Views of the NSW Refugee Health Improvement Network

Refugee Health Improvement Network

This paper was prepared for the Mental Health Commission of NSW to support the development of the Strategic Plan for Mental Health in NSW 2014 – 2024

October 2014
The NSW Refugee Health Improvement Network (RHIN) was established in 1999 by the NSW Refugee Health Service as a forum for health and non-government organisations to discuss refugee health issues and identify multi-sectoral strategies to improve the health of refugees in NSW. Key contributors to this paper include the NSW Refugee Health Service, the Asylum Seekers Centre of NSW, the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), Settlement Services International, and the Transcultural Mental Health Centre.

The NSW Refugee Health Improvement Network welcomes the opportunity to have input into the draft Strategic Plan for Mental Health in NSW, via the Mental Health Commission of NSW.

BACKGROUND

A “refugee” is a person who has fled their country of origin and who has been, or is at risk of being, persecuted. Persecution may include denial of basic rights and of access to services, imprisonment without trial, beatings, torture and other mistreatment. Australia’s migration program includes a humanitarian stream that is specifically for refugees and others from a refugee-like background.

"Asylum seekers" are people who have applied for protection and are awaiting determination of their status. At some point all refugees have technically been asylum seekers. In Australia there are two groups of asylum seekers:

- those that arrived with a visa - they are allowed to live in the community whilst their applications are processed; and

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1 The internationally accepted definition of a refugee, set out in Article 1A, 1951 Convention on the Status of Refugees, is a person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside of the country of his nationality and is unable or owing to such a fear is unwilling to avail himself of the protection of that country.
those who arrived in an unauthorised manner by plane or boat - these persons are generally placed in immigration detention centres, after which they may be granted a visa to remain (temporarily or permanently) or may leave the country (voluntarily or otherwise).

More refugees settle in NSW than any other state: in the five years from January 2009 to January 2014, 21,846 humanitarian entrants were settled in NSW. They came from a variety of countries including Iraq, Iran, Afghanistan, Burma, Sri Lanka, Pakistan, China, Egypt, Bhutan, and the Democratic Republic of the Congo. Sydney settled the largest number of people, followed by Newcastle and Wollongong, and smaller numbers in rural areas such as Coffs Harbour, Wagga Wagga, Lismore, and the Hunter.

There are also a large number of asylum seekers living here. Nationally 22,708 asylum seekers are living in the community on temporary bridging visas after spending time in immigration detention. Up to three thousand asylum seekers who arrived with a valid visa are also living in the community, often with even less support. There are others residing in Community Detention with smaller numbers in Villawood Immigration Detention Centre.

**Refugees and mental health**

People from a refugee background are at increased risk of poor mental health as a result of past trauma and post-migration stresses. They are more likely than the general population to experience anxiety and depression disorders, and Post Traumatic Stress Disorder (PTSD) in particular. There are numerous risk factors, including a strong correlation between the amount of exposure to traumatic events and psychological distress. Adverse psychological outcomes are not only linked to trauma experienced before and during escape and exile; PTSD is also linked to post-migration stress and financial pressure in particular. Those who are currently seeking asylum and those who have experienced prolonged detention have an even greater risk of poor mental health.

Despite the higher risk of poor mental health, national research indicates people from ethnic backgrounds have low rates of access to mental health services. Factors that affect under-utilisation include language, low levels of mental health literacy, limited knowledge of service availability and service types, shame and stigma, lack of interpreter use by service providers, cultural unfamiliarity, confidentiality concerns, difficulty forming a trusting doctor-client relationship, and incompatibility between treatment expectations of both doctor and client.

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2Department of Immigration and Citizenship Settlement Database, 2014.
3Department of Immigration and Border Protection, Immigration Detention and Community Statistics Summary, 31 December 2013.
4As at 31 December 2013 there were 598 people are living in Community Detention in NSW. Source: Department of Immigration and Border Protection, Immigration Detention and Community Statistics Summary, 31 December 2013. Community Detention is a form of supported release for vulnerable groups, including unaccompanied minors, with complex needs. International Health and Medical Services has responsibility for their health, which is delivered through a network of contracted health providers.
9Colucci E et al *Barriers to and facilitators of utilisation of mental health services by young people of refugee background*, (Melbourne, January 2012).
Asylum seekers face additional barriers, related to cost, Medicare ineligibility for some, and a fear that poor health will affect their claims for protection. There are also particular issues relating to access and equity in mental health for rural and remote regions, including barriers to accessing services and limited capacity of service providers to provide appropriate mental health support for CALD communities, including refugees.\textsuperscript{10}

Refugees and asylum seekers require special consideration; trust and safety is a major hurdle to overcome. Some clients have been tortured by people in positions of trust, and a therapeutic relationship may take more time to establish. In one review of cultural aspects of care it was noted that it is more important to build a relationship than to solve a problem.\textsuperscript{11}

Recovery is centred around hope, resilience and being connected. These aspects are often challenging for refugees and asylum seekers who often have difficulty connecting with health services and with the wider community. Approaches to recovery include avoiding pathologising trauma reactions as anything other than normal reactions to abnormal experiences.

\textit{Mental health care}

There are many aspects of the NSW mental health system that work well. Of particular note is the responsiveness to the acutely unwell, recognition of the importance of specialised agencies such as the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) and Transcultural Mental Health Centre (TMHC), and initiatives such as the Safe Start peri-natal programme. However, service delivery for persons of refugee background with mental health issues can be problematic.

Specialist services such as TMHC and STARTTS provide services for persons from a refugee background but neither replaces mainstream mental health services - rather they are specialised agencies providing expertise in working with persons from diverse cultural backgrounds, or with histories of refugee trauma. TMHC does not provide long-term case management or acute care; STARTTS specialises in trauma treatment and rehabilitation, not working with persons with a mental illness.

General Practitioners (GPs) can have a central role in managing mental health issues, with some community groups reporting high prescription rates for depression and anxiety,\textsuperscript{12} but other GPs have little understanding of the needs and experiences of people from a refugee background. Access to primary care is believed to be low overall reflecting a range of cultural and service-related barriers. Reluctance by GPs to use interpreters is not uncommon. Take-up of initiatives such as Better Access and ATAPS is believed to be poor for this population group,\textsuperscript{13} particularly as allied health practitioners in private practice are not able to access fee-free interpreting from the Translating and Interpreting Service. Finally, NGOs such as the Asylum Seekers Centre provide some additional mental health services to asylum seekers, including counselling and psychiatric assessment, most of which is provided by volunteer health professionals.

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\textsuperscript{13}ATAPS records low levels of non-English speaking users, see the Centre for Health Policy, Programs, and Economics, \textit{18th Interim Evaluation Report - An overview of the achievements of Tier 1 and Tier 2 ATAPS}, (University of Melbourne, July 2011).
Policy context

National and state documents highlight the need for equitable access to mental health services which are culturally safe and have culturally competent staff. The Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012–2016 reaffirms the review of NSW Health Multicultural Health Plan 2008-2012 which recognises refugees and survivors of torture and trauma as a specific population group at risk, including those in regional, rural and remote areas, and sets out enhancing cultural competencies in mental health as a strategic priority.

The NSW Refugee Health Plan 2011-16 addresses various aspects of mental health including: that sustained efforts be made in mainstream mental health services to promote accessible and appropriate services for refugees and that the special needs of refugees and asylum seekers with mental health problems be considered, particularly through the implementation of refugee-related sections of the NSW Multicultural Mental Health Plan.

KEY ISSUES

There are numerous approaches to promote and treat mental health. While the following focuses on the delivery of mental health services, RHIN commends the approach taken by the Commission that the whole person be central to the Plan, not just the person's mental health. Key protective social determinants include a welcoming community, affordable housing, accessible education, social participation and a safe environment.

The following key issues have been identified for this target group:

**Difficulty getting services for people who are unwell but not acutely so**

While RHIN members have found that mental health services are very responsive to persons who are acutely unwell, there are real difficulties finding services for those who are not acute but require immediate assessment and significant short term and ongoing treatment and support.

Community mental health services’ admission criteria often require evidence of a pre-diagnosed mental illness. These criteria may be difficult for newly arrived people to meet in that they are unlikely to have detailed past medical records. It is often extremely difficult to get a timely psychiatric review in public mental health services. With few psychiatrists in the private system willing to bulk bill, newly-arrived people of refugee background have few options.

Some community mental health teams fail to adequately triage patients of refugee background - not viewing PTSD as warranting immediate assessment and management, or viewing depression and anxiety disorders as situational and therefore not appropriate for admission or other urgent intervention. Assessments often do not appear to take into account factors such as the lack of family and friends as support, insecurity, lack of community connections, and the general losses they have experienced living in exile.

Follow-up of those who require ongoing engagement with mental health can be poorly organised. Even those with consistent suicidal ideation or in need of crisis support may fall through cracks, since there is no particular agency "holding" the client or supporting them through the maze of mental health services. As a counselling service, STARTTS can only offer very short term and linkage when it comes to case management. It is often not clear who can provide ongoing case management.

Finding ongoing support can also be frustrated by the perception that refugee and asylum seekers have their own, adequate mental health services. However, the STARTTS VMO psychiatrist and registrar are at full capacity, nor does their counselling staff necessarily have general mental health expertise. The perception of specialised service need is exacerbated by the mainstream view that mental health issues in this population are all past trauma-related. For some clients, particularly asylum seekers, there is trauma prior to arrival but it is the continuous stress after arrival that is causing poor psychological health.
Increased number of high risk populations

Due to Australian Government policy, there are currently an increasing number of asylum seekers living in the community on temporary bridging visas with limited support\(^{14}\), most of whom have been through detention. Detention has been found to contribute to the risk of ongoing PTSD, depression and mental health-related disability, the longer the period of detention the more severe and persistent the mental disturbance.\(^{15}\)

Increased frequency of emergency department presentations and acute inpatient admissions amongst asylum seekers are linked to:

- profound uncertainty about their future
- instability around the process and granting of protection
- increased stress due to separation from families and limited or no options for reunification
- increased poverty and hopelessness
- living in the community for protected periods with limited support or work rights\(^{16}\)

For other asylum seekers who arrived with a valid visa and are living in the community while awaiting a decision, some receive minimal support\(^{17}\) and are dependent on charity organisations. The limited support offered presents additional risks to their mental health.

Without being able to establish a sense of security and safety, therapeutic goals are often limited to helping the client cope with the continuous stress of the asylum seeking process rather than addressing other core traumas. Mainstream services may reject them at this point because they do not have a diagnosis, despite very real symptomology. NGOs try to fill the gap despite being insufficiently funded and dependent on volunteers.

Treatment of a mental illness may also be hampered by fluctuating Medicare access\(^{18}\). The NSW Policy regarding Medicare-ineligible Asylum Seekers (PD2009 _068] allows for access to a range of public health services, although it is not uncommon for services to be unaware of the policy and refuse admission or seek to charge. Without Medicare, asylum seekers cannot see a GP without paying an upfront fee. No asylum seekers are eligible for a Health Care Card, making the cost of medication prohibitive in some cases.

Another highly vulnerable group is likely to be people on Temporary Humanitarian Concern visas. These temporary visas will now be given to people who have been found to be refugees but entered Australia by boat seeking asylum. Temporary protection has been associated with anxiety, depression and PTSD\(^{19}\), and a pattern of growing mental distress, ongoing resettlement difficulties, social isolation, and difficulty in the acculturation process.\(^{20}\)

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\(^{14}\) Asylum seekers released from detention on a Bridging Visa E are eligible for financial support and minimal case management through Asylum Seeker Assistance Scheme (equivalent to 89% of Centrelink Special Benefit). Highly vulnerable clients may be eligible for additional support through Community Assistance Support. BVE holders who arrived before 13 August 2012 generally have work rights, those who arrived after that date do not.


\(^{17}\) This group must demonstrate that high vulnerability in order to be eligible for ASAS. If they are not eligible for work rights they not be eligible for Medicare.

\(^{18}\) Expired Bridging Visa Es (and the Medicare access attached to it) have been allowed to lapse since the federal election.


policy changes prevent family reunion even if applicants are found to be refugees, and will also have an adverse impact on mental health.\textsuperscript{21}

\textit{Shortage of services specialising in adolescent mental health}

Adolescent mental health services can be extremely difficult to access - for example, South Western Sydney LHD has a 14 month waiting list. This waiting period delays diagnosis and treatment and adds to the stressors of the adolescent’s settlement, including impacts on ‘catching-up’ on education they missed during war and exile.

\textbf{PRIORITIES}

The following have been identified as priority areas:

\begin{itemize}
  \item Asylum seekers living in the community
  \item Adolescent mental health services
  \item Non-acute diagnosis, support and case management
\end{itemize}

\textbf{SOLUTIONS}

No policy can change the trauma people experience prior to arrival in Australia. Likewise the impacts of certain government policies on asylum seekers that may have adverse impacts on mental health, are outside the control of the State. Some key predictors of poor mental health can be mediated, particularly post migration stress.

Research\textsuperscript{22} identifies that positive resettlement outcomes for refugees and asylum seekers can be fostered by:

\begin{itemize}
  \item effective & humane resettlement services
  \item community supports
  \item timely family reunion
  \item work & education opportunities
  \item countering xenophobia & racism
  \item targeted mental health interventions.
\end{itemize}

The Mental Health Commission of NSW can play a crucial role in the latter; namely targeted mental health interventions. These should include:

\begin{itemize}
  \item recording ‘refugee background’ as a measure in mental health assessment. Data on ‘overseas born’ is a limitation on planning for this client group. We recommend that the data variables “ethnicity” and “refugee background” be included to provide more useful measure of service utilisation and for service planning.
  \item capacity building of other (mainstream) services to work with survivors through training including working with interpreters, cross-cultural competency, and trauma recovery. Training needs to be focussed on developing the mainstream workforce to work with increasing diversity and complex needs.
\end{itemize}


promotion of bicultural and bilingual mental health staff, and support of their skills to work within and across cultures within the Australian health/mental health settings. For example, more enhancement for TMHC to employ, train and supervise bicultural mental health workers in local teams.

investing in non-acute services that support people with ongoing mental health difficulties. Making it easier for clients to access a psych reviews and adolescent mental health services in particular may be able to arrest a decline in mental health rather than issues becoming more acute. For example, TMHC requires dedicated funds for a part time psychiatrist/consultant/advisor.

improving access to adolescent mental health services for young people and their families. Co-locating mental health services within youth and community services that have an existing relationship with young people could reduce stigma and the negative impact of being connected with these services.

consideration of asylum seeker status as one priority group for admission to community mental health teams.

integration of mental health into general health services to help avoid stigma associated with mental health issues. Increased GP support to provide mental health care and appropriate referral, including closer liaison with culturally specific GPs.

promotion of culturally appropriate evidence-based mental health promotion programs to address low rates of access to mainstream mental health services. For example, ongoing support for TMHC to create a specific targeted mental health campaign with a focus on those with torture and trauma backgrounds, particularly those from new and emerging communities, to address the stigma, discrimination and other barriers to engaging with mental health services.

development of appropriate resources for mental health promotion and wellbeing with refugee communities. Use of CALD focus groups to ensure that people from CALD backgrounds have access to information that is of value, and appropriate.

development of a CALD mental health literacy package or education program; linking in with cultural leaders and advisors across the state, to provide greater education about mainstream mental health services and what supports exist for mental health and wellbeing issues.

supporting CALD carer support groups run by the TMHC, and look at expanding these services to ensure adequate coverage across the state.

support of the Transcultural Rural and Remote Outreach Project and its expansion to bring the benefits of the project to other rural sites not previously in scope. For TMHC to work with rural services, particularly those that have a higher volume of CALD consumers, in increasing their multicultural mental health workforce, and ensuring services are culturally relevant and competent.

creating more opportunities to involve cultural advisors and leaders into mental health services, as part of quality improvement strategy to further develop services that meet the needs of a diverse community.

assisting non-mental health services to navigate mental health services in each Local Health District through a centralized resource facility or other capacity for workers to better access and refer to mental health resources.

building better links between acute mental health services and community services. Department of Immigration and Border Protection, mental health services, community based services and STARTTS to improve case coordination of asylum seeker clients at times of crises; for example, involve community services in discharge planning.
Key References

- Colucci E, Minas H, Szwarc J, Paxton G, & Guerra C (2012) *Barriers to and facilitators of utilisation of mental health services by young people of refugee background*, Foundation House, University of Melbourne, Centre for Multicultural Youth and Royal Children’s Hospital Melbourne, Melbourne.


