Supplementary Submission from the Forum of Australian Services for Survivors of Torture and Trauma to the Senate Select Committee into Mental Health

5 July 2005

Contents

1. Introduction

The fact that most refugees have survived horrific experiences, yet re-establish their lives in Australia is evidence of their enormous survival strengths. Nevertheless, they suffer a higher incidence of certain physical and mental health problems than migrants and people born in Australia arising from negative influences on their health before, during and following their forced movement. They are less likely than other migrants to have family and community support in Australia to assist them in accessing mental health care and related services; generally have lower levels of literacy in their first language and are less proficient in English; and face greater challenges in finding housing and employment. Although FASSTT agencies provide training for health and community service professionals, Australian health care providers are not routinely trained to identify and deal with issues of particular concern to refugees.

1.1 Key recommendations:

1.1.1 Provide additional resources for specialist mental health interventions for psychological and social effects of torture and trauma

1.1.2 Extend early intervention programs in mental health, especially for children and adolescents

1.1.3 Improve access to and the responsiveness of mental health systems to refugee torture and trauma survivors

1.1.4 Build the capacity of schools to be mental health promotion settings for young refugees

1.1.5 Build the capacity of refugee communities to enable recovery from torture and trauma and improve resettlement

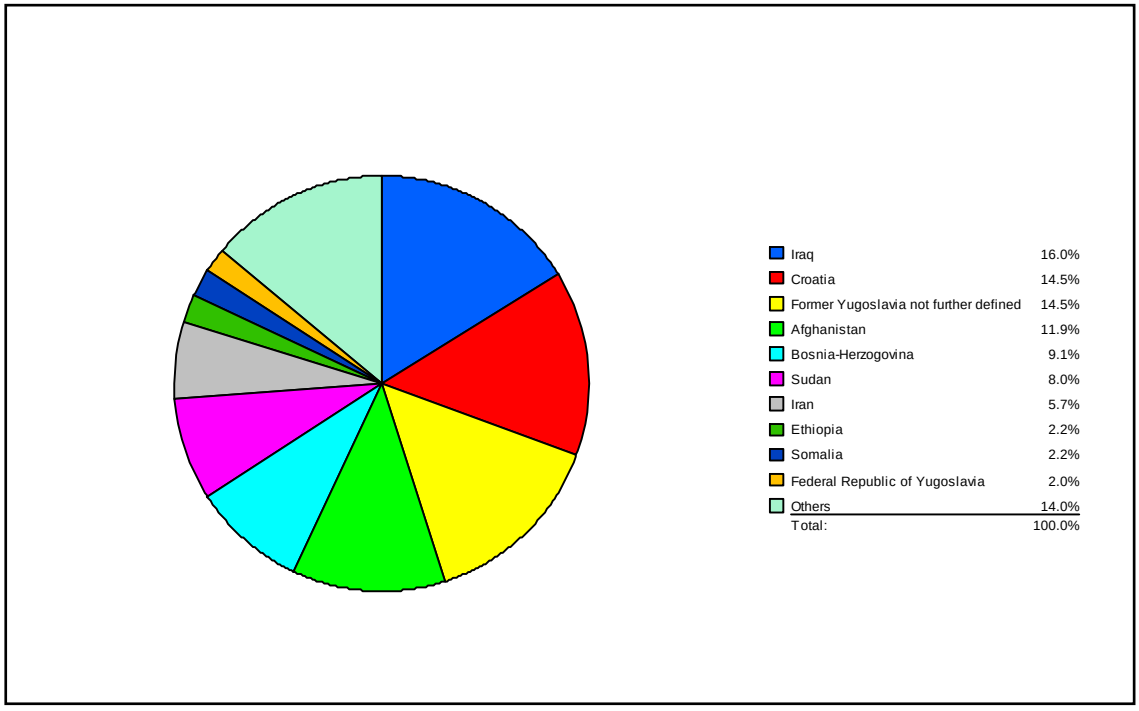
2. Refugee Demographic Profile

More than 620,000 refugees and displaced people have settled in Australia during the last 50 years. An estimated five per cent of the Australian population - a million people - have had direct experience of the refugee situation, as refugees themselves or as a result of having refugee parents (Jupp 2002 181).

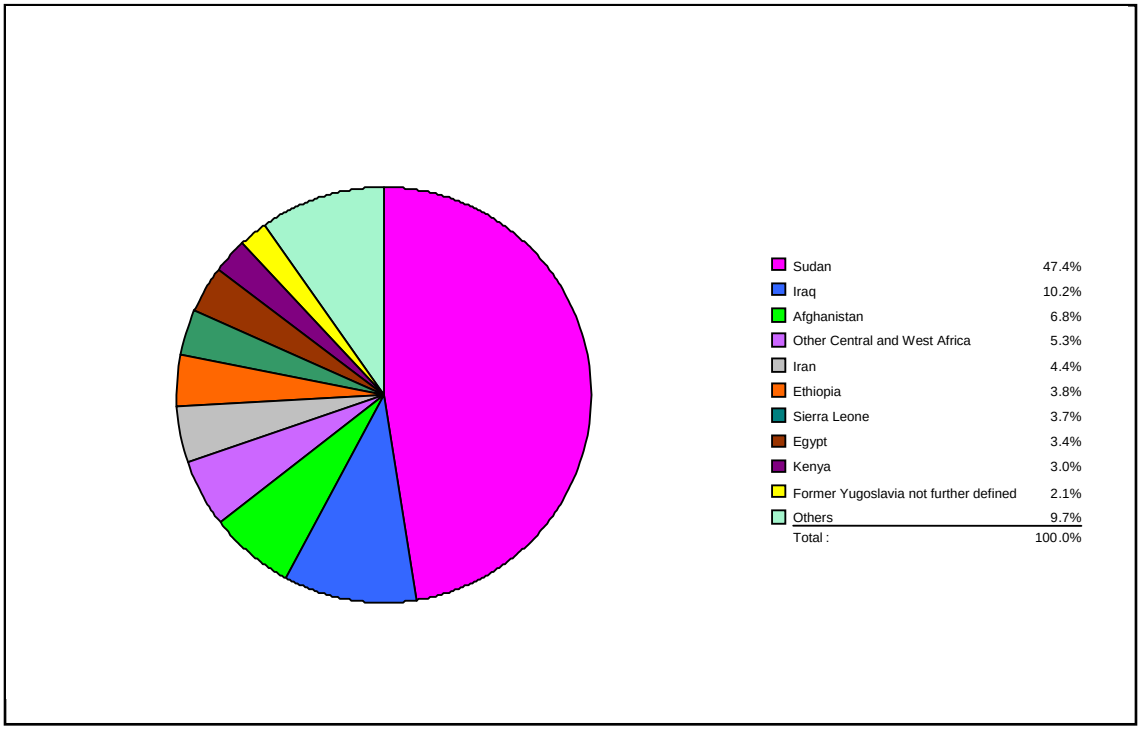
The national origins of people entering under the Humanitarian Program have changed significantly over the last five years. In 2000, nearly 50 per cent of people entering under the offshore resettlement program were from Europe, 23 % were from the Middle East and South West Asia and 16% from Africa. In 2004, 68% came from Africa, 21% were from the Middle East and South West Asia and less than 10% were from Europe (see Figure 1).

In 2004-05 the Humanitarian Program has been set at 13,000 new places. Of these, 6,000 places are allocated to refugees (a 50% increase on previous years), and 7000 places are allocated to the Special Humanitarian Program and onshore protection. About 75 per cent of the offshore places are planned to come from Africa and about 20 per cent from the Middle East and South West Asia.

Figure 1: Changes in Humanitarian Program Countries of Origin



Humanitarian Program Intake Jan-Dec 2000



Humanitarian Program Intake Jan-Dec 2004

3. The refugee experience

Refugees flee the violence of war and direct persecution which takes many forms including torture, imprisonment and the denial of the right to express their religious and cultural identity by or with the complicity of the authorities. Many refugees spend considerable periods in countries of asylum where they are regarded as unwelcome and burdensome aliens (UNHCR 2002). The mental health effects of these experiences are often exacerbated by experiences after arrival in settlement countries. Table 1 below summarises common pre and post-arrival experiences that affect the mental health of refugees.

Table 1: Factors affecting refugee mental health

Experiences in countries of origin and asylum	Experiences in the settlement environment
• forced displacement • violence and human rights abuses • loss of and separation from family members, often in violent circumstances • deprivation of cultural and religious institutions and practices • periods of deprivation and poverty • lack of access to health care • constraints on access to education, employment, family and community support, and adequate income • detention centre experiences • prolonged uncertainty about the future	• absence of family members, home and community • lack of social and family support • guilt about family members remaining in difficult circumstances overseas • limited access to cultural and religious institutions and cultural communities • stress associated with learning a new language, adjusting to a new culture and dealing with the practical tasks of establishing life in a new country • unemployment and underemployment • poverty • insecure housing • lack of understanding, and in some cases, racist and xenophobic behaviour, in the wider community.

3.1 Torture and Trauma Experiences

Health assessments by VFST of people who entered Australia under the Humanitarian Program indicate that 8 in 10 have experienced psychological or physical abuse of some kind. Table 2 shows the percentage of adult clients who have experienced a range of torture and trauma experiences (VFST 2000). While this data is drawn from the VFST, the material is indicative of all torture and trauma agencies across Australia.

Table 2: Experience of Torture and Trauma

Experiences of torture and trauma – VFST adult clients (percentage frequencies)	
Direct physical violence e.g. beatings, electric shock, rape	67
Witnessing physical violence	83
Forced isolation	42
Harm/threat to family	84
Refugee camp	20
Internal displacement	48
Imprisonment	30

A NSW study of Humanitarian Program entrants found that 1 in 4 had been subject to torture or severe trauma (Iredale et al 1996). Similar patterns emerge in a number of studies conducted elsewhere in Australia and overseas (Papageorgiou et al 2000; Hondius et al 2000; Ward et al 2001).

3.2 Mental health problems - adult refugees

The psychological sequelae of torture and trauma associated with war and state-sanctioned violence have been extensively documented. The most commonly reported diagnosable disorders are post traumatic stress disorder (PTSD), major depressive disorders and anxiety disorders. Prevalence rates of these disorders vary considerably and depend on the particular population under study. For clinical samples, rates of PTSD are very high. For example, 65 per cent of Bosnian refugees attending a clinic in United States and 48 per cent of refugee patients attending a clinic in Oslo were assessed as experiencing PTSD (cited in Silove and Kinzie 2003). The rates are related both to the degree of exposure to traumatic events and settlement factors (Basoglu, Paker and Ozmen 1994; Mollica et al, 1997; Guarnaccia and Lopez 1998; Howard and Hodes 2000). Some factors such as poor socioeconomic status and family separation contribute to further mental health problems. Other factors such as social support moderate the effects of previous traumatic experiences (Hauff and Vaglum 1995; Gorst-Unsworth and Goldenberg 1998).

A focus on diagnostic disorders or symptomatic effects can obscure the far-reaching effects of torture and trauma on everyday functioning. Ability to carry out daily tasks and attend to basic needs can be seriously impaired in torture and

trauma survivors (Allden 2002). Learning ability which is crucial to adjustment in a new country is seriously disrupted by poor concentration, memory impairment and sleep disturbance (Allender 1998). Pain resulting from physical injuries and psychosomatic complaints such as headaches and gastrointestinal disturbances are also debilitating in everyday life.

Other effects are difficult to measure, but the loss of meaning and purpose to life and the shattering of assumptions central to human existence, such as trust, are enduring reactions, affecting the capacity to form relationships and adjust to life in a new country.

Long-term studies of survivors of torture and trauma who have suffered massive trauma show that mental health problems can persist at a severe level for many years (Kinzie, Boehnlein and Sack 1998).

The VFST undertook routine assessment of all those recognized as refugees under the UN Refugee Convention who arrived in Victoria during financial year 1997/1998. Over 40 per cent of entrants were assessed as suffering psychological problems which severely interfered with every day functioning and were unlikely to abate without specific assistance (VFST 1998).

The most commonly reported mental health effects of refugees are summarised in Table 3.

Table 3: Mental health effects of the refugee experience

Mental health effects	Key issues
• depression • anxiety • grief • guilt • somatic disorders • attachment and relationship difficulties • a loss of a sense of hope, meaning and purpose to life • loss of identity and a diminished sense of belonging • internalised mistrust and suspicion • post traumatic stress disorder symptoms • cultural adjustment and intergenerational issues	• mental health effects associated with exposure to traumatic experiences and other antecedents in the course of the refugee experience • may persist long after arrival in a safe country • can be exacerbated by stresses and lack of resources in the period of resettlement.

3.3 Gender

While displacement is difficult for all refugees, women are often the most seriously affected for a range of reasons, coupled with the fact that their needs are often likely to go unnoticed (Allotey 1998; Burnett and Peel 2001).

The Humanitarian Program includes the Woman at Risk visa for women identified by the UNHCR as being particularly vulnerable. There is a consensus internationally that women selected as part of the Woman at Risk program require more intensive physical and mental health care and social support (UNHCR 1998; 2002). Approximately 500 Woman at Risk visas are allocated each year.

Refugee women may have particular mental health and social support needs deriving from:

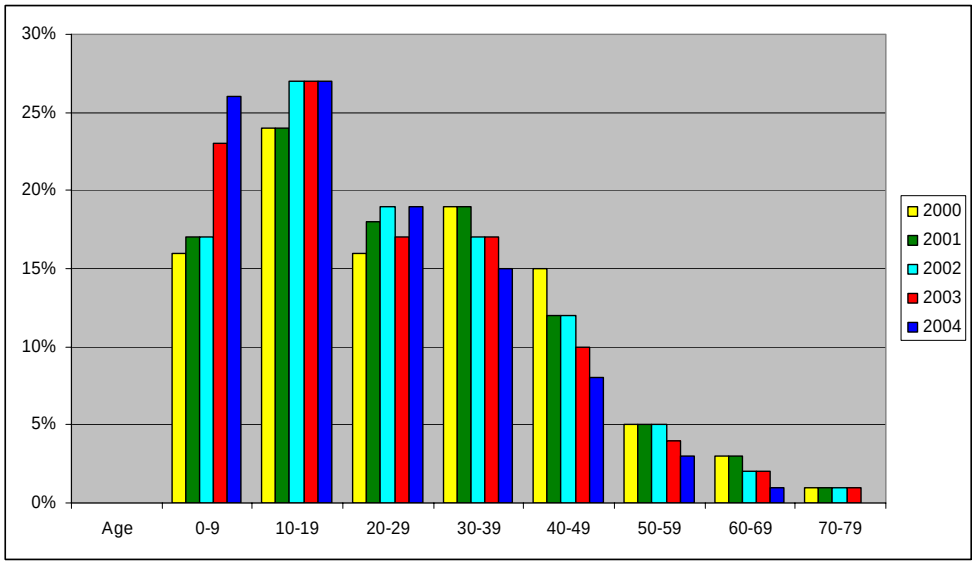
- previous experiences of physical and sexual assault and rape (Chung et al 2001)
- most take on roles they are unaccustomed to, including becoming the head of the household and taking responsibility for community cohesion (UNPF 2000; UNIFEM 2000)
- responsibility for large and extended families – female refugees from Sudan, Somalia, Ethiopia, Eritrea and Afghanistan who arrived in recent years have particularly large families, on average between four and seven, and up to 12 dependents
- vulnerability to social isolation after migration - this is particularly the case for women who have lost family members and/or are not in paid employment in Australia
- divorce and serial marriage may be common for families under stress, which leaves women with sole responsibility for children
- women may feel reluctant to voice their needs, especially in cultures where men are traditionally the spokespeople
- women are less likely than men to speak English
- women are more likely to report poor health and depression
- women from some cultural backgrounds are likely to have low levels of literacy and low health literacy in particular

Refugee men for whom identity may be integrally linked with their paid work, their roles as providers and their participation in civic society, may experience particular mental health difficulties adjusting to the loss of social status that often accompanies resettlement, especially if they are unemployed or unable to work in their former professions (Hermansson et al 2002).

3.4 Children and young people

The largest proportion of Humanitarian Program arrivals are now children and young people. The proportion of children and young people in the Humanitarian program has increased from 38% in the year 2000 to 53% in 2004. This increase has been particularly significant in the 0-9 age group, with 27% of the humanitarian program falling into this group in the year 2004 compared to 17% in the year 2000 (see Figure 2).

Figure 2: Age Groups in Humanitarian Program



The environment children and young people grow up in has a powerful impact on their mental health and wellbeing, the effects of which may persist into adulthood (Centre for Community and Child Health 2000; DHS 2001). In general, those who experience adverse circumstances or stresses (known as risk factors) are more vulnerable to developing physical and psychosocial difficulties (ibid).
The impact of risk factors is cumulative i.e. the more risk factors one is exposed to, the greater are one's chances of developing behavioural difficulties and other health and social problems (Carter 2000).

Generally speaking, children who have secure attachments to family and supportive relationships with other adults and whose families are harmonious and well connected with their community tend to fare better as adults than those without these resources (ibid 2000). Strong family and community support has been found to be especially important in times of change and transition.

The longer term health effects of disruptions to family functioning are illustrated by the experience of children of war veterans who had suffered exposure to combat related violence and conflict. Studies suggest that these children are vulnerable to the development of mental health problems persisting into adulthood (Harkness 1993).

At the same time, there is substantial evidence to suggest that there are 'protective factors' that can build children's and young people's resilience and reduce their

vulnerability. As is the case for risk factors, the more protective factors experienced by children and young people, the lower their risk of developing problems (ibid).

Among the protective factors which have been identified as associated with the mental wellbeing of children and young people generally are their sense of belonging, positive school climate, opportunities for success and recognition of achievement, school norms against violence and good physical health (CDH&AC 2000). These factors are also salient for the refugee population.

There is growing evidence to suggest that it is possible to reduce risk factors and build protective factors through interventions with individuals, families and communities (ibid; CDH&AC 2000). Some of these interventions, such as those aimed at the pre-school years, have a more significant influence on children and young people who are socially disadvantaged than is the case for their more affluent counterparts (Carter 2000 96).

It is on the basis of this evidence that Australian governments have developed an increasing interest in early intervention and prevention in early childhood and adolescence, placing particular emphasis on those most in need (Raphael 2000).

As a population, refugee children and adolescents are both at high risk of exposure to risk factors and have reduced access to factors that are known to protect and promote health. They have experienced multiple traumatic events including loss. Changes in family and community relationships resulting from dislocation and resettlement experiences further adversely affect children and young people by weakening the support available to them. Some children and young people are further exposed to specific risk factors such as family discord, parents who have serious health problems, unstable relationships with parents or carers and lack of peer support.

Of particular concern are young people who arrive as unattached refugee minors. While Australia no longer formally selects unaccompanied refugee minors for settlement through its Humanitarian Program, a small number arrive each year as asylum seekers. For example, 66 of the 1,320 Temporary Protection Visa holders who came to Victoria between July 2000 and March 2002 were unattached minors (VOMA 2002a). In addition, an increasing number of young people entering through the Humanitarian Program arrive with relatives to whom they are not necessarily closely attached. These family structures can be vulnerable to breakdown. A number of households are headed by young people themselves. Data on the number of such households is being currently sought.

Case example

Two Sudanese sisters were referred to VFST by an English Language Centre after a teacher noticed they had become very frightened after an ambulance had come to the school. Assessment at their home revealed that the sisters were part of a family of five, headed by their 20 year old sister as guardian. Their parents had died some years ago and they were waiting for the visa processing of their aunt who still lived in Sudan. In the course of assisting the sisters with settlement in school, they received news that their aunt had disappeared. The anxiety and grief caused by worry about their aunt and their young cousins left without their mother required intensive support, counselling and extensive advocacy with international agencies.

Overall, young people from immigrant communities are not over-represented in the prison and juvenile justice system. However, there is an over-representation of young people from some ethnic groups and some of these have substantial numbers from refugee backgrounds (Coventry et al; RRAC 2002; DHS 2000). The reasons for this are not fully understood, but may be due to a range of factors including social and economic marginalisation, policing practices, and young people's lack of familiarity with civil rights, responsibilities and laws in Australia.

Some of the risk factors to which refugee children and young people may be exposed occur prior to arrival and so are beyond the control of governments and service providers in Australia. However, as is the case with adults from refugee backgrounds, evidence suggests that the quality of the environment following arrival, particularly in the family and school, also has a significant influence on their overall mental health and settlement prospects (Athey and Ahearn 1991; Raundelen 1993; Dyregrov et al 2002; Gabarino and Kostelny 1993; Hjern et al 1998; Gorst, Unsworth and Goldberg 1998). Reducing exposure to adverse factors in the settlement environment can also help to reduce the cumulative impact of risk. This suggests that there is considerable potential to 'make a difference' by offering support and building protective factors early in the lives and settlement of refugee children and young people.

A recent report to the National Youth Affairs Research Scheme also notes that in contemporary policies refugee young people tend to be considered only as a sub-set of culturally and linguistically diverse communities. The report, *Wealth of All Nations: Identification of strategies to assist refugee young people in transition to independence* draws attention to the assumption implicit in humanitarian and settlement policy that young people's needs are best met by strengthening the capacity of their families to support them. Although this is a critical strategy, a consequence is that few interventions have been developed that focus directly on the needs of refugee young people themselves. Furthermore, given the often overwhelming nature of settlement concerns, parenting issues are often neglected by services providing settlement and other forms of psycho-social support to families.

The report assembled considerable evidence documenting that in some areas refugee young people had markedly lower rates of service utilization than was the

case for other young people (Coventry et al 2002). The access barriers facing adults from refugee backgrounds discussed previously in this submission are often compounded for young people by their lack of confidence in dealing with the adult world (VFST 1999).

FASSTT agencies have undertaken extensive work with refugee children and young people through schools. A significant issue emerging from this work is that refugee children and young people face barriers in qualifying for additional educational support which is generally dependent on children being diagnosed with an intellectual disability. Refugee children whose learning and behavioural difficulties relate to past deprivation and current settlement stresses often fail to qualify for this support, despite their obvious need.

3.5 Mental health for refugees who hold Temporary Protection Visas and community based asylum seekers

In addition to issues affecting the mental health and well being of people offered permanent settlement, the mental health of people who have been granted Temporary Protection Visas and of community based asylum seekers are affected by factors including:

- separation from family - neither group may apply to have family members join them in Australia. As well as limiting access to the protective effects of family support, anxiety and guilt about the fate of family members left behind is a common consequence of prolonged separation (Jaques and Abbott 1997)
- uncertainty about their future in Australia (VFST 2002b)
- stress associated with the refugee determination process, which for some applicants lasts a number of years (Asylum Seeker Project 2003; Silove et al 1993)
- detention centre experiences (Steel and Silove 2001 and VFST 2002b)
- negative attitudes toward asylum seekers in the community (Smith 2003).

As well, holders of Temporary Protection Visas and community based asylum seekers are not entitled to the full range of services which are available to people offered permanent settlement under the humanitarian program. The restrictions may prevent or impede them from accessing essential services effectively and may adversely affect their health and wellbeing.

The most significant restrictions in relation to health and community services funded by the Australian government are as follows.

Holders of Temporary Protection Visas are not entitled to:

- free interpreting for Medicare related services provided by private general practitioners and specialists

- services provided under the Integrated Humanitarian Settlement Strategy except for Early Health Assessment and Intervention, which is available for the first 12 months after release from detention.

Community based asylum seekers are not entitled to

- a Medicare card unless they have work rights attached to their visa
- a Health Care Card
- subsidized medicines under the Pharmaceutical Benefits Scheme, which are available to people with a Medicare or Health Care Card
- Centrelink benefits
- free interpreting for Medicare related services

There are relatively few research studies on the mental health effects of the asylum-seeking process or the mental health effects of temporary visa status. A review by Steel and Silove (2000) has shown that asylum seekers are at heightened risk of trauma-related psychiatric disorder. A recent analysis of client data collected by VFST showed higher levels of psychological symptoms amongst asylum seekers compared with clients with resident status who were receiving trauma counselling (VFST, 2005).

4. Interventions for Refugees

Historically, public mental health services for adults funded by state governments have focused on those with serious mental illness, with responsibility for the care of those with high prevalence and non-psychotic disorders such as depression and anxiety being seen to lie with GPs and psychiatrists and funded by the Australian Government through Medicare.

Recently there has been increasing recognition that non-psychotic disorders are more common and account for a greater and increasing proportion of the burden of disease than was previously thought (CDH&AC 2000a). There is also growing evidence that these disorders have their origins at least in part in negative social and environmental influences.

Accordingly, the Federal and State governments have increasingly emphasized strategies for the treatment of non-psychotic disorders and for early intervention, illness prevention and mental health promotion. This shift is evident in the National Mental Health Plan.

4.1

Specialist mental health interventions

Evidence shows that appropriate interventions for trauma related psychological disorders and symptoms involve a combination of individual/family counselling, pharmacological intervention and advocacy to support access to resources and services required for settlement.

FASSTT agencies provide direct services to survivors of trauma and torture in the form of counselling and other services. FASSTT agencies also train other service providers who have contact with survivors of torture and trauma; develop resources to enhance the understanding of the needs of survivors among health and welfare professionals, government and the wider community; and work with government, community groups and other providers to develop services and programs to meet the needs of survivors.

In recent years FASSTT agencies have seen a sustained increase in the demand for their counselling services. This is due to a number of factors including the Early Health Assessment and Intervention program which has increased the identification of entrants requiring more intensive professional support. As well, FASSTT's work with other services has led to an increased number of people with complex needs being identified and referred for assistance.

Long waiting times are characteristic for accessing FASSTT counselling services. This is stressful for the people awaiting support. Prolonged waiting times also work against an early intervention approach and the benefits that flow from this to the individuals and the broader service system. The increasing demand for direct services also affects the capacity of FASSTT agencies to undertake the developmental work necessary to build the capacity of the wider service system to work with survivors of torture and trauma, resulting in workforce pressures on mainstream services and an increase in demand for specialist services in the longer term.

To meet the overall need of refugees for mental health services it is essential to improve refugees' access to specialist services and build the capacity of mainstream services to respond effectively.

Issues of access to mental health services for CALD communities are well-documented. Barriers specific to refugees are summarised below in the health promotion section. One barrier highlighted in a survey of private psychiatrists conducted by VFST was their lack of familiarity in working with refugee survivors of torture and trauma (VFST 2002a). However many psychiatrists stated that they could work with refugee clients in partnership with an agency such as VFST which would assume responsibility for advocacy and support issues and provide professional and administrative support.

In 2003 the Department for Human Services funded VFST and VTPU to establish a one year pilot project to engage private psychiatrists and other mental health professionals in the provision of services. The program was also supported by funding from ANZ Trustees. The program is now recurrently funded by DHS, Victoria. It has proven to be an effective approach to engaging private

psychiatrists working with people from refugee backgrounds and should continue to be supported and expanded to other states and territories.

4.1.1 Better Outcomes in Mental Health Care

In 2002, the Australian Government introduced Better Outcomes in Mental Health Care, aimed at engaging general practitioners in the care of clients with mental health problems. Under the initiative, general practitioners are able to claim remuneration through Medicare for conducting an assessment and undertaking a mental health plan and review (known as the '3-step mental health process').

GPs wishing to be involved are required to complete specialist training in mental health. Under the initiative, they are permitted to use specified interventions and offer six services in a 12 months period and a second series of six services following formal review.

It is possible that a capacity building approach similar to the pilot program with psychiatrists described above could be implemented with GPs building on the Better Outcomes in Mental Health Care initiative. In exploring this approach particular consideration would need to be given to:

- whether the model of service provision is appropriate for addressing refugee related psychological sequelae, in particular the number of sessions and types of interventions offered
- whether GPs are sufficiently confident to provide mental health care to refugees
- how capacity building in the GP workforce could be supported.

4.2 Early intervention in mental health

Along with health promotion, early intervention is an important principle for enhancing refugee mental health outcomes. There is a substantial body of research showing that there are benefits to both the individual and communities, and cost benefits to the services system, in identifying and treating problems at an early stage before they become more costly and complex to treat and lead to the development of secondary problems (CDH&AC 2000). A review of the costs of providing services to survivors of torture and trauma found that the costs of treating mental health problems were offset by a decrease in the use of general medical services in the order of 10 to 20%, by increases in productivity and a reduction in Disability Adjusted Life Years (Rupp and Sorel, 2003).

Early intervention encompasses intervention soon after arrival in Australia as well as intervention early in the life cycle. Australia's Integrated Humanitarian Settlement Strategy funds early health assessment and short-term torture and trauma counselling interventions for newly arrived humanitarian entrants. Through early assessment, refugees requiring health and mental health interventions can be identified. People requiring longer-term interventions are

referred to specific programs provided by FASSTT agencies. By addressing issues related to torture and trauma experiences at an early stage of settlement, humanitarian entrants can more effectively participate in other aspects of their lives, for example in learning English and attending school for children.

Early intervention from the developmental perspective is critical for refugee children and young people. As mentioned earlier, the humanitarian intake largely consists of children and adolescents. Early intervention programs are important in addressing immediate psychosocial issues such as isolation, cultural dislocation, intergenerational conflict and lack of familiarity with educational and health systems. Early intervention also identifies children and young people at high risk of emotional and behavioural problems which may persist if not addressed. However settlement patterns are increasingly geographically spread (as a result of the need for affordable housing) and it is difficult to reach and support children and young people who are dispersed.

It is also important to be planning and implementing strategies to reach parents of communities who arrived as child survivors. For example a small number of clients have referred themselves for assistance with caring for their children as a result of having recognized that their own earlier experiences of trauma and loss were affecting their parenting of infants. These child survivors thus far are from the Cambodian community but they highlight the importance of transgenerational effects.

Transgenerational effects of trauma are well documented (Harkness 1993) and many studies now show the effects of traumatic events and neglect on neurophysiological systems in the brain (Chore 2002; Shonkoff and Phillips 2000; Shore 1997).

A key focus of Government strategies should be to ensure that services and programs are appropriately targeted to refugee children, young people and their parents so that they are offered support early in their development. Strategies should include children born of refugee parents.

4.3 Health Promotion

Important psychological and social risk factors for survivors of torture and trauma and their communities are isolation after the traumatic event, continued exposure to powerlessness, new losses, perceived injustices, marginalisation, racism and discrimination, minority status, socioeconomic disadvantage and community fragmentation. Protective factors are safety and sense of control over life, coping skills, kinship and friendship networks, connections to community and neighbourhood, capacity to give meaning to suffering, dignity, employment and opportunities for future, participation in community and host society and freedom from discrimination.

A comprehensive mental health strategy requires the inclusion of prevention and mental health promoting strategies which address the above factors and target populations as well as individuals and families.

The changing demographics of Humanitarian entrants have significant implications for health promotion as some important risk factors and protective factors for physical and mental health change.

Health promoting strategies relevant for a refugee population can address a host of factors. Three crucial areas to focus on are access to quality mental health services; building the capacity of schools to be a mental health-promoting setting for the young refugee population; and strengthening refugee communities.

4.3.1 Access to responsive mental health systems

Mental health problems particularly require responsive and sensitive professional care, and professional awareness of the impact of pre-arrival experiences and settlement. Utilisation of mental health services and their capacity to respond effectively is problematic for several reasons:

- Negotiating a new and unfamiliar health system may be a complex undertaking particularly for those with multiple health needs requiring numerous investigations and follow-up appointments.
- Cultural and language differences characterise the relationship between refugees and health care providers.
- Many refugees will be unfamiliar with illness prevention approaches and may be unaccustomed to the culture that characterises relationships between health care users and providers in Australia (eg the emphasis on choice and informed consent).
- Some refugees may find it difficult to prioritise health concerns in the context of other settlement tasks such as housing and employment.
- Issues of stigma and fears of being seen to be “crazy”.
- Fear of being overwhelmed by emotional issues should they become a focus for treatment.

Building the capacity of health providers in general health and mental health service provision to be responsive and address barriers to access is therefore an important mental health promotion goal.

4.3.2 Schools as health promoting settings for young refugees

In 1996, VFST developed and introduced a structured early intervention health promotion program of school based work with refugee children, their parents and teachers, recognising that there is a limited understanding of the particular needs of such young people in the Australian school system and in the broader society. Schools have increasingly become aware that refugee students have a limited chance of progressing past Year 10 because of disrupted schooling, their lack of English, their lack of integration, and their lack of knowledge of the school system in Australia. For this reason, VFST’s expertise has been welcomed by schools providing education in a cross cultural setting.

In promoting refugee health in schools, VFST aims to enhance the mental health and well being of refugee children and young people; assist their settlement; and improve their educational opportunities. VFST is committed to conducting future school based health promoting activities, and has funding to fulfil some strategies. Current objectives are to enable schools with significant enrolments of refugee students to assess the school's refugee responsiveness and implement a whole of school approach to working with refugee students. Another objective is to further develop and disseminate VFST school resources designed for implementation in the classroom.

Important future goals are to further develop the capacity of the education system in regional/rural areas to provide a supportive environment to refugee students, working closely with new arrivals programs (Integrated Humanitarian Settlement Strategy).

4.3.3 Strengthening communities

Strengthening communities promotes recovery from traumatic events and promotes adjustment and settlement for communities. FASSTT agencies piloting community strengthening strategies as a means of promoting recovery and resettlement are showing very positive results.

The aim has been to provide effective and innovative local solutions to local issues by responding to stated needs (from both the South Sudanese community themselves and service providers working with them). Work has been conducted in partnership with the South Sudanese community to develop resources and plan activities that will contribute to the well-being of the community through building on the leadership capacity of community members and strengthening families.

A range of future strategies have been generated on the basis of work conducted thus far. They include - the facilitation of engagement of Sudanese parents with schools including representation on school councils; facilitating the engagement of community leaders with services responding to problems of violence and child protection; participation in intergenerational communication and discussion of intergenerational conflict; a program of workshops and meetings with community members to provide support for problems arising out of trauma and displacement such as grief and isolation; and training community members who act as advisors and mediators to respond to mental health difficulties and prevent family breakdown.

4.4

Community Health

Community health services play an important role in health care for refugees and asylum seekers and it is proposed that this should be strengthened. Community Health Services are particularly well placed to provide assistance because they have the capacity to link new arrivals with social groups and networks and to take action to address broader social determinants of poor mental health.

In addition to community health centres, agencies concerned with family support, domestic violence and sexual assault services, require funding and resourcing arrangements to reflect the need for longer consultations and interpreting costs.

Particular consideration should also be given to mechanisms for supporting counsellors working with refugees and asylum seekers, including supervision, debriefing and professional development.

5. Data Collection

5.1 Population Data

Information on the size, location and characteristics of groups is vital to plan for current and changing needs. There are two data bases relevant to planning for people from refugee backgrounds, the Settlement Data Base compiled by the DIMIA and the Australian Bureau of Statistics (ABS) Census of Population. However these data bases when used either individually or together do not provide a comprehensive picture of the size, composition and location of Australia's refugee and asylum seeker population.

It may be possible to develop a rough picture of the size and demographic characteristics of Australia's new arrival refugee population by using country of birth coupled with year of arrival data, selecting countries on the basis of recent intake patterns documented in the Settlement Data Base. Despite its limitations, this approach may be acceptable in a health planning context.

Relatively little ABS data on new arrival small and emerging communities is published in hard copy or electronically as a matter of course. Agencies wishing to better understand the demographic characteristics of smaller communities can obtain information but to do so requires time and expertise which only some health and community service agencies may have.

The availability of demographic information about people of refugee backgrounds in Australia could be improved by establishing an accessible data base of information from government and non-government sources.

5.2 Service utilization data

With few exceptions, services in the health and community services sector do not collect data that enables service users from refugee backgrounds to be distinguished from other clients from culturally diverse communities. There are some services for which definitive knowledge of refugee experience is important for the purposes of providing care, for service planning, evaluation and accountability.

Data should be collected on the use of health and community services by people of refugee backgrounds and disseminated to service planners and providers.

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