AFRICAN AUSTRALIAN COMMUNITIES LEADERSHIP FORUM

INC. NO. A01047501 | ABN: 76 115 820 171

African Australian Communities Leadership Forum's submission to the Royal Commission in Victoria Mental Health

This submission is made on behalf of the African Australian Communities Leadership Forum (AACLF).

Francis Roger Nii Lanteye Acquah ***In December 2017, Francis was awarded Doctor of Science (D.Sc) Honoris Causa by the Commonwealth University.***
Francis is a Credentialed Mental Health Nurse and the Clinical Director of Positive Mental Health Program (**PMHP**) and the Founding President of the Mental Health and Well-being Foundation. Through the work of the foundation there are six PhD students studying in the area of mental health in Australia. The foundation has been holding conferences in Ghana to educate clinicians and non-clinicians with the effort to reduce stigma and suicide prevention.

Francis has over 30 years experience as a Psychiatric Nurse across public and private health care settings. **PMHP** provides mental health support, counselling, psychosocial rehabilitation and reintegration into society. PMHP also provides mental health psychosocial supports for NDIS participants. Current practice includes working with in the Youth Justice Service and the Forensic System in Melbourne, Australia. He is a Mental Health First Aid instructor and has used his experiences to educate the community about mental health and reduction of stigma.

Francis is Community Trainer and was involved in the delivery of "Stepping out of the Shadows": Reducing Stigma in Multicultural Communities. Francis has presented at National and International Conferences including Australia, UK, Finland, Canada, Singapore, Ghana, Senegal, Malaysia and Dubai, UAE.

Francis is a Multi award winner – Living legend Award 2013 from Celebration of African Australian National Awards 2013; Meritorious Service Award Excellence in Multicultural Affairs 2013; African Media Community Leader Award 2014; Australia Day Award and in 2015, Francis was recognised by his peers and was awarded the **AUSTRALIA Mental Health Nurse Achievement Award 2015.** ***Francis is a Fellow of the Australian College of Mental Health Nurses awarded by the Australian College of Mental Health Nurses***. Francis is past Assistant Governor in Rotary International District 9790 and two-term President of the Rotary Club of Greensborough and the Inaugural Chairman of the Nelson Mandela Commemorative Committee Melbourne Inc. *Francis has a passion in supporting the needs of the Australian-African, migrant and CALD communities in terms of mental health support, guidance and awareness, and Francis have a proven background of consistently achieving exceptional mental health outcomes as an advocate for minority groups.*

Keith Bhebhe International Master's degree in Addiction Studies, Bachelor of Science (Hons) in Mental Health Nursing
Keith is a mental health nurse manager, drug and alcohol specialist and a Community leader with 14 years of healthcare experience, in Australia and UK. He holds an international Master's degree in Addiction Studies, Bachelor of Science (Hons) in Mental Health Nursing. Current roles include: Acting Program Manager Forensicare Serious Offenders Consultative Services – A Government Mental

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Health Service focusing on management of individuals who have a history of serious violent and sex offending and/or sexual offending and serious mental illness/disorder (SMI) and complex needs; and part-time Penington Institute Workforce Development Officer. Keith is also recipient of the Williamson Community Leadership Program 2018. Recent professional projects include: Self-Harm and Suicide Prevention education program in Corrections services; Methamphetamine 'ICE' education programs for frontline staff; Scoping study into drug use trends among African Youth in Victoria; Introduction of Trauma Informed Care in Acute Forensic services; Management of Violence and Aggression in secure services; Educating staff in risk assessment tools in mental health services; Problematic use of prescription medication and Naloxone training to front-line workers in Victoria's 17 DHHS regions; and Hepatitis C – New treatment, education and research.

Linet Gesora

I am an Accredited Mental Health Social Worker with extensive experience in Mental health, Family Therapy, and Care and Protection. I am generalist counsellor at Goonawarra Medical Centre, Sunbury and at Positive Mental Health Program, South Morang. I provide Psychological support to clients experiencing a range of mental health issues under the Medicare Health benefit scheme, NDIS, Targeted psychological support services (North West Area Mental Health service)EAP, and private fee paying clients. A range of therapeutic supports are provided including relaxation strategies, Shema therapy, ACT, CBT techniques, emotional regulation techniques etc. Treatment is tailored to an individual's needs through a holistic approach.

Arhet Geberat BA Social Work, MA Educational Leadership, Diploma in Welfare and Community Services; Accredited Mental Health Practitioner; Accredited Mental Health First Aid Instructor

Arhet is a Clinical social worker and bilingual case manager at Mercy Mental Health Service since 2006. Providing client-focused mental health service to clients both from the Horn of Africa and other cultural backgrounds through assessment, planning, implementation and evaluation of clinical interventions and by ensuring a holistic approach to the client, their family and carers. And engaging with clients in their preferred language from the identified predominant community languages relevant to the catchment area. She also provides 12-hour mental health first aid training to the African community leaders and staff. Arhet had been working in private practice since 2008 in part time capacity providing counselling under better access program. She has nine years of extensive working experience in settlement service provision, particularly with refugees and migrants.

What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination within the African Australian Communities?

For a variety of reasons our community members are not accessing the primary mental Health care, mental health promotion and specialist community services which might prevent or lessen their mental health problems. We have reached a point in the relationship between the African Australia communities and mental health services where there are truly Circles of Fear. Some of the African Australians mistrust and often fear services. While in the inpatients services or prison services, staff are often wary of the Black community, fearing criticism and not knowing how to respond, and

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fearful of young Black men. The cycle is fuelled by prejudice, misunderstanding, misconceptions, stereotyping and sometimes racism.

The settlement process is thus frequently difficult. The experience of culture shock cannot be underestimated (Davis & George 1993). Australia's social, political and legal systems are vastly different. Complex immigration and welfare systems together with a lack of English and access to resources exacerbates the situation.

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.

Due to fear of stigma and lack of knowledge of symptoms of mental illness, families keep people at home until crisis point.

Furthermore, little awareness within the African community's 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. 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.

Unfortunately, sometimes our community associates mental illness with being detained in hospital and involuntary treatment in a confined and restrictive environment. There is an accumulation of tragic experience that resides within the collective memory; stories about successes, innovative services and good practice are somewhat elusive or prove difficult to sustain.

The vexed question of mental health and 'race'/ethnicity (African Australian) has been an issue of concern and debate for a number of decades in the Western world. Numerous commentators, particularly within ethnic minority or Aboriginal communities, have asked why is it that mental health services continue to fail Black people. In the face of an ever-increasing number of Black people entering mental health services and their negative experiences of services, the attitude of clinicians has been questioned. A study by Lewis et al., (1990) found that psychiatrists were more likely to perceive Black people as violent, therefore racism or prejudice could account for the differential experience. Another study in UK found that stereotype to be no longer valid, yet the authors still recognised and acknowledged that racism remained evident within mental health services (Minnis et al., 2001). However, Spector (2001) concludes that racial stereotyping and particularly perceptions of dangerousness do influence patient management.

Black people see using mental health services as a degrading and alienating experience: the last resort. They perceive that the way services respond to them mirror some of the controlling and oppressive dimensions of other institutions in their lives, e.g. exclusion from schools, contact with police and the criminal justice system. There is a perception that mental health services replicate the experiences of racism and discrimination of African Australian and black people in wider society, particularly instances where individuals have experienced the more controlling and restricting aspects of treatment.

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Media stigmatization

In Victoria, African Australian young people (particularly those from Sudan) have been subject to characterisation in the media as violent and criminal. This is likely to compound many of the difficulties we are already facing, such as social marginalisation and difficulties in gaining employment. This array of pressures and barriers to social integration (as well as the heightened scrutiny that attends stigmatisation in the media) makes mental health, trauma and problematic substance use among this cohort a particularly fraught and difficult issue.

Service barriers

Research conducted in Australia on service provision for African Australian young people from refugee backgrounds with comorbid mental health and substance misuse problems identified four main 'themes' regarding barriers to health service engagement. These were: organizational and structural barriers; access and engagement (i.e. lack of information and engagement in information provision in a meaningful way); treatment and service delivery (rigid or inappropriate therapeutic approaches); and training and resources (participants reported that service staff were not well-equipped to meet their needs).

Some of our people have experiences of trauma, poverty, or who are disengaged or marginalised and greater risk of problematic alcohol or drug use. Due to several factors, problematic drug use within African-background youth in Victoria is often hidden from view, resistant to intervention and isolated from the mainstream alcohol and other drug (AOD) treatment system.

These barriers are not experienced in isolation, and likely compounded the difficulty of accessing services. This presents a significant problem for a cohort that is difficult to engage anyway. The results that this cohort are reluctant to engage in mainstream services and mainstream services are not adequately equipped to engage youth from African-backgrounds in the event that they do.

Lack of prevention, detection and early intervention strategies

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.

From experience of African community social workers, it is evidence that African families, individual's women, men and youth 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.

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, [redacted] one of our community member with a mental disorder was locked up in [redacted] because he had no identification or travel documents with

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him, he had not been taking his medication as he an involuntary client after being released from hospital, he was confused and he had lost all his documents, plus his mobile phone. He was released from the detention centre and admitted to Hospital/Psychiatrist Unit when an inmate from Ethiopia contacted African community support worker on the client's behalf. The support worker faxed a copy of his travel document which was on his client file to the case worker officer.

Main Stream Mental Health 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.

People from Africa being small groups/communities and only recently settled, are often unorganized 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.

Effects of policies and recovery outcomes.

Sometimes families, extended families, carers are excluded from being part of the health plan for their loved ones. Each case should be treated as individual case not fit all. When their son/daughter is dead they are the first people to be notified while under the disguise of confidentially they could not be informed where they were referred too.

Communication – interpreters

Unlike ethnic 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

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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.

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

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 unemployed, 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.

Barriers to employment include: lack of networks, lack of Australian work experience, lack of recognition of overseas work experience and qualification and language problems.

There is a need to recognise the importance of practical issues such as employment 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.

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 do not communicate well in English, this is an added barrier.

Institutional racism

Historically, institutional racism has contributed to disparities in access to health care. Even dress code and accents, rather than the inability to speak English, have been noted as identifiers of vulnerability to discrimination (Weerasinghe, 2012; Holland & Ousey, 2011). In a bid to address institutional racism some services inadvertently exacerbated the problem by positioning themselves as 'colour blind' or a 'one size fits all' service. This has now been recognised as culturally insensitive and ineffective. Many services in Victoria are not pro-active when it comes to meeting the needs of African Australian clients` needs.

Lack of awareness and trust

Some African Australian community members are less able to identify poor mental health or perhaps western concepts of ill health, which can contribute to a lack of awareness of sources of help (Keating, 2009). Cultural pressures and ideology impact on some African Australian community members and religious groups' access to healthcare (Weerasinghe, 2012), for example the imperative to 'save face' and maintain social status and moral reputation (Mereish, 2012). Fear of stigma can also be a barrier and there may be the feeling that care is a family responsibility (Cooper et al. 2012).

Negative perceptions of mental health services can stem from perceived racism, language barriers and doubts about the cultural competency of services (Cooper et al. 2012). Alarmingly, 'a real and potent fear exists' within some African Australian communities 'that involvement with mental health services could eventually lead to their death' (Keating & Robertson, 2004). These factors can result in a delay in seeking help with the consequence that some BME communities only access services at crisis point and are reluctant to engage (Keating et al. 2003).

Fear

Fear is a phenomenon that is inextricably linked with both racism and mental illness. Fear is a component of race relations and racism. Some African Australian community people are often cast as 'the Other' and therefore viewed with suspicion, hostility and anger. The basic fear of 'the Other' is a central aspect of racism in all parts of our society and affects relationships within mental health services between African Australian service users and professionals. Sivanandan (1991) has argued that the fear with which most African Australian people regard mental health services seems to be grounded in an association with other, more obviously coercive, agencies such as the police or prisons.

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Combine these different layers of fear – the fear of African Australian people by service providers, fear of mental illness and fear of mental health services – you arrive at a pernicious circle of fear: a circle that impacts negatively on the engagement of African Australian or Black people with services and vice versa.

An example of Victorian research that looked at the views of ethnic minority communities` experiences views figures of authority:

The recently published report supports these views: "Police are good for some people, but not for us" Community perspective on young people, policing and belonging in Greater Dandenong and Casey (Weber 2018).

Limited research due to fear and stigma

We are a small population in Victoria and exhibit additional barriers to robust data collection, such as low service engagement and a level of community resistance to inquiries or interventions. We have challenges in understanding the need for these services and as they are not geared towards what we consider is our needs. There is problematic alcohol and drug use and related phenomena such as mental illness, which are both highly stigmatised social issues and can be difficult to discuss. Discussing these issues in ways that are culturally responsive to and accessible for our poses some further challenges. We have community members who are African but unfortunately, they do not have the resources to let go their jobs to look after their own.

In addition, due to unfair representation in the Australian media, our African community (especially Horn of Africa and Sudanese) understandable are reluctant to discuss issues such as AOD misuse, mental health or post-migration acculturation difficulties with external agencies. This wariness to discuss challenge is also present in a range of organisations working with this community. This reluctance to contribute to the stigmatisation, this also poses a significant barrier to collecting reliable and accurate data.

Despite the heightened vulnerabilities within our community (as well as the heightened public and media scrutiny), little research has been done on substance misuse among African Australian Communities in Australia.

Coercive pathways

African Australian are more likely to experience higher compulsory admission rates to hospital, greater involvement in legal and forensic settings and higher rates of transfer to security facilities. Thus, the interface between mental health care and the Criminal Justice System is of crucial importance, whereby diversion necessarily takes on a greater significance and urgency, and perhaps a slightly different dynamic, when it comes to provision of services for black and ethnic minority groups.

Cultural competence

Cultural competence involves taking into consideration an individual's background. In some services, due to a lack of cultural competence, decision makers may be pathologising some cultural norms and this has massive impact on someone`s experience of the mental health journey.

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Strategies to improve the Victorian community's understanding of mental illness, reduce stigma, discrimination and access to services.

Recommendations

1. Program, projects developed should be committed to a holistic, intergraded and psychosocial rehabilitation approach to service delivery go a long way in helping the recovery process (Sengaaga Ssali, 1998, Williams, 1987)

   Five broad health promotion principles espoused in the 1986 Ottawa Charter underpin this project:

- promoting health through public policy;
- creating a supportive environment;
- strengthening community action;
- developing personal skills; and
- re-orienting health services beyond a clinical and curative focus.

Immigration and detention centres

2. People from cultural and linguistic divers back ground should not be put in detention or deported without different media publicity and contacting community groups.
3. People from culturally and linguistic diverse communities need appropriate education awareness raising about mental health illness and the service system
4. Organisations with 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.
5. 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 community's organisation

6. 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.
7. 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.
8. Communities need assistance in gaining access to resources in order to help themselves — to run workshops on organisation and management for the African communities, for example. There is also a need to train African counsellors, social workers and mediators (some from each of the ethnic groups).

Community needs

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9. 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 before attending the medical health system, perhaps incorporating this process into Australian community services.

Language and information

10. 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

11. 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

12. A range of strategies to simplify and streamline service delivery should be promoted. These 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; developing common assessment processes and streamlining financial and other reporting requirements for funding programs to assist services managing a range of funds.

13. That appropriate assessment protocols for CALD consumers be developed and disseminated to increase the capacity of primary care providers to detect and manage the early signs and symptoms of mental health problems and mental illness

14. 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.

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15. There must be greater flexibility within bureaucratic procedures. The current emphasis on making the person 'fit' the system should be replaced; an 'outreach' model of health care should be considered.

16. 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.
17. Collect and make accessible information for cares 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.

18. 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

19. 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.
20. There needs to be increased opportunities for social support, particularly for women with children and single men — providing 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

21. There is a continuing need to develop cultural awareness regarding pre- 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 respectful and appropriate ways. Cross-cultural training should be made available for 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

22. 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

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advocate for increased funding in order to ensure an adequate budget for interpreters. 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.

23. There is a need to employ multiple methods. For example, having community information available at places people go to regularly, such as: Centrelink, the Adult Migrants English Service (AMES), ethnic shops and doctors' offices.

Use local resources, knowledge and skills

24. Traditional support within communities can take the form of visits, buying presents, talking, or just spending time together. The use of natural traditional therapies (such as henna painting, hair plaiting, herbal medicine, massage, or reading the Koran) can be extremely helpful.

Research is needed which focuses on:

25. 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.

Resourcing/Funding

26. That funding should be provided to research and production of 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.

27. That jurisdictions enter partnerships with community organisations and NGOs to develop models of collaboration and funding to increase the capacity of community organisations and NGOs to effectively meet the needs of CALD consumers with mental health problems, their families and carers.

28. That funding be provided to develop training program and support materials for NGOs and community support services to develop their understanding of mental health and mental illness in CALD communities and how to provide culturally appropriate services to CALD mental health consumers.

29. That funding be provided to develop and disseminate throughout CALD communities translated information delivered in a variety of media about early signs and symptoms of mental health problems and mental disorders, where to get help and how to provide support.

30. That national mental health media strategies provide funding to engage multilingual media in mental health promotion through media education campaigns on a range of issues.

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31. That States and Territory mental health services be required to provide CALD consumers, their carer's and families with information on their rights under state and territory legislation in an understandable manner appropriate to their language and culture.

32. That funding be provided to support the development of evidence-based recovery and rehabilitation programs for CALD consumers and that recovery and rehabilitation programs developed address the needs of culturally diverse communities.

33. That funding is provided to review the availability, quality and cultural appropriateness of support and information for carers and families of CALD people with a mental illness, and pilot and evaluate innovative programs and resources to support them.

34. That an independent multidisciplinary mental health panel which is experienced in the delivery of mental health services to culturally diverse population group, and includes consumer and carer representation, be established to oversee the delivery of mental health care in immigration detention centres, including assessment of the mental health status of detainees and the subsequent provision of culturally appropriate and quality mental health care.

35. That adequate recurrent funding be provided by all jurisdictions for early intervention and prevention programs for newly arrived young people from diverse backgrounds who are at risk of developing mental health problems and associated behaviour problems, leading to involvement with juvenile and criminal justice systems.
36. That jurisdictions review existing data on service utilisation, and established data collection systems for their capacity to identify CALD consumers of mental health services, to establish baseline data, and to identify gaps and make appropriate improvements.

37. That jurisdictions ensure that initiatives to develop standardised outcome measures and performance monitoring tools are culturally appropriate and reflect the complexity of needs of CALD consumers, their families and carers.

2. 2 What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

The diversion services within the Victorian Courts is a great example of what is working well

The issues touched upon above there remains a lack of evaluative research and policy initiatives which show what works for our community.

Possible solution: African Australian Communities Specific Diversion services

Identify the learning and training needs of clinicians and other professionals who work alongside mental health professionals, for example, the police. In a liaison and diversion capacity.

Point of arrest African Australian Community Nominated Representation

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The point of arrest is a vital moment in the criminal justice pathway, where sound practical decisions can change the course of an individual's interaction with the Criminal Justice System. It would be a great an opportunity for statutory and community agencies to work in partnership and forge a network across which knowledge can be shared.

For example, The Mental Health workers at the African and Caribbean Mental Health Services (ACMHS) in Manchester (UK) have good links with the local police and this has led to them being consulted at the point of arrest and custody suite stages.

For example, setting up an African Australian Community Mental Health Court Liaison

The court liaison practitioner is works with already existing Mental Health Advice and Response Service (MHARS) run by Forensicare. Can an extra role be created to address the African Australian challenges? The practitioner's main role is to refer clients to African Australian services that can provide ongoing support in the community

3.What is already working well and what can be done better to prevent suicide?

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

What makes it hard for within the African Australian Communities to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

It is well documented that African Australian Community people also face massive disadvantages within the education system, not only in terms of academic success but in terms of the risk of being excluded from school or being referred to specialist psychological services for children with learning difficulties or behavioural problems.

There is a level of disenchantment with services amongst some of our community members, and their families and carers, that there is the feeling that services do not have the best interests of our needs at heart.

Possible solution: Setting up African Australian Mental Health Service Team, including peer support workers. Currently there are several African Mental Health Community programs, it appears that there are not able to meet the demand. For example, the Multicultural Mental Health Services, which is not adequate. There is need for an umbrella services that can bring these groups to work together, for example in the Court Services. The team can supplement the work of Community Justice Reference Group (Youth Detention Centres).

Where practitioners lack a cultural expertise, they need to be able to effectively partner relevant culturally-specific agencies, such as the suggested African Australian Mental Health Service Team or any other well established evidenced based practice group.

This team could provide an indication of how African Australian service users can be supported into or sustained in treatment. In an ideal world, the team would assist the service user to recognise their mental health needs, work with the mental health services and can contribute to pre-sentence

reports by making professional and culturally sensitive suggestions and recommendations towards management of the client. The team would be multidisciplinary (nurses, OT, SW and Psychologist) and will also available to accompany client, service user, offender managers to home visits where necessary.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

What are the drivers behind some the African Australian communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

To address this question, we have focused on substance misuse, even though we are aware there are multiple drivers. General AOD use including Methamphetamine

There is a broad consensus that alcohol and cannabis are the primary drugs of choice, with small and often highly hidden patterns of methamphetamine use. Other drug taking practices such as chewing khat (a plant native to Africa, the leaves of which have a mild stimulant effect), using inhalants or 'chroming', drinking non-beverage alcohols such as mouth-wash, and misuse of cough syrups are being reported to occur at very low levels.

Alcohol use is common among our community, with a small sub-group engaging in very heavy drinking sessions as described above. Some youth do engage in this sort of drinking it was more common among highly disengaged adult men.

It is important, however, to note that while drug and alcohol use does occur in our community, this community is not unique in that respect. What makes this community noteworthy, is its low engagement with services and how hidden many aspects of their mental health and AOD use remain, even to specialist's services for both mental health and in AOD treatment.

Regarding use of methamphetamine, workers who work within African Australian community, report that methamphetamine use is common among a small but significant sub-group. They all note that methamphetamine is more likely to be smoked, inhaled or ingested than injected. Smoking was identified as the primary method as well as the most likely vehicle for initiation. As stated, cannabis smoking is not uncommon among our community and due to low levels of knowledge about different types of drugs, young people could quickly transition from smoking cannabis to methamphetamine without an appreciation of the difference. It appears that some African Australian Youth may think that, just because they're used to smoking cannabis, they get handed something to else to smoke and just take it, thinking it's the same or near enough anyway. And because they can smoke cannabis regularly without serious consequences, they assume it's the same with ice.

The serious concerns about methamphetamine use in our community is for two reasons. The first is the intense stigmatization of methamphetamine and those who use it: Our community is already stigmatised, they are subjected to unfair and racist depiction in the tabloid media in Victoria/Australia, and methamphetamine use just slots in very neatly with those stigmatising narratives.

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The other reason is that our community has a high incidence of traumatic histories associated with forced migration. We note that drugs like alcohol and cannabis may not be very good mechanisms for coping with trauma, but the interaction between trauma and alcohol and cannabis were relatively unproblematic:

These drugs are depressants, and while alcohol and violence do have a relationship, it's far from determinative. But methamphetamine is not an ideal substance for someone with severe, violence-related trauma to be on.

Again, the theme that emerges here is not that the use of methamphetamine or any other drugs is unique to our community, but that the additional hardships and barriers we face increase the capacity and likelihood of significant harm. In turn, low level of service engagement, low levels of institutional trust and low capacity of services to deliver culturally appropriate service provision, compounds these harms, rendering them unamenable to effective responses.

Possible strategies to improve engagement

Services need to work towards understanding our people. Printing leaflets and setting up services no-one understands or knows about will not address the issue. Primary Health Networks need to partner with locals in co-planning and strategies and not to present a finished product and expect African Australians to just go along with it.

Contingency Management Approach

The paying of service users travels expenses whether visiting for an appointment, group-work or to see the nurse, is not new. However, it comes with its own dilemmas. The voucher scheme whereby service users receive a $10 -$30 voucher for every three workshop sessions they attend.

Limited Grant Management experience

African Australian communities have limited experience in sourcing and managing funding or grants. There is a severe a lack of support for and guidance on applying for funding from mainstream budgets. Those that receive any, there is time-limited and are too small or make any impact or do not run for long enough to allow evaluation of the possible impact of the project.

6. What are the needs of family members and carers and what can be done better to support them?

What are the needs of family members and carers of African Australian communities and what can be done better to support them?

For carers, like service users, they don't understand the system, they fear that the illness would eventually lead to their loved one's death (due to police intervention) or confinement in prison or mental health hospitals

Person or carer/family centred intervention

Personalisation entails that services are tailored to the needs of the individual, carer/family rather than delivered in a 'one size fits all' fashion. There is an acknowledgment and understanding of

diversity of need, and families and carers are more readily involved. The emphasis should be on dignity, humanity and respect.

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

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8. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

What are the opportunities in the Victorian African Australian Communities for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

Release from Prison

Establishing a liaison and diversion initiative would ensure that they proactively partner local prison mental health in discharge planning.

Research suggests that men recently released from prison are eight times more likely to die by suicide than the general population (Pratt et al. 2006).

African Australian Mental Health Team could work in partnership with what is already in place NGO to support African Australian offenders being released from custody. The team would be able to address a range of issues, such as substance misuse, child custody and domestic violence.

Co-planning

African Australian Community service users and carers should be represented at all levels, not just within community-based agencies but also within statutory agencies responsible for commissioning or providing liaison and diversion.

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

Thinking about what Victoria's mental health system should ideally look like in supporting the African Australian Communities, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

There is an argument that services should reflect the community they serve and comprise of a diverse workforce, which is representative in ethnicity and gender. The rationale is that African Australian Communities clients will often feel comfortable accessing services where the staff group reflects their background, resulting in a better quality of engagement and interaction between client and practitioner (Nacro, 2009). However, the primary concern of many service users is receiving high quality, person-centred services, rather than services that happened to be African Australian Communities led:

"People just want to be treated well. You don't always need a Black person to look after you, you need someone who's respectful. When you're at your most vulnerable, when your mental health is

completely shot – how much more vulnerable can you be? This is compounded when the courts are making decisions about you; it's compounded when you don't speak the same language… basic respect is the starting point."

(African Community member).

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

Working in partnership

African Australian communities' user groups should be supported to work in tandem with other groups, because working in isolation reinforces marginalisation and can lead to stereotypical views.

Clearly African Australian communities-led initiatives cannot and should not be the only appropriate provider of services for African Australian communities but by developing links with a range of potential providers, initiatives would be best placed to access the most effective outcome for their African Australian communities' clients. The creation of formalised links with African Australian community-based organisations can assist non-specialised liaison and diversion services to contextualise information during assessments, assist with translation, act as an onward referral and provide a link with other services. Without communication with community-based services, African Australian people with mental health issues are unlikely to be identified unless their behaviour gives cause for concern (Loucks, 2007). The African Australian communities are keen to stress that links between community agencies are as important as those between them and the statutory sector. This is consistent with the findings of Breaking the Circles of Fear (Keating, 2002).

11. Is there anything else you would like to share with the Royal Commission?

Barriers to data collection

We are a small population in Victoria and exhibit additional barriers to robust data collection, such as low service engagement and a level of community resistance to inquiries or interventions. The have challenges in understanding the need for these services and as they are not geared towards what we consider is our needs. There is problematic alcohol and drug use and related phenomena such as mental illness, which are both highly stigmatised social issues and can be difficult to discuss. Discussing these issues in ways that are culturally responsive to and accessible for our poses some further challenges. We have community members who are African but unfortunately, they do not have the resources to let go their jobs to look after their own.

In addition, due to unfair representation in the Australian media, our African community (especially HoA and Sudanese) understandable are reluctant to discuss issues such as AOD misuse, mental health or post-migration acculturation difficulties with external agencies. This wariness to discuss challenge is also present in a range of organisations working with this community. This reluctance to contribute to the stigmatisation, this also poses a significant barrier to collecting reliable and accurate data.

Despite the heightened vulnerabilities within our community (as well as the heightened public and media scrutiny), little research has been done on substance misuse among African Australian Communities in Australia.

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Limited Resources

It has been challenging to put together answers that seek to address the challenges faced by the African Australian Communities as we are a wide diverse group. I cannot imagine how challenging it would be to put a view on how, for example the Europeans in Australia`s views on the mental health services. Due to the diversity, complex situation and limited resources, we have put this document in the best we could, in view of the above-mentioned challenges.

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