance of practical issues such as employment, environmental factors, social and economic circumstances, family and other relationships issues for these people, and also work towards addressing these needs that, left undressed, can lead to further metal health problems

Homelessness:

- It is common for people to become homeless when they are not well and on many occasions people in the community and African welfare workers get pressured in finding and are expected to provide accommodation and to care for these clients who are not well. For example:
  - > *In March 2005 EACACOV was requested to find accommodation for an African client who was homeless and who appeared leady be discharged from a Psychiatric Hospital in the Southern Eastern Region of Melbourne. The Hospital social workers put a lot of pressure to EACACOV staff and African communities' members to find/provide accommodation for a client from Ethiopia who needed to be discharged from Dandenong Psychiatric hospital. They were going to discharge him into a lodge/rooming houses accommodation, because he was occupying a bed while there was hospital bed shortages.*
  - > *With the assistance of DIMIA consultant we contacted the Victoria Chief Psychiatrist Office – Ms Mitchell-Dawson, phone 9616-7662 who intervene and our client was allowed to stay in the hospital until we found him accommodation in Ascot Vale through the Victorian Office Public Housing.* ***(See case study bellow)***
- Services like Richmond Fellowship - Psychosocial Rehabilitation services, Adobe, Melbourne City Mission Disability Services and may others disability accommodation services do not provide crisis accommodation.
- Furthermore, these places have assessment procedures/requirements and clients have to fit in their assessment requirements and if the person does not communicate well in English, this is an added barrier.

(E) The special needs Groups such as children, adolescents, the aged, Indigenous Australian, the socially and geographically isolated and people with complex and co-morbid conditions, drug and alcohol dependence,

Special needs groups

- The African communities in Australia falls under the special needs group of culturally and linguistic diverse background (CALD) though this group was omitted in the Senate Select Committee on Mental Health inquiry points in the terms of reference (f).

  African-Australians in Victoria reveal an extraordinary diversity of ethnic groups, languages, cultures, socio-economic, educational, rural or urban and colonial backgrounds.
- The special needs groups mentioned included, children, adolescents, the aged, Indigenous Australian, the socially and geographically isolated and people with complex and co-morbid conditions, drug and alcohol dependence, the people from CALD background are not even mentioned or considered for special needs by the Senate Select Committee on Mental Health inquiry points of the terms of reference (f).

- People from Africa being small, emerging groups/communities and only recently settled, are often unorganised and unable to offer much support to members. Therefore, for most Africans settlement experience differs from that of other immigrants to Australia. A complex immigration and welfare system, together with a lack of English and access to resources, exacerbates the situation.
- Insufficient knowledge and understanding amongst the mental health sector of culturally acceptable methods of diagnosis and treatment, resulting in, lack of alternative treatment, social rehabilitation options other than medication.
- Lack of attention paid to the underlying causes and the following environmental factors influencing the person's metal state: personal, social and economic circumstances, family and other relationships, and the physical and organizational environment of new and recently arrived Africans.
- Main stream service providers lack resources and time to attend to the special needs of recently arrived groups.
- Practitioners may not have time to establish trust and rapport, and may make a hasty diagnosis that does not take into account the clients previous experiences, history and cultural background.

(G) The role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness.

Mental health problem/illness — stigma, carers, diagnosis and treatments

- Carers' lack knowledge and skills to recognition early symptoms of mental illness.
- The issues most common among the target group include: depression, psychosis, schizophrenia, family relationship problems, antisocial behaviour and suicidal gestures, acting out, pain which might be due to physical muscles or bones damage or psychological factors.
- The majority go to the hospital or are taken by police at crisis point. No access to the services beforehand, by the time they are brought to service, they are very sick and sometimes family relationship has broken down or very exhausted.
- Carers lack information about existing support services and networks, such as how to access carer's allowance and social support. The African carers have no resources and specialised skills required to be able to care adequately for people with specific health needs.
- There is a need for training of GPs around mental health issues, especially with new arrived refugees.
- GPs needs constant training around mental health issues, identification of mental illness symptoms, medication and resources, as they are the first point of contact for *most clients.*
- There is a lack of preventive services which address the needs of families or traditional therapeutic treatments — for example, using herbs, massage therapy, hair plaiting and other non-chemical medications

Brief Client Case Study

By way of illustration the case of Eden is typical ((because of confidentiality is protected by change of name and some alterations to the case). However, if further information is required could be supplied with the consent of the client.

Pre-migration Experience

Eden is a single man, 25 years of age. He came to Australia as a refugee through the refugee and humanitarian program, on visa class 200 and he arrived in Australia in April 2004.

He has neither family nor relatives in Australia. His English skills both oral and written are limited. Eden's father died when he was 2-3 years old.

Eden was born in Eritrea, but grew up in Ethiopia with his mother and sister. When Eritrea got independent from Ethiopia, Eden and many other young men and women who were in Ethiopia were captured, tortured and were deported back to Eritrea. He letter managed to escape from Eritrea to Sudan where he lived as a refugee. He escaped persecution in Ethiopia and Eritrea he has been tortured and experienced severe hardships and traumas for many years prior to coming to Australia.

Post- migration and settlement experience in Australia – health issues.

When Eden arrived in Australia he was accommodated in the flats managed on behalf of the Department of Immigration, Multicultural and Indigenous Affairs (DIMIA)'s, sharing with another young man from Eritrea who also came to Australia at the same time as a refugee. This man spoke the same language/dialect (Tigrinya) as Eden.

In June 2004 Eden moved into private rental accommodation by himself. Eden started displaying symptoms of not coping – not being well

Eden was referred by friends to the Eastern and Central Africa Communities of Victoria, settlement services and fortunately one of the EACACOV's social workers could speak Eden's language, Tigrinya and that worker became the core worker for Eden.
He become very agitated at times, complained of headaches, became very forgetful etc. He was not safe living by himself. He needed social support. Eden was attending AMES English classes, but he was not able to follow it. The worker became concerned and worried about Eden's well-being.

He needed an institution/carer, to care for him. He needed help/medical, psychological, general support, physical and social support

Action

- EACACOV worker convinced Eden to see a doctor (psychiatrists).
- Eden was diagnosed as suffering from **c**linical depression – post traumatic stress disorders. The depression was as results of conflicts from when he was living in Ethiopia/Eritrea
- He was prescribed Medication to calm him down.
- Contacted , psychologists/councillor at The Foundation House – The Victorian Foundation for Survivors of Torture (VFST)
- The worker rung Eden regularly to remind him to take his medication
- The worker sometimes visited him at home – outreach services and some times the worker picked him up and took him to appointments

Eden Denial and Psychotic behaviour

Eden believed that there was nothing wrong with him and the medication was the one, which was making him sick. He refused to attend medical appointments and to take his medication.

He did not want to talk to the EACACOV worker as he believed that the worker wanted to put him into psychiatric hospital with sick people.

In December 2004 Eden informed the worker that he wanted to go to visit friends at Gold Cost.
The EACACOV worker made arrangements for him to go to the Gold Cost. The worker contacted his friends to organise accommodation for him and to meet him at the bus terminal.

On 9 January 2005, the EACACOV worker was contacted by a psychologist at Gold Cost Emergency Hospital. Eden had been brought in by an ambulance unconscious. He was not eating and he did not

want to return to Melbourne as he believed he will be put in hospital, with mad people. Eden was discharged from hospital to come back to Melbourne.

Eden at Villa Wood detention Centre Sydney

On 14 January 2005 Eden was locked up in Villa Wood Detention centre Sydney, because he had no identification or travel documents with him; he had lost every thing including his mobile phone and contacts. He had not taken his medication for days and he was confused. He was released and admitted to Banksia Mental Health Hospital/Psychiatrist Unit when an inmate from Sudan contacted EACACOV's workers on Eden's behalf. The worker talked to a case worker officer at the detention centre, who requested the worker to fax to the detention Centre, Eden's identification papers/documents. The staff faxed a copy of his travel document which was on his file, to the case officer. He was released from the Detention Centre and was admitted at Banksia Mental Health Hospital, Sydney.

When Eden got better the Hospital contacted the EACACOV worker, to organise accommodation for Eden in the Western Region of Melbourne, Footscray or Ascot Vale, as there are many people from Ethiopia and the Ethiopian Orthodox Church, which he thought would provide him with social support. The EACACOV staff did not hear from him until a social worker from Dandenong Psychiatric Hospital, contacted EACACOV staff in March 2005 requesting staff to find Eden accommodation as he was due to be discharged from hospital.

Eden in Dandenong Hospital, homeless and no identification.

In March 2005 EACACOV staff received telephone calls from the VFST psychologists and the Social worker from Dandenong Psychiatric Hospital, requesting EACACOV staff to assist with providing accommodation to Eden's as he was homeless and he was due to be discharged from hospital. ECACOV staff contacted youth housing, crisis Centres, personal support services, disability supported accommodation and many mental health support services but in vain. Most of the services do not provide crisis or accommodation. Eg, Abode, Macaulay Program etc. The only avenue left was rooming housing or lodge accommodation which was inappropriate for Eden health needs.

The Hospital social workers put a lot of pressure to EACACOV staff and African communities' members to find/provide accommodation for Eden. They were going to discharge him into lodge or rooming accommodation, because he was occupying a bed while there was hospital bed shortages.

Eden needed supported accommodation, with intensive care, EACACOV and the African community in general has no resources and the specialised skills to care for his health needs.

With the assistance of DIMIA consultant we contacted the **Victoria Chief Psychiatrist Office – Ms Mitchell Dawson,** who intervened and Eden was allowed to remain in the Hospital until we found him accommodation in Ascot Vale through the Victorian Office of Public Housing.

Eden discharged from hospital

At the end of April 2005 Eden was discharged from the psychiatric hospital and moved into a Ministry of Housing property in Ascot Vale. EACACOV through its African Holistic Settlement Services continues to provide Eden with practical hands on support, counselling and referral to other services when required.

It is hard to imagine what would have happened to Eden, if he did not have EACACOV practical support /advocacy and if the Victorian Chief Psychiatrist did not advocate on his behalf.

CONCLUSION:

Involuntary admissions

- Little awareness exists within communities about early symptoms that might result in serious mental health problems if left unaddressed. As a result, client's access services only when they reach a crisis point and in most cases are admitted as involuntary clients to mental health institutions or clinics.

- There is very limited supported accommodation for people with mental illness especially people from culturally and linguistically diverse background (CALD) and the assessment procedures acts as a barrier to assessing services
- Preventative programs/services are non existence
- Existing mental health services are only concerned, that people from African communities or CALD background do not access their services. However, the services available are not appropriate for their needs and are not accessible.

Recommendations

Immigration and detention centres

- People from cultural and linguistic diverse back ground should not be put in detention or deported without different media publicity and consultation with CALD community groups and ethno-specific organaisation.
- People from culturally and linguistic diverse communities need appropriate education awareness raising about mental health illness and the service system.
- Organisatios like EACACOV with knowledge of CALD community's/backgrounds be funded to provide support services in terms of supported accommodation and family, social support as this would enhance better mental health outcomes.
- Work with the African leaders/communities and health professionals to develop fact sheets in simple English with information such as what is depression, how to identify mental disorders symptoms and for health workers to explain the African refugees experience of depression and suggestions for culturally competent communication.

Training of communities organisation

- There is a need to engage community leaders and provide them with training and resources in order to work as facilitators within their communities. Community leaders need access to ongoing training in mental health issues, diagnosis and response. We need our own solutions.
- Similarly, mental health workers need to develop skills for understanding and working with community networks in responding to people with coping difficulties. Training is needed in the development of shared understandings and common definitions in relation to mental health.
- Communities need assistance in gaining access to resources in order to help themselves, e.g., to run workshops on stress management. There is also a need to train African counsellors, social workers and mediators (some from each of the ethnic groups).

Community needs

- There is a need to increase community awareness, to promote education and to de-stigmatise mental illness.
- To promote acceptance of mentally ill people within the community and ensure their access to mainstream services.
- There is a need to encourage the development of communal support within the Australian context: this may mean organising community elders in a paid form to provide substitute services (for example, for older women to stay with young mothers when they have just given birth; such assistance from African women could reduce trauma, stress and postnatal depression).
- The community could also employ healers to conduct traditional rituals, perhaps incorporating this process into Australian community services and the medical system.

Language and information

- While the provision of appropriate translations is essential for the provision of information, disseminating that information must be carried out in several media forms in order to access and engage

the communities. Providing written information is not always the most effective way of reaching people, as literacy skills vary.

Continuing programs

- Specific programs need to be designed to meet the needs of Africans; in particular the mental health needs of the elderly, single women and young people. In addition, continuous programs on the effects and management of stress are needed for men and, more importantly, for women.
- Inter-generational consultation forums for both children and parents are also needed. Preventive measures increase patients' chances of being well and can be very effective in decreasing the severity of illness.

Develop a responsive/flexible approach to service delivery and case management

- A range of strategies to simplify and streamline service delivery should be promoted. These can include facilitating joint case planning; simplifying referral pathways; promoting active cooperation via co-locating or 'out-posting' services; working in collaboration with African community leaders and social welfare workers.

  Develop common assessment processes and streamlining financial and other reporting requirements for funding programs to assist African/ethno specific organisation accessing and managing funds.
- There is a need to develop a policy framework that integrates prevention, early intervention, crisis management and long-term support with housing, independent living, and clinical and community support, thereby reducing the chances of clients getting 'lost' in the system. There should also be greater provision for one-to-one support and referral and a broad conception of health, including mental, physical, and social aspects.
- There must be greater flexibility within bureaucratic procedures. The current emphasis on making the person 'fit' the system should be replaced with flexible approach, an 'outreach' model of health care should be considered.
- Western health practices and beliefs should be balanced against the health practices and beliefs of other cultures, absorbing and using different techniques where appropriate.
- We should also consider alternative strategies in casework: for example, group work and other therapeutic methods, and natural medicine.
- Collect and make accessible information for carer s about mental illness, care and treatment options and additional services which may be of use.

  Furthermore, develop and run educational sessions for carers on ways to manage their caring role and provide information on agencies, if available which provide such programs.
- When considering the needs of carers, it is important to be aware and to acknowledge that many carers, especially women with mental problems will themselves be caring for children, older relatives, disabled family members or for another person with a serious mental illness.

  Therefore, carers in this situation will have similar needs to other carers, and the strategies outlined above will be relevant.

Promote community-based support services

- Policy change is needed to address major structural issues. More resources for services, particularly for clients with multiple issues, are required. The issues of housing, employment, education, and family separation must be addressed.
- There needs to be increased opportunities for social support, particularly for women with children and single men. Provide meeting places for recreation and discussion, such as African drop-in centres, coffee shops, youth clubs and centres and Internet cafes.

- There should also be greater provision for group work activities based on peer support models in recreational programs.

Develop cultural competence

- There is a continuing need to develop cultural awareness regarding pre-migration and post-migration experiences and culturally appropriate methods of diagnosis and treatment, as well as developing skills in working with culturally and linguistically diverse clients in a respectful and appropriate ways.

  Cross-cultural training, information provision by African professionals or CALD groups should be made available to service providers so that they are more aware of the issues and needs of the communities and can work from a model of cultural sensitivity. Such training needs to be regularly updated.

  The key to effective and appropriate service provision is working together through collaboration between services and the communities.

Improve communication methods

- In order to ensure improved communications clients should be treated in a welcoming and dignified manner and their informed consent obtained at an early stage. Counsellors should advocate for increased funding in order to ensure an adequate budget for interpreters and support workers. There should also be an increased recruitment of bi-cultural workers. Skills to work effectively with interpreters should be developed for all mental health workers.
- There is a need to employ multiple methods, for example, having community information available at places which people visit regularly, such as: Centrelink, the Adult Migrants English Service (AMES), ethnic shops and doctors' offices.

Use local resources, knowledge and skills

- Traditional support within communities can take the form of visits, buying presents, talking, or just spending time together having traditional coffee. The use of natural traditional therapies (such as henna painting, hair plaiting, herbal medicine, massage, or reading the Koran) can be extremely helpful.
- There is a need for increased resources and information, such as a directory of Africans working in the welfare industry, especially doctors, nurses, social workers, priests, Imams and anyone who has experience of working with Africans. There is a need for a list of other treatments besides medication (for example, traditional healing). A list of mosques and churches could be provided.

Research is needed which focuses on:

- Identifying those interventions which improve the accessibility and relevance of services.
- Enhancing the process of recovery for people from CALD backgrounds
- Mental health clinical services and disability support services could develop collaborative relationships with local African community groups and mainstream health services, to identify areas for investigation.

Should you require further information, please do not hesitate to contact me on (03) 9510-0167

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