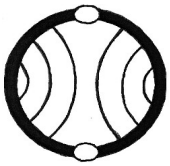
Companion House
Assisting Survivors
of Torture and Trauma



Submission to the ACT Legislative Assembly Standing Committee on Health and Disability

Early Intervention and Care of Vulnerable Children in the ACT

April 2008

1. Terms of Reference

To inquire into and report on the early intervention and care of vulnerable children in the ACT, focusing on the unborn child and infants aged 0–2, with particular reference to:

- children of drug affected parents;
- antenatal and postnatal care and support services available for vulnerable parents and their children;
- early identification of a child at risk;
- specific issues related to indigenous parents and children; and
- any other relevant matter.

2. Companion House Assisting Survivors of Torture and Trauma

Companion House is a community based not for profit association formed in 1989. We work with people who have sought safety in Australia from torture, persecution and war. Most of the people we work with are refugees or have a refugee -like background. We work with adults and children and both newly arrived people and longer term settlers in the ACT and regional NSW.

Companion House provides medical, counselling, advocacy and community development services to communities affected by torture and trauma. We also have a comprehensive training and community awareness program for service providers and the community at large, aimed at building expertise in and sensitivity to the needs of refugees.

Our medical service provides GP services to newly arrived refugees and asylum seekers in their first six months to one year in Australia. Patients are then referred on to an appropriate community GP. We also provide medical services in an ongoing way to a small number of complex cases and asylum seekers. However, our medical service has become increasingly under pressure to provide an increasing volume of ongoing GP service due to GP shortages in the ACT and difficulties in finding community GPs to refer to for ongoing care.

ACT Government invests in a range of Companion House services. ACT Health provides funding to support the medical service, counselling and community development services. ACT Government has also recently entered into a tripartite agreement with Companion House and Centacare to provide transitional housing to newly arrived refugees and asylum seekers.

3. Refugees in the ACT

Approximately 200 refugees and asylum seekers arrive in the ACT each year, on a variety of entry pathways. Over the last six years the majority of entrants to the ACT have been proposer supported entrants from Sudan and Sierra Leone. There have also been people arrive from a large variety of other backgrounds including people from Afghanistan, Burma and Iraq.

The pattern of arrivals has now changed, reflecting changes in Australia's intake. Larger numbers of people from Burma and Iraq are now arriving, and this trend is expected to continue.

The ACT continues to have a small number of asylum seekers arrive each year. People are from a vast array of different backgrounds including from China, West African countries and Pakistan. We estimate that there are no more than 10-20 new asylum seekers each year into the ACT.

Importantly, newly arrived refugees and asylum seekers have a high fertility rate. The majority will be between 20-25 years old. Although source countries for refugees will change over time, the importance of services for vulnerable women, unborn babies and infants from refugee backgrounds will continue to be a key issue for the ACT service systems over the long term.

4. Service Systems for Refugees and Asylum Seekers

Newly arrived refugees have six months access to intensive support with settlement issues from Centacare and the possibility of referral to the Migrant Resource Centre at exit from Centacare services. People have access to the Companion House medical service over the first six months to year in Australia and access to counselling and community development services from arrival with no time limits. In addition, of course newly arrived people have access to the same range of social entitlements as other Australian residents, including Centrelink and the job network.

Asylum seekers and temporary visa holders have much more limited access to settlement services and do not receive Centacare, Migrant Resource Centre or job network services for example. They can however, access Companion House services. ACT Government has also put in place a range of very helpful reforms which give asylum seekers access to ACT health systems.

The cases studies and issues described in this submission are focused on people who have been in Australia for more than six months and were not linked in to on arrival service systems. Nonetheless, some issue are also relevant to newly arrived people also. Companion House for example has struggled to meet the increasingly intensive primary health needs of newly arrived people over the last four years. We have a submission to ACT Government to increase the capacity of our medical service which, if successful, will greatly assist our ability to work with many of the issues identified.

Nonetheless, many of the observations made in this paper are actually best met by increasing the capacity of existing mainstream systems.

The following case studies describe two scenarios where medical practitioners believe a loss of life was imminent. The case studies illustrate what can happen when people become very marginalised from service systems. Many humanitarian entrants are well linked into service systems and support. However, in these two examples, vulnerable women and children fell through the gaps and became at high risk.

5. Ante natal and post natal care and support services

5.1 Case Study One

Holly arrived as a refugee in the ACT in 2005 with her husband and small child. She had spent 11 years in a refugee camp and her husband had a long experience of war and combat. Holly was supported by the Companion House medical service and counselling team over the first year of her arrival.

There was significant domestic violence in the household and Holly was injured to the extent she could no longer care for her child about 18 months after arrival. She then had some period of separation from her husband. She struggled with the expectations of Australian service agencies about how the domestic violence would be handled and the very different expectations of her own community. It was difficult for her to find people she could trust and she relied most heavily on women from her own community.

Holly subsequently became pregnant again. Due to a stated fear of Care and Protection services removing her children she avoided all contact with medical or service agencies until a later stage of pregnancy. None of Holly's own children had been removed from her care but she knew of other children in her own community who had been removed. Many people in her community were increasingly distrustful and suspicious of service agencies and their connection with Care and Protection services.

Holly did come back to Companion House seeking antenatal care at 28 weeks pregnant. She had a medical condition which threatened the well being of her and her baby. Companion House's medical service concluded that if she had approached a service for antenatal service earlier it was likely that the condition would have been better managed and provided less of a risk to mother and child.

Holly was referred to the hospital antenatal clinic and was able to have her first appointment at 31 weeks.. She was not well and not able to think clearly or manage her health well. Much of this was due to her medical condition and deterioration in physical health. There were no antenatal outreach services available for Holly. Due to the high risk her condition posed to the health of her and her baby Companion House staff took the unusual step of allocating a staff member to transport her to appointments and went with her to navigate through the hospital system,

Holly was admitted to hospital in a medical crisis due to rapid deterioration of her condition at 34 weeks gestation. She was obliged to have a cesarean section to save her life. This process was traumatic due to Holly and her husband's deep belief in traditional birthing practices and resistance to medical intervention. The interpreter also became distressed and exhausted. and tension developed between the interpreter and Holly's husband.

After the birth of the baby Holly and her two children went back to stay with a friend as it was not safe for her to be with her husband.. Holly and the baby and her children lived in a small house with six other people. There were some outreach services available to her at this point from the Maternal and Child Health Nurses who provided a series of home visits which were of benefit to mother and baby.

Holly's medical condition needed ongoing medical intervention and frequent adjustment of medication. However, after discharge from hospital, continuity of care was disrupted and failed communication between the hospital, specialists and Holly left her without important medication for some time. Holly was unwell, had two small children to care for and had no access to transport.

Communication between the hospital, specialists and Companion House was not adequate to ensure Holly's ongoing treatment. There was a strong need for ongoing outreach and case management of her care and post-natal services.

5.1.1 Issues arising from the case study

Holly received highly professional and dedicated care in the hospital system and from a range of health professionals. Feedback from the community is often very positive about midwives in the hospital system in particular. However, there are range of important issues which arise from this case study and point us towards improvements that can be made in our health and welfare systems for the early intervention and care of vulnerable children.

A. Care and Protection Services

There is some important work to be done with new and emerging refugee communities and Care and Protection services. Care and Protection services need to build greater expertise and relationships with communities to ensure that their role is understood and that they have the capacity to work constructively with them.

People from refugee backgrounds need assistance to learn about expectations and parenting in their new context. Just as importantly, Care and Protection services need to build better processes and protocols to minimize fear and suspicion. Whilst there is no room here to draw out the complexity of these issues, the case study does illustrate the potential effects of such fear, and resulting reluctance to seek help from agencies, on pre-natal and post-natal health.

B. Outreach Services and Case Management/ Coordination

The case study also clearly illustrates the need for an outreach service for high risk vulnerable women in their pregnancy and after their delivery (home visits by a midwife before birth as well as after). Companion House currently provides this intensive support ourselves - we have to, because in some recent cases we knew that the patient and baby were physically at risk from a complicated pregnancy. We are not currently funded for intensive outreach support and it puts significant pressure on staff.

An outreach service, or increased capacity in existing services to carry out outreach, would be able play a strong role in case management or coordination to ensure good access to care and continuity of care. The special needs antenatal nurses from TCH provide a good service and this might be a service model to build on.

C. Housing Issues

Housing issues have been the biggest barrier to successful refugee settlement in the ACT for a number of years. There is a lack of adequate housing which results in refugee mothers and infants living in overcrowded and stressful conditions.

Stressful living conditions are one of the many issues in the case study we have provided. For many less complex cases, overcrowding is the single biggest risk issue for mothers and infants from refugee backgrounds and has been for some time.

D. Interpreters

The case study throws some light on the difficult role of an interpreter in health care settings, particularly child birth. We commend the hospital for their commitment to interpreter use in this case. We struggle to ensure that all parts of the hospital or health system use interpreters, as we will mention again later.

The issues in the case study point to the need for more training and support of interpreters in new and emerging refugee communities. The interpreter is often a close community associate of the patient and has received limited training. Where the hospital finds there is a pattern of conflict and misunderstanding, some training of interpreters could facilitate solutions which will benefit vulnerable unborn children and infants.

E. Cross Cultural Issues and Birthing

For some communities there are difficult cross cultural issues associated with the clash between traditional birthing beliefs and modern medical intervention. This is an issue that can only be resolved through education and discussion between communities and relevant hospital services,

One refugee community in particular is passionate in their belief that interventions are made without adequate communication or information sharing with the parents. One community leader said that women from his community are now going to hospital as late as possible in their labour to ensure that unwelcome and unexplained interventions are not made. Companion House hopes to continue work on this issue.

5.2 Case Study Two

Bess was a young woman who arrived in the ACT as a refugee without any family with her. Bess had lived eight years as an illegal entrant in her first country of asylum after a traumatic war experience. She was a highly energetic and optimistic young woman. She did not have strong links to the community of people from her ethnicity in Canberra. She did not arrive directly into the ACT, but migrated from another Australian capital city to Canberra to meet friends, and as a result, did not have strong ties to Companion House and did not attend the medical service.

Bess had not realized that she was pregnant before she left her country of first asylum and was highly challenged by the idea of becoming a single mother so early in settlement. She knew it would disrupt her schooling and language acquisition early in her settlement. Nonetheless, Bess went ahead with the pregnancy in an optimistic spirit. She had a healthy pregnancy and gave birth to a healthy baby boy. The baby thrived . Bess, however, was quite isolated. She did not have many sources of parenting support or advice. She sometimes became overwhelmed with the baby's crying and his refusal of certain foods as he started to eat solids. The only parenting support available was in English however she had not had the opportunity to build her English skills. Services she did contact did not offer to use an interpreter or seek out translated information for her.

She could not further her English study as there was no childcare available to her. She worked hard to find a childcare centre with the capacity to take her son whilst she attended English classes but no centre was available and her son was placed on a long waiting list.

When Bess weaned her baby she started to feed him coca-cola in a bottle. It was a relief to her that the baby would actually take the drink as she had no success in weaning him on other liquids. The baby spent some months with this soft drink as his major sustenance.

Bess's baby was usually healthy and robust. However, he developed gastroenteritis and rapidly became very dehydrated. Bess was unable to recognize that her child was seriously ill. Whilst Bess was visiting a friend a Companion House counsellor with a nursing background happened to be visiting and on seeing the child immediately organised for the baby to attend a GP appointment at Companion House. The Companion House GP then sent the child to hospital. The child was significantly dehydrated from rota virus infection, and without immediate intravenous re-hydration, could have died at home. Whilst medical care at the hospital was good, it is worth noting the Emergency Department staff did not know how to book an interpreter and were guided through the process by a Companion House staff member.

5.2.1 Issues arising from the Case Study

The case study illustrates the challenges for a young newly arrived mother with limited support. She was a healthy and energetic young woman who provided good care for her son. However, limited support and knowledge of infant health issues put the baby at risk.

A. Culturally appropriate parenting support.

As the case study illustrates, newly arrived refugees cannot always call on their parents or family members for advice. Bess's baby was dying from gastroenteritis but she was unable to recognize that her child was seriously ill . The only parenting support available from mainstream services in the ACT is in English. The Tresillian helpline was not useful in this context as they do not use interpreters. There is a need for greater effort to be put into building multilingual and cross cultural resources for non English speaking parents. Many written resources actually already exist in other states and could be used by existing services. Other examples of helpful strategies could be protocols and training for services in interpreter use.

Companion House does run a number of parenting programs for some communities, but these are usually time limited projects and do not reach all communities.

B. Infant nutrition

There is a lack of maternal knowledge about healthy foods in the Australian context for some newly arrived people and there is an ongoing need to provide education and information about infant and child nutrition.

C. Interpreters

The case study illustrates a reluctance of some agencies to use interpreters. The lack of interpreter use means that meaningful communication is often simply not possible and people cannot access valuable information or understand even simple information being explained by health professionals. In addition to the scenario described in the case study, there are also some sectors of the hospital that are reluctant to to use interpreters, which has the potential to put parents, infants and children at risk.

D. Childcare

There is a real difficulty for some women to find childcare to attend English classes. For the first six months or so women will access classes at the Adult Migrant English Program(AMEP) and will have access to childcare in most cases. However, other classes post the AMEP tend not to have childcare provided and women are left with much more limited access to English language instruction. This can potentially increase the isolation of the mother, providing a further risk factor for infants and children.

It is worth noting that Canberra College (Stirling Campus) provides schooling to school aged girls with children in their very useful program Canberra College Cares. Teenage girls with children access schooling and childcare and health care services in an integrated program, a model that has been very useful to a number of girls from refugee communities.

6. Early identification of a child at risk

In Case study one in 5.1 the unborn baby was at risk as a result of lack of trust in service providers, communication issues and the lack of outreach support and care coordination. Medical practitioners believe that both mother and baby's lives were in imminent danger because of late engagement with medical services, communication difficulties during the birth and lack of continuity of care post birth.

Distrust and fear of Care and Protection and services associated with Care and Protection is one other major issue. Another important element is the cultural conflict between traditional ways of dealing with domestic violence and current Australian approaches. Both these issues point to the need for sustained work by statutory authorities and service agencies to build links and trust with communities, ensure protocols are in place for working with refugee families and provide education on cultural transition and parenting.

In Case study two in 5.2 early identification of the need for parenting support and information on nutrition is the major issue for our health system in early identification of a young child at risk.

7. Conclusion

This submission outlines eight recommendations, all of which are summarised overleaf. The two most important issues for ACT health and welfare systems are housing issues and the need for greater antenatal and postnatal outreach support and case coordination for vulnerable at risk women and children. Medical practitioners involved in the two case studies described in this paper nominate increased antenatal and postnatal outreach visits as the most important service provision need for high risk women and small children.

In many of the listed recommendations, Companion House has a role to play or is already working to provide solutions to identified issues. We are advocating in relevant service systems about the need for more childcare options, better care and protection processes and more consistent use of interpreters, We hope to maintain and expand programs for parents and education about domestic violence and cross cultural issues and birthing.

However, other mainstream services in the health sector and parenting support sector in particular also need to be aware of the need to be able to provide multilingual and culturally sensitive services.

In particular, Care and Protection services needs to have better processes and protocols in place to ensure they are using interpreters, understanding cultural issues and making useful interventions.

8. Summary of Issues and Recommendations

1. **Housing:** There is a real need for increased access to housing for vulnerable high risk mothers and infants. We hope the new ACT Government Refugee Transitional Housing Program will go some way to meeting this need.
2. **Outreach and case management/coordination services:** Antenatal and postnatal care services need to have greater capacity for outreach and care coordination for vulnerable high risk families. Companion House is trying to provide some of this work for high risk refugee patients without adequate resources.
3. **Interpreter use and training;** The health system needs to have more consistent use of interpreters in antenatal and postnatal care and training for interpreters in areas of identified need.
4. **Culturally appropriate parenting support:** There is a need for more culturally appropriate and multilingual parenting support. This includes education in the area of infant nutrition and identification of serious illness in infants as priorities.
5. **Childcare:** Limited options for childcare for women, particularly for women attending post AMEP English classes increases the isolation of vulnerable women.
6. **Care and Protection:** Build expertise of Care and Protection, stronger processes and protocols for working with refugee families and stronger trust and relationships between this agency and refugee communities.
7. **Domestic violence:** There is a need for a sustained effort to provide culturally accessible messages about domestic violence to new and emerging communities and continued efforts to build links between relevant agencies and refugee communities.
8. **Cross cultural issues and birthing**: There is a need for education and discussion between communities and relevant hospital services about birthing issues, better training and support of interpreters to facilitate communication, and a commitment from both the community and hospital to improve communication .