Integrated Mental Health Services for Refugees and Asylum Seekers

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Key terminology

A **refugee** is a person who has fled his or her home due to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, and who is unable or unwilling to return to his or her country of origin. In Australia this definition includes refugees and humanitarian entrants with permanent resident visas.

An **asylum seeker** in Australia is a person whose application for refugee status has not yet been determined. Asylum seekers arrive in Australia by boat or by plane with or without a valid entry visa. They may live in the community or be detained in immigration detention centres and other facilities.

A **mental illness** is a heath condition in which a person's ability to think, communicate and behave appropriately is so impaired that it interferes with the person's ability to deal with ordinary demands of life. Without effective treatment end support, the outcome for the person may be significant distress, impairment, disability and/or disadvantage. A person is described as having a mental illness when their thoughts, feelings and behaviour cause them or others distress, and are not in keeping with their cultural background. Examples are schizophrenia, depression and anxiety disorders.

The **mental health sector** as referred to in this report encompasses all mental health services funded by the state and federal governments for the purpose of treating both diagnosed, and undiagnosed mental illness. These services seek to intervene early to prevent the onset of mental illness and to intervene where early signs of ill-health are present.

The **refugees and asylum seekers support sector** as referred to in this report includes settlement services, and specialist refugee and asylum seeker services, as well as those generic services that have developed sub-specialties or discrete programs in refugee and asylum seeker mental health or health.

Executive summary

This document presents the work of the project *Integrated Mental Health Services for Refugees and Asylum Seekers,* a project lead by the HealthWest Partnership. The establishment of the project was sponsored by four local mental health services seeking to improve the responsiveness of the public mental health system to the needs of refugees and asylum seekers.

Early needs analysis pointed to a highly fragmented service system with minimal communication between the mental health sector and the sector providing support to refugees and asylum seekers. The project sought to enhance integration and service coordination between these sectors through partnerships, resource development, capacity building, service system development and collaborative action.

The project was supported by notably high levels of stakeholder engagement and commitment. Stakeholders engaged in the project reported that their networks expanded, their knowledge of the service systems increased individually and collectively, and as a result their confidence to use the systems, particularly the mental health system, increased markedly.

A key achievement of the project was a resource designed to assist settlement services to understand and more readily access local mental health services. Not unexpectedly, the production of this resource proved to be as important as the final product, providing the opportunity to present, and discuss the project with around 200 settlement and mental health practitioners.

Despite achieving significant gains, the project was limited in its ability to effect the change that is needed for the system to effectively respond to the complexities of refugee and asylum seeker mental health, and wellbeing more broadly. The efforts of the project and the project partners were continually challenged by a rapidly changing policy environment and significant sector reforms. This was a major factor influencing the work of the project. The changing policy and program environment was accompanied by high levels of uncertainty – which impacted severely on clients and services. This was true for both the refugee and asylum seeker, and the mental health programs – although the former was perhaps more pronounced in its impact.

As evidenced throughout this report, the current service system does not yet adequately respond to the mental health needs of refugees and asylum seekers living in the western region of Melbourne. In this region the development of a comprehensive and viable *integrated model of mental health service delivery for refugees and asylum seekers* appears to remain unlikely for the foreseeable future. The fragmented nature of the service system and the continued funding uncertainties are major impediments to ongoing service development and integration.

The need for further integration is also emphasised in the recently released *National Review of Mental Health Programmes and Services* (2014). However the major finding of this review focuses on the need to realign the program towards earlier intervention:

> *Shifting the centre of gravity of funding away from the acute, crises end, towards prevention, early intervention and community services which reduce the onset of illness, complications and crises into more community-based psychosocial, primary and community mental health services.*[1]

[1] National Mental Health Commission, 2014: The National Review of Mental Health Programmes and Services. Sydney: NMHC

This will be an important consideration for further discussions within the mental health sector about how mental health and wellbeing resources should be managed to provide the best possible care for these very vulnerable people.

The report also calls for a Victorian policy on refugee and asylum seeker mental health that might support both the *Victorian Refugee Health Action Plan* (2014) and the recently released *Refugee and Asylum Seeker Health Services Guidelines for the Community Health Program* (2015). It is important that high level discussions occur between all stakeholders about respective roles and responsibilities, and how mental health and wellbeing resources should be managed.

The report concludes with a number of recommendations for collaborative action and encourages HealthWest and their partners to pursue opportunities beyond the scope of this project to address child and youth mental health and mental health literacy amongst refugees and asylum seekers living in the western region of Melbourne.

Introduction

The *Integrated Mental Health Services for Asylum Seekers and Refugees Project* (the Project) commenced September 2013, concluding in March 2015. Over the initial 12 months the Project was supported with funding from a partnership comprised of Mercy Mental Health, the Mid-West Area Mental Health Service, cohealth (formerly Western Region Health Centre), BreakThru People Solutions, and the HealthWest Partnership. A further 6 months of the Project was supported by the HealthWest Board.

The rationale for the Project was based on an acknowledgement by the participating agencies that a range of service enhancements were required to improve access, and increase participation of refugees and asylum seekers in mental health services. It was envisaged that integrated pathway development would facilitate smooth transitions between services, and create a better client experience.

In Australia asylum seekers and refugees experience high rates of post-traumatic stress disorder (PTSD), depression, anxiety and psychosomatic disorders. The prevalence found by researchers (42-52% for posttraumatic stress disorder and 56-61% for major depressive disorder) is substantially higher than that of the general Australian community (i.e., 6.4% & 4%, respectively). Of greater concern was that the majority did not have a current mental health diagnosis.[2]

There are particular factors that contribute to this increased level of ill-health. Insecurity of tenure and living with the fear of forced removal from Australia has been found to have significantly affected and dangerously compromised the wellbeing of this population group. Discrimination and stigmatisation are also contributing factors which lead to adversity for asylum seekers and refugees living in the community. Access to adequate supports, services, and avenues for social inclusion are therefore imperative.

Project Aim

The primary aim of the Project was to:

Investigate how the public adult mental health service system in the western metropolitan region of Melbourne can better respond to refugees and asylum seekers who have a mental illness, or who are at risk of experiencing an episode of acute mental illness.

Objectives

- Identify the barriers and enablers that affect the capacity of refugees and asylum seekers, and the individuals and agencies acting on their behalf to create pathways to access mental health services.
- Develop a model and strategies that support integration and service coordination between public mental health services, settlement services and refugee and asylum support services based on the Service Coordination Framework and examples of good practice.

At its conclusion the Project was to make recommendations to the Project partners regarding sustainable enhancements to the services, processes, and support structures to improve the mental health of refugees and asylum seekers.

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[2] Hocking, D.C., Kennedy, G.A. & Sundram, S. (2015), Mental disorders in asylum seekers: The role of the refugee determination process and employment, *Journal of Nervous and Mental Disease*, 203 (1).

Target group

The target group under consideration was refugees and asylum seekers who have been resident in the western metropolitan region community for up to ten years. This period was nominated in acknowledgement of the reality that mental health issues related to a person's refugee and/or asylum seeker experience may emerge many months, or years after arrival, and/or that these issues may persist over lengthy periods of time.

The Project was to address the needs of the target groups within the geographical areas covered by HealthWest and the Project partners. The focus therefore was the local government areas of Brimbank, Maribyrnong, Hobsons Bay, Wyndham and Melton.

Methodology

The overarching project approach combined features of action research with program logic planning. The project employed a half-time worker for 18 months.

Project Governance

The Project Officer established and coordinated a Project Advisory Group which drew membership from settlement services, adult mental health services, specialist refugee and asylum seeker services, and other key stakeholders such as local government. Day-to-day oversight of the Project was undertaken through HealthWest. Representatives from the following organisations actively participated in the Project Advisory Group:

- Mid-West Area Mental Health
- Department of Health & Human Services
- Breakthru People Solutions
- Neami
- cohealth
- Mercy Mental Health
- Asylum Seeker Resource Centre
- Foundation House
- New Hope Foundation
- AMES
- Spectrum Migrant Resource Centre
- Melton City Council
- Wyndham City Council
- Medicare Locals

Project planning and development

Early in the Project a forum was conducted with key stakeholders to understand how mental health services were working with refugee and asylum seekers and with other support systems. A range of case studies were considered to reflect upon the experience of the client, and to assist in developing an understanding of the systemic barriers and enablers that impact upon, and shape the service system. Two workshops were held with case studies being contributed by Settlement Agencies, Community Mental Health Services, and the refugee health GP Liaison Project. The issues, barriers and enablers raised were consistent with the discussions of the previously held forum, providing additional detail and insight. At the end of the case study sessions participants were asked to identify the priorities for action that had emerged from this process. These fell into three categories:

- Communication and coordination, including information sharing (including feedback process, referral processes, protocols and guidelines)
- Service model development (to support understanding around where to refer, eligibility, etc)
- professional development and capacity building (linking into existing training, working with GPs and mental health services etc)

The Project Officer then completed a problem formulation which was updated over time.

Once established, the PAG membership increased its capacity through a series of guest speakers scheduled for each of the Project meetings. As their collective understanding and networks evolved they refined the focus of the work, and identified new opportunities. Ongoing needs analysis and solution formulation was also supported by ongoing review of a wide range of published and grey literature, and maintaining awareness of relevant changes to immigration policy, practice and sector reforms.

Evaluation

At completion of the Project the Project Officer surveyed members of the Project Advisory Group to explore the perceived benefits of their involvement, and reflections upon the project outcomes. A total of seven surveys were collated. Members of the Project Advisory Group were also invited to share reflections upon the Project during meetings and during individual consultations.

Project outputs

Set out below are the key achievements of the Project together with a discussion of theses. For a complete narrative of reflections upon the Project refer to Appendix 6.

Partnerships

Key achievements

- Establishment of the Project Advisory Group
- Increased membership of the HealthWest Partnership
- Establishment of a Refugee and Asylum Seeker Working Group in the Mid-West Mental Health Alliance

Discussion

The Project contributed significantly to the development of strong supportive partnerships, particularly between settlement services and mental health services, many of whom did not have established relationships, or a history of working in partnership with each other.

These partnerships were viewed as key to the Project's success. Considerable effort was placed on maintaining the engagement of all stakeholders, and informing everyone about the service system. Surveys completed by members of the Project Advisory Group indicated that as a result of their participation their networks expanded, knowledge increased individually and collectively, and as a result confidence to use the system increased markedly.

Encouraged by the strong partnerships developed, at the conclusion of the Project, HealthWest supported the Project Advisory Group to become an ongoing working group of the Mid-West Mental Health Alliance. There was unanimous support from the members, with the majority indicating they would continue to participate.

Importantly, the Project increased the membership of the HealthWest Partnership, providing a pool of expertise regarding refugee and asylum seeker issues to the Board and the membership.

The project has been an effective bridge builder between the two sectors and facilitated what was possible given the policy, funding and service constraints on both sides. (A member of the Project Advisory Group)

Resource development & capacity building

Key achievements

- A series of planning documents
- Inter-agency communication tools
- Referral pathways tool and resources
- Regular guest speakers at Project Advisory Group meetings

Discussion

The members of the Project Advisory Group were continually supported to enhance their knowledge of relevant aspects of the local service system, and issues affecting refugee and asylum seekers' mental health. In addition to presentations and updates at each meeting, relevant information and

professional development opportunities were also regularly distributed via email and through HealthWest's fortnightly eBulletin.

A series of planning documents was developed early in the Project. These were used to identify where the partners could apply their collective resources to best value and impact. Tools were developed which were used to promote inter-agency knowledge transfer, and an improved understanding about respective roles and responsibilities. These included lists of acronyms, and a scan of all the relevant networks and governance groups operating in the catchment.

A referral pathways tool was designed to assist settlement and other refugee services to understand and more readily access local mental health services (Appendix 5). The production of this resource proved to be as important as the final product. This provided the opportunity to present and discuss the Project with around 200 settlement and mental health practitioners. Those involved directly in the design and content of the tools gave and gained additional information through their input. The tool was disseminated widely with the support of the Project Advisory Group to over 40 service providers across the catchment. The dissemination of the tool was supported by presentations at a range of services and networks.

Service system development

Key achievements

- Enhanced admission and discharge data collection processes (Western Health - ongoing)
- Trial pathway from ASRC to Neami

Discussion

Throughout the Project there were a number of opportunities to make recommendations to the Project partners regarding service system design and practice. For example, the Project Officer worked with the Macedon Ranges North West Melbourne Medicare Local's GP Project and Western Health to have refugee and asylum seeker patient identifiers included in the new ward based admission and discharge data collection tools.

The Project Officer also facilitated the development of a trial pathway for asylum seekers in the west from the Asylum Seekers Resource Centre (ASRC) to Neami's Mental Health Community Services in the West. The trialling of a new screening tool for the mental health of asylum seekers[3] raised the question as to how agencies might be able to facilitate a pathway into mental health community support services for those who scored as being at risk, and needing an intervention. This work is ongoing and will continue to be monitored.

Collaborative action

Key achievements

- A position statement on refugee & asylum seeker health
- Representation on a number of local networks

[3] This tool has been developed, and is being trialled by Dr D Hocking and A/Prof S Sundram under the auspice of the Florey Institute (unpub).

Discussion

In November 2014 the HealthWest Board endorsed a position statement on refugee and asylum seeker health (Appendix 3).

Throughout the Project HealthWest participated in, and presented progress reports to a range of relevant networks and committees including:

- Settlement Advisory Committees (Inner/Mid-West)
- Wyndham Humanitarian Network Health and Wellbeing Group
- Wyndham Asylum Seeker Network
- Mid-West Mental Health Alliance
- Western Refugee Health Partnership
- Western Mental Health Professionals Network

The partners also lobbied the Department of Health and Human Services to undertake policy development within the mental health program regarding the mental health of refugees and asylum seekers.

Enablers & challenges

Below is an overview of the enablers and challenges to the Project. This Project was supported by notably high levels of stakeholder engagement and commitment. The Project made significant gains in enhancing service coordination across the settlement services and mental health system. However despite achieving the Project objectives, the Project was limited in its ability to effect the change that is needed for the system to effectively respond to the complexities of refugee and asylum seeker mental health and wellbeing. In particular, the efforts of the Project and the partners were made difficult by a rapidly changing policy environment, and significant sector reforms as detailed later in this section.

Enablers

- A shared commitment and sense of urgency to achieve the Project objectives.
- Commitment and expertise from the refugee and asylum seeker support sector: including specialist services and settlement programs.
- Interest and expertise from the mental health sector,.
- A strong governance structure provided relevant expertise and support.
- Support from partner agencies, especially management to actively engage with the Project.
- Continuous communication across Project stakeholders to maintain engagement.
- Utilisation of best practice exemplars from other regions.
- An increasing body of evidence and research (e.g. regarding how communities develop resilience).
- Increasing awareness as to where the Project could make a difference.

Challenges

- Understanding the unique complexities associated with mental health in this context - including stigma and discrimination and the need for culturally responsive services.
- Language services are underfunded and in many situations under-utilised.
- Lack of contemporary data to support system change.
- Need for expansion of services, and expertise across the mental health and refugee and asylum services workforce to provide complex case management and 'holistic' client support.
- Need to improve communication about refugee and asylum seeker mental health both within the mental health service sector, and between mental health programs and others proving health and welfare services to refugees and asylum seekers.
- Need for advocacy for state government policy regarding provision of mental health services for refugees and asylum seekers, including clear definition of roles and responsibilities of each sector.
- Variable engagement with mental health services due to financial pressures and competing priorities.
- Destabilised policy climate – refugee and asylum seeker programs are subject to range of Federal Government policy and program changes that are confusing to the sector and the client/community (e.g. complex system of eligibilities and costs).
- Processes and initiatives targeting systems change for vulnerable groups require long term investment in a climate predisposed to short term interventions.

Immigration policy

As noted, the political context, and the associated policy environment for refugees and asylum seekers in Australia has continued in a state of flux for some years now (Appendix 2).

Throughout the Project there were a number of policy shifts within the national refugee and humanitarian program that is currently oversighted by the Department of Immigration and Border Protection. Concurrently the Department of Social Services (DSS) implemented a major reorganisation of the Settlement Program to create the Status Resolution Support Service (SRSS). Under these new arrangements the Department realigned program streams, reduced services for asylum seekers, and made some changes to the provider agencies. During 2014 DSS also gained responsibility for a range of settlement programs, including the administration of payments to refugees and asylum seekers through Centrelink. These, and the other program amendments that took place over 2014 disrupted the efficient functioning of the service system, and reportedly created heightened anxiety amongst clients.

Refer to Appendix 2 for a timeline of selected major decisions made by the Government since the inception of the Project.

Mental health reforms

Similarly the Victorian sub-acute mental health system was recommissioned in 2014 to realise the Mental Health Community Support Services. There were significant national, and state changes in funding arrangements and service models, which continue to affect the delivery of services. At a national level, the sector is also contemplating the pending implementation of the National Disability Insurance Scheme (NDIS) and how this model will be applied to people with mental illness.

Discussion

Whilst the Project has made significant gains in enhancing service coordination across the settlement services, specialist services and the mental health system, it is the experience of the Project that the current local system does not yet adequately respond to the mental health needs of refugees and asylum seekers. In the HealthWest catchment the development of a comprehensive and viable *integrated model of mental health service delivery for refugees and asylum seekers* appears to remain unlikely for the foreseeable future.

The most recent *National Review of Mental Health Programmes and Services* (2014) has stated:

> *There is a lack of: - integration and coordination—service providers, as well as governments and their various agencies, often are operating in silos, in isolation of each other and of the broader system. Indeed, contractual arrangements can encourage this, with structural barriers preventing more collaborative approaches - capacity and flexibility—many small providers providing often vital but only small parts of a comprehensive service, with what flexibility they have impeded by stringent reporting and funding requirements* [4]

The Review also confirmed that:

> *People who have an experience of immigration to Australia or who have fled traumatic home circumstances as refugees have specific mental health experiences and needs which must be accounted for if support is to be effective. Not only do experiences of migration often exacerbate or create mental distress, but people can find the response of Australian mental health supports inappropriate to their needs*.[5]

When viewed from the 'helicopter' perspective, the fragmented nature of the overarching service system and the continued funding uncertainties for both core services, and practice enhancement activities are major impediments to service development and integration (refer Table 2 below for further description of barriers and enablers). The impact of an under-developed service system on an already very vulnerable and disoriented population has been substantial.

The Asylum Seekers Resource Centre (ASRC) has been directly involved in managing at the interface of these programs and has put forward its viewpoint.

> *The burden of care falls primarily to the asylum seeker sector when an asylum seeker presents in mental health crisis, especially when they present as acutely suicidal. Whilst asylum seekers are eligible for emergency services through the DHS health directive, the response to asylum seekers who are in mental health crisis is inconsistent and pressure is often placed on the asylum seeker sector to manage the crisis. Clients referred to (mental health crisis services) or taken to the emergency department are often assessed and provided with an immediate response to the acute illness but there is often limited or no post admission management or ongoing care provided. Asylum seekers in this situation are often past the crisis acute stage but are often continuing to experience severe acute mental health episodes. The lack of post admission management often leads to multiple (crisis) referrals and admissions for asylum seekers. The consequence of this is that the asylum seeker sector,*

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[4] National Mental Health Commission (2014), *The National Review of Mental Health Programmes and Services*, Vol. 1, NMHC, Sydney, p.39.

[5] *Ibid.*, p.107.

often the ASRC Counselling Program, is expected to provide this role despite not being a crisis service or resourced to undertake such a role.[6]

Staff in these services, and in the refugee health nurse program often described themselves as 'holding clients' who were experiencing quite severe symptoms and were waiting to access mental health care.

In reflecting on the effectiveness of the health system for asylum seekers, the ASRC was concerned to highlight that:

The current model of care provided to asylum seekers is inequitable and ineffective resulting in a long term cost to asylum seekers and also the Australian community. The model of care is reactive rather than preventative, and opposes a model of early intervention. This results in a greater long term reliance on health and welfare systems than would be needed if adequate support was provided to asylum seekers from the time of their arrival. [7]

The National Review (2014) prioritised a change in program emphasis.

Shifting the centre of gravity of funding away from the acute, crises end, towards prevention, early intervention and community services which reduce the onset of illness, complications and crises into more community-based psychosocial, primary and community mental health services.[8]

The experience of the Project would strongly endorse such a redistribution of resources. In the short term however, emphasis should remain on partnerships and integration with community mental health support services. Optimising this relationship promotes (long term) recovery, and acts to help prevent increased burdens on acute mental health services and organisations such as the ASRC.

It is also important that further discussions occur within the mental health sector about how mental health and wellbeing resources should be managed to provide the best possible care for these very vulnerable people. Central to this work is consideration of the partnerships that are needed with key stakeholders in the settlement, community health and specialist refugee health sectors. A useful product of these discussions would be a specific Victorian policy on refugee and asylum seeker mental health that might support both the *Victorian Refugee Health Action Plan* (2014) and the recently released *Refugee and Asylum Seeker Health Services Guidelines for the Community Health Program* (2015).[9]

Given the breadth of possible work, small, time-limited projects such as this must make some hard decisions about where the time and resources available can best make a positive and visible impact. The planning documents clearly identified those areas that were "out-of-scope" – these areas were excluded because of issues including resources, timing, and whether the project was well 'positioned' to have an impact on a nominated issue.

Those areas that were deemed "out-of-scope" by the Project Advisory Group included addressing the quantum and range of language services funded through Translating and Interpreting Service (TIS), developing and implementing a plan for community engagement and education, and creating a mental health literacy strategy. These areas, however remain highly important and given further

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[6] Asylum Seeker Resource Centre (2010), *Destitute and uncertain the reality of seeking asylum in Australia*, ASRC, Melbourne, p.9
[7] *Ibid.*, p.28.
[8] National Mental Health Commission (2014), *The National Review of Mental Health Programmes and Services*, Vol. 1, NMHC, Sydney, p.41.
[9] Department of Health and Human Services (2015), *Refugee and asylum seeker health services: Guidelines for the community health program*, Victorian Government, Melbourne.

resources local work, particularly in mental health literacy, and community participation would be well aligned with HealthWest's strategic priorities as well as Project interests.

Some opportunities did arise where the Project was able to take some initiative to support system change. These activities underscored the need for agencies such as HealthWest to create cross-sector collaborations. The partnerships have moved from the early phase of the Project where comments such as following were made:

This is the first time we have been involved in a project or committee process like this where we work with mental health services staff
(Representative from a settlement service)

I wasn't aware there was such a thing as refugee health nurses
(Representative from a settlement service)

This is the first time that I've sat down with a representative of [the adjoining mental health service].

I didn't know there was such a thing as a Crisis Assessment Team in the local Emergency Department
(General Practitioner)

Other discussions focussed on, for example, how to respond appropriately to new policy and program changes, how to transition clients more effectively from one service to another; how to work more effectively with General Practice; and what resources are available to assist clients experiencing particular problems. Through these conversations the platform of care is being strengthened and it can be hoped that better client outcomes and increased program efficiencies will result.

Moving forward

This section of the report identifies some key unmet needs and addresses the issue of sustainability of the work undertaken as part of the Project.

Youth mental health

A major area of work yet to be addressed focuses on youth mental health – where youth is defined as those aged between 12 and 25. The Project Advisory Group gave high priority to working with youth, however the Project did not have the resources, or the time to address the discrete needs for the mental health and wellbeing services and programs that are required by this cohort. Given that childhood and adolescence are critical periods that lay the foundation for lifelong wellbeing, improving the mental health of young people should remain a significant social and public health concern.

In Australia, the onset of mental illness is typically around mid-to-late adolescence. The prevalence amongst adolescents aged 13-17 years is 19%, and those aged 18-24 years old have the highest prevalence of any age group: over one in four (26%) young Australians experience a mental illness every year. Common mental illnesses in young Australians are: anxiety disorders (14%), depressive disorders (6%) and substance use disorders (5%).[10]

The National Survey of Mental Health and Wellbeing (Australian Bureau of Statistics, 2010) showed that while the prevalence of mental illness is relatively high in young people, they have a relatively low use of mental health services compared with older age groups. This is especially true for young men aged 20-24.

More pertinent to this report, during the past 12 years, close to 30,000 refugees arrived in Victoria of whom approximately half are children and young people. It is well established that refugees have high risk factors for mental health problems, yet their use of mental health services is even lower than that of the Australia wide norm. Further, there is a dearth of detailed data about how the service system is responding to these youth. The Centre for Multicultural Youth (CMY) in 2014 noted that:

> *Despite the prevalence of trauma amongst young refugees there are no systematic studies of the mental health of this group in Australia. No local (Victorian) data exists on the rate of referral of refugee children and young people to mental health services.*[11]

Children are also impacted by their refugee and asylum seeking experience and potentially over long periods of time. Clinicians from the Children's Hospital at Westmead Refugee Clinic reported evidence of trauma and Post-Traumatic Stress Disorder (PTSD) in children exiting detention.

> *We have seen a very large number of children who have been in detention centres. More than half of all the asylum seeker children we are currently seeing are suffering from post-traumatic stress … A number of children have been deeply traumatised by their time in detention resulting in post-traumatic stress disorder, nightmares and self-harming.*[12]

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[10] Kitchener, B.A. and Jorm, A.F. (2009), *Youth Mental Health First Aid: A manual for adults assisting youth*. ORYGEN Research Centre, Melbourne.

[11] Centre for Multicultural Youth (2014), *Mind Matters: The mental health and wellbeing of young people from diverse cultural backgrounds*, CMY, Melbourne, p.10.

[12] Australian Human Rights Commission (2014), *The Forgotten Children: National Inquiry into Children in Immigration Detention*, AHRC, Sydney, p.205.

The barriers and facilitators to mental health service engagement for refugee and asylum seeker young people are many, and may include:

> *The low priority that children and young people of refugee backgrounds place on mental health; lack of knowledge of "mental health" and services; distrust of services; and the stigma associated with psychosocial problems and help-seeking.*[13]

Given that both the barriers, and the enablers are poorly understood, Colucci et al support an examination of both as they recognise that in the absence of such research, "policy makers, service planners, and mental health professional have little option but to draw unreliable inferences from research based on children in the general population or ethnic minority adults".[14]

In response to this need, the Project findings point to opportunities focused on further pathway development, and working in partnership with other organisations concerned to explore and develop strategies aimed at developing resilience amongst refugee and asylum seeker youth. Of particular interest is the potential to work with educational organisations such as the Western English Language School (WELS). WELS is a receiving school for migrants and refugees who have little or no English, and where teachers have identified a significant number of students experiencing significant socio-emotional difficulties.

Finally in looking for ways forward the authors reference a recent young people's roundtable, "The community can help link young people with services and suggested training community leaders as advocates (for mental health education) in their communities".[15]

Within the context of Project activities there has been some discussion about working with senior community members and religious leaders who are often the first point of contact for young people and for adults experiencing mental health problems. Currently Victorian Transcultural Mental Health (VTMH) is conducting a project in the east of Melbourne that focuses on providing this education for religious leaders, however no work such as this is occurring in the west. Some very preliminary discussions took place between Project staff and both Action on Disability in Ethnic Communities (ADEC), and VTMH in which it was agreed that a collaboration on work in this area would be a valuable direction to pursue.

Community leaders education and support

In their 2013 report Cultures in the Know - Enabling Multifaith Communities to Improve Mental Well-being Action on Disability in Ethnic Communities (ADEC) reflected on their experience:

Most communities access a trustworthy religious leader, a faith congregation or community endorsed healers either before accessing the mainstream services and/or during the period of illness and recovery. Faith leaders are a critical link between communities that are seeking support to restore their well-being and services that are trying to improve the health and well-being in communities.[16]

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[13] Colucci, E., Minas, H., Swarc, J., Guerra, C. & Paxton, G. (2015), In or Out? Barriers and facilitators to refugee-background young people accessing mental health services, *Transcultural Psychiatry*, pp.1-25.
[14] *Ibid*., p.5.
[15] *Ibid*., p.18.
[16] De Silva, S. & Santhanam–Martin, R. (2013), *Cultures in the know: Enabling Multi-Faith Communities to Improve Mental Wellbeing*, ADEC & VTPU, Melbourne.

In 2010 ADEC had identified that:

> *Despite literature and everyday practice experience demonstrating the importance of the interface between faith communities and formal mental health service delivery, few attempts have been made to establish collaboration between the formal service delivery system and religious/traditional practitioners.*[17]

A number of reasons were posited for this lack of partnering including the lack of congruence between religious values and practices and the scientific basis underpinning a (western) medical model – and the current practice of mental health. In contrast, faith leaders are often well trained in providing theological education and spiritual direction, but they are often not trained in the identification and appropriate referral of mental health issues.

ADEC developed a proposal for a project that targeted the faith leaders of the Umma Islamic Group and Pastoral Care Workers of the Yarra Deanery from 5 Christian parishes. The project was funded by the Manningham Council and conducted successfully over 2010-2011. As noted above there has been some further action in this area, and ADEC and other agencies are interested in pursuing further projects.

Sustainability

One of the most important questions for projects such as this is how the better features of the project be sustained once funding has ceased. From the perspective of the key stakeholders core features associated with engagement and sustainability include:

- commonly held goals arising from the need to protect human rights
- a sense of having to maintain continuous effort on all 'fronts' to care for the clients
- mutual respect for the project partners
- the opportunity for continuous learning
- the sense of small achievements made through being part of the project process, and
- providing information that empowers people to do a better job.

There are some important resourcing requirements that are associated with the continued successful conduct of this type of work and these include:

- provision of a supportive governance arrangement
- definition of achievable goals
- a capable chairperson for the group
- an on-going schedule of group learning activity
- communication with management of services to secure support
- on-going communication with, and resourcing for the group.

For the Project to continue to build upon the gains, HealthWest sought an auspice arrangement that would provide both congruence of purpose and a viable administrative setting. The Mid-West Mental Health Alliance was seen to be the best choice – especially given its 5 year history and the fact that a number of other relevant workgroups such as housing and employment operate under its structure. This arrangement is being established at the time of this report being produced.

[17] De Silva, S. & Santhanam–Martin, R. (2013), *Cultures in the know: Enabling Multi-Faith Communities to Improve Mental Wellbeing*, ADEC & VTPU, Melbourne, p.6.

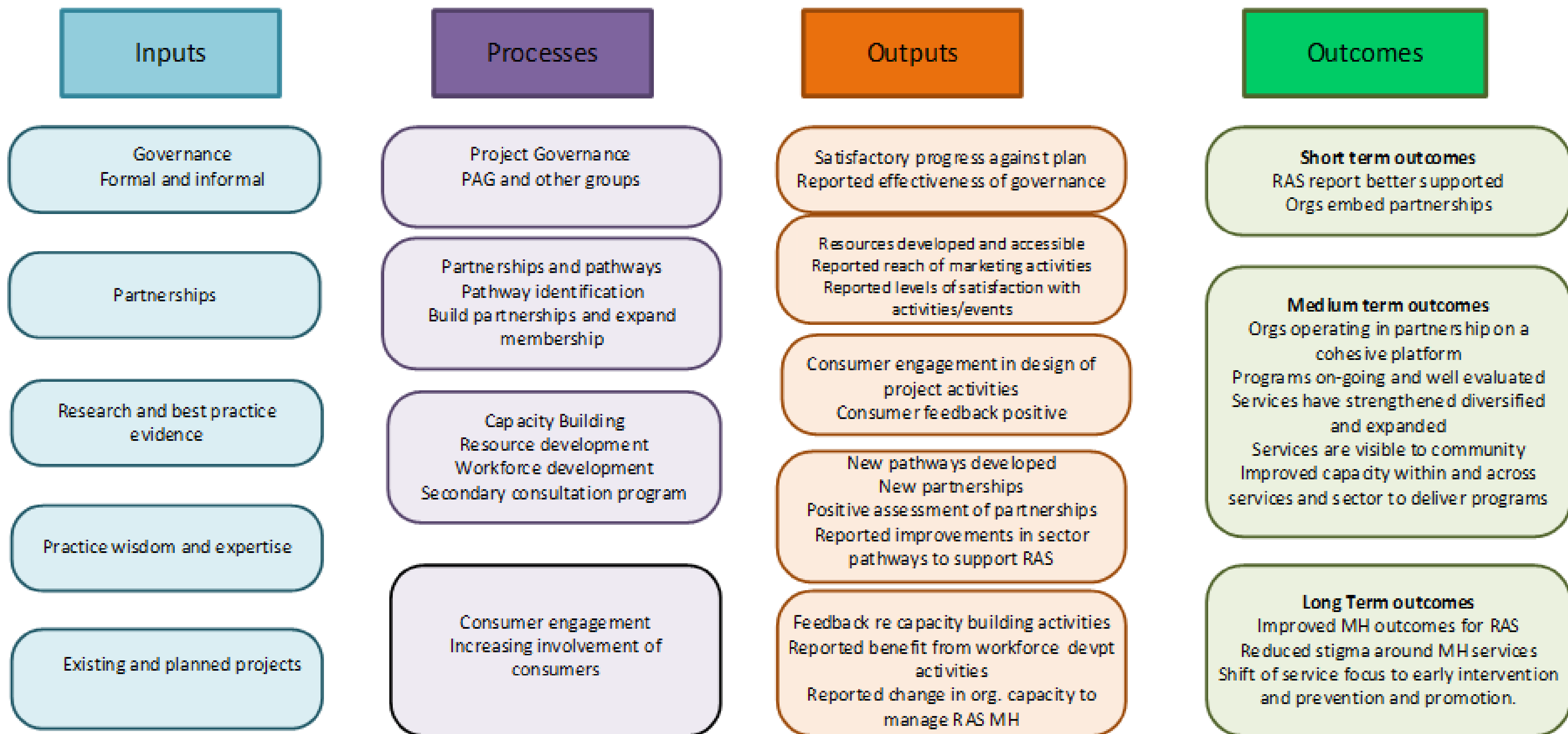
Recommendations

Within the HealthWest Partnership the Project has successfully raised the profile of refugee and asylum seeker mental health and mobilised action to address long-standing systemic issues. Given the prevalence of mental illness amongst this population group and their difficulties accessing and engaging with the service system, there is no doubt that refugee and asylum seeker mental health must remain a priority for HealthWest and their partners. There is an opportunity to build upon the momentum gained through this Project and pursue new projects and partnerships. Below is a list of key recommendations for the HealthWest Partnership, accompanied by explanatory notes.

Recommendations	Explanatory notes
Contribute to Victorian Government policy development regarding the mental health of refugees and asylum seekers.	It is anticipated that there will soon be opportunities to contribute to the development of Victorian Government policy regarding the mental health of refugees and asylum seekers. With a mobilised and informed membership HealthWest is well placed to contribute to such policy development.
Ensure the mental health of refugees and asylum seekers remains a priority of the mental health sector in the west.	HealthWest should pursue the opportunity to establish a refugee and asylum seeker working group in the Mid-West Area Mental Health Alliance. Other opportunities may also present through area based planning activities.
Pursue capacity building partnerships with community leaders (and/or youth) to enhance mental health literacy.	HealthWest could pursue opportunities to partner with organisations whom have developed successful pilots in other catchments, such as the Action on Disability in Ethnic Communities (ADEC) and Victorian Transcultural Mental Health (VTMH).
Continue raising awareness of refugee and asylum seeker mental health in mainstream health and front line services across the west.	HealthWest and partners could continue disseminating the referral pathway tool and promoting a greater understanding of the unique circumstances of refugees and asylum seekers in the context of mental health.
Pursue service coordination and system development projects with a focus on child and youth refugee and asylum seeker mental health.	HealthWest could build upon the existing engagement of settlement services and pursue partnerships with the Royal Children's Hospital Child and Adolescent Service, Orygen Youth Health, Headspace and the Western English Language School (WELS).
Apply for membership of the Victorian Refugee Health Network (VRHN) Reference Group or VRHN Primary Health Care Working Group.	These groups would enhance HealthWest's profile and commitment to refugee and asylum seeker health. Members of the Reference Group include representatives from relevant State Government Departments and partners of HealthWest. The Primary Health Care Working Group brings together key stakeholders to build the capacity of the sector to provide more accessible and appropriate services.

Appendix 1

Program logic for the Integrated Mental Health Services for Refugees & Asylum Seekers Project (2014-15).



Appendix 2

Timeline of selected major decisions made by the Government since the inception of the Project

18 October 2013
Temporary Protection Visas (TPVs) are reintroduced. TPVs allow their holders to stay in Australia for up to three years, after which time their protection claims will be reassessed. As with the previous TPV policy (in place between 1999 and 2007), TPV holders are not allowed to sponsor their family members for resettlement, cannot return to Australia if they travel overseas and have limited access to settlement services. Unlike the previous policy, TPV holders who are still in need of protection after their visa expires cannot apply for permanent residency. The Minister can grant permanent residency by discretion after a person has held a TPV for five years.

2 December 2013
The Australian Senate passes a disallowance motion preventing the reintroduction of TPVs.

14 December 2013
In response to the disallowance of TPVs, the Australian Government issues a regulation which renders refugees who arrive by boat ineligible for a permanent Protection Visa.

19 December 2013
The Minister for Immigration issues a directive specifying that family visa applications lodged by refugees who arrived by boat should be the lowest processing priority, meaning that they have virtually no chance of success. The directive applies to all family visa applications currently in the pipeline as well as all future applications. People affected by the directive who have an application pending will not have their visa fee refunded should they choose to withdraw their application. There is no priority for families facing compelling or compassionate circumstances. The directive does not apply to Australian citizens.

January 2014
In another response to the disallowance of TPVs The Australian Government begins to grant Temporary Humanitarian Concern visas (THCs) to refugees who arrived by boat, as an alternative to TPVs. THCs were originally introduced in 2000 to allow people on Temporary Humanitarian Stay visas (a short-term visa originally developed in 1999 to allow for entry and temporary stay in Australia in humanitarian crisis situations) who were in need of continuing medical attention to remain in Australia. The conditions attached to THCs are similar to those attached to TPVs.

25 June 2014
Immigration Minister Scott Morrison introduces a Bill to Parliament that requires asylum seekers to prove that there is evidence of a greater than 50% chance of them suffering significant harm, including torture, in a receiving country, in order to remain in Australia.

19 August 2014
Children to be removed from detention. Scott Morrison announces that over the rest of the year, children will be removed from immigration detention centres. This policy applies to children who arrived in Australia before July 19 2013. Children who arrived after this date, will be subject to offshore processing and sent to Nauru

September 2014
The Government introduced ‘Operation Sovereign Borders’ which mandated Australian authorities use force to intercept and turn back boats ferrying asylum seekers to Australia. The consequence is that it has become possible to focus on those 5,514 asylum seekers who are currently detained in Australia and on Nauru and Manus Island (as of 30 September 2014).

December 5 2014
The Migration and Maritime Powers Legislation Amendment (Resolving the Asylum Legacy Caseload) Bill 2014 was passed through the Senate, resulting in significant changes to Australia’s humanitarian program. These changes include:

- The reintroduction of Temporary Protection Visas and the introduction of Safe Haven Enterprise Visas, neither guaranteeing permanent protection;
- The removal of references to the 1951 UN Refugee Convention, enabling the government to use their own definition of a 'refugee';
- The introduction of a Fast Track System for processing the paper applications of asylum seekers, which prohibits the asylum seeker from reviewing the case if the application process has been executed correctly;
- Allows the Minister to return boats to a country regardless of whether there is a reciprocal agreement in place.
- This Act gives the Minister unchecked, arbitrary and dictatorial powers to deny protection to those seeking asylum in Australia and to control the lives of those being persecuted

March 2015
Migration Amendment (Protection and Other Measures) Bill 2014

Amends the *Migration Act 1958* to: clarify the responsibilities of asylum seekers to provide and substantiate claims in relation to protection visas; enable the Refugee Review Tribunal to draw an unfavourable inference about the credibility of claims or evidence raised by a protection visa applicant for the first time at the review stage; create grounds to refuse a protection visa application when an applicant refuses or fails to establish their identity, nationality or citizenship; provide that a protection visa will not be granted to a family applicant unless the visa was applied for before the family visa holder was granted their visa; define the risk threshold for assessing Australia’s non-refoulement obligations under certain treaties; amend the framework in relation to unauthorised maritime arrivals and transitory persons who can make a valid application for a visa; provide for changes to the processes and administration of the Migration Review Tribunal and the Refugee Review Tribunal; and clarify when a review of a decision in relation to an application is ‘finally determined’

Appendix 3

Position Statement

Position Statement

The health and wellbeing of refugees and asylum seekers

This position statement sets out the HealthWest Partnership's commitment to the improved health and wellbeing of refugees and asylum seekers in the west of Melbourne.

Refugees and asylum seekers are among the most vulnerable and marginalised communities in Australia. The political, economic and social circumstance of recently-arrived refugees, and, more particularly, asylum seekers, is in flux. This, in turn, contributes to the development of new health issues and/or escalation of pre-existing conditions. The personal histories of individuals and families are often characterised by war-related torture and trauma, deprivation and ill-health.

There is a growing body of evidence supporting the need to strengthen the service system that provides health and wellbeing services and programs for refugees and asylum seekers. More specifically, systems improvement strategies need to span the spectrum from primary health promotion to acute tertiary care – and across the lifespan of individuals from infancy to old age.

HealthWest recognises the importance of working with service providers to enhance their understanding of the health and wellbeing needs of refugees and asylum seekers. HealthWest will support capacity-building activities that up-skill organisations to provide more culturally responsive and better informed services.

HealthWest confirms that refugees and asylum seekers have the right to be informed and involved in the decisions that impact on their health. To this end, we will support local systems and processes that enable refugees and asylum seekers to participate in the social, economic and political life of the community.

HealthWest appreciates that positive action is required to improve the population health status of refugees and asylum seekers. This includes strategies designed to achieve equity of access to, and participation in public health services and programs. We will advocate across all levels of government, and within the public health sector for initiatives that will positively impact on the health and wellbeing of these vulnerable groups. We will encourage and engage in the development of relevant statewide, regional and local policies and plans. These documents provide the necessary mandate for the establishment of programs and services that will assist people to recover from existing injuries and illnesses, and enable them to optimise their physical and mental health for the future.

Endorsed by the HealthWest Partnership Board

November 2014

Appendix 4

Referral pathways tools

Refugee and Asylum Seeker Mental Health Care: Referral Options in the Western Catchment of Metro Melbourne

	Presentation	Service option	Contact
Public mental health and community health services	**Mental health crisis - client at risk of potential harm to self or others**	Psychiatric Triage Ambulance Police	Ambulance/Police 000 Midwest Mental Health Triage Service 1300 874 243 Mercy Mental Health Triage Service 1300 657 259 Orygen Youth Health Youth Access Team (15-25 yo) 1800 888 320 Royal Childrens Hospital Mental Health Services Intake (0-15 yrs) 1800 44 55 11
	Identified mental health need but not at immediate risk - significant levels of disturbance and disruption to the ability to function psychologically/ socially due to the illness	MidWest Area Mental Health Services (MWAMHS) Mercy Mental Health Orygen Youth Health (15-25 yrs) RCH Mental Health Service (RCHMHS)	MWAMHS Mental Health Triage 1300 874 243 Mercy Mental Health Triage 1300 657 259 Orygen Youth Health Triage 1800 888 320 RCH Mental Health Services Intake 1800 44 55 11
	Significant disruption to the ability to function and perform everyday survival linked activities	Mental Health Community Support Services (MHCSS) Personal Helpers and Mentors Program (PhaMs)	MHCSS Regional Intake and Assessment 1300 379 462 (NEAMI) PhaMs CoHealth 9362 8181 (Maribyrnong, Wyndham, Hobsons Bay) PhaMs BreakThru 9365 9500 (Brimbank, Melton)
	Some moderate level of disturbance and disruption to the ability to function psychologically/ socially	General Practitioner Refugee Health Nurse Headspace (12-25 yrs)	Refugee Health Nurse locations: ⇒ CoHealth Footscray 8398 4100 / Kensington 8378 1625 ⇒ Djerriwarrh HS / Melton CHC 8746 1100/87461333 ⇒ ISIS Primary Care Wyndham 8734 1400 / Sunshine 9313 5000 Headspace Sunshine 9927 6222 / Werribee 8001 2366
	Depression, anxiety, grief and loss Journey and settlement issues	Community Health Service Counselling	Community Health Service Counselling: CoHealth 8398 4178 ISIS Primary Care Counselling Intake 9296 1200 Djerriwarrh Health 8746 1100 (Melton)
Specialist services	Mental health issues associated with torture and trauma and requiring a specialist response that includes services and support	Foundation House	Western Region Office 9300 8670
	Mental health issues associated with trauma, risk and vulnerability for asylum seekers living in the community	Asylum Seekers Resource Centre	ASRC Footscray 9326 6066

Refugee and Asylum Seeker Mental Health Care: Referral Options in the Western Catchment of Metro Melbourne

Family and Children's services

Royal Children's Hospital

Specialist Mental Health service providing community based care for children 0-15 years old from locations at Flemington, Sunshine and Hoppers Crossing. Inpatient care is provided from the hospital for children 12-18. Intake: 1800 44 55 11

RCH Immigrant Health Clinic

Provides a multi-disciplinary assessment service for recently arrived children of a refugee background, including medical and education/ development assessment. Asylum seeker children and children in detention are also seen. Post-arrival health screening can be provided if required. 9345 5522 or helen.milton@rch.org.au

School Support Services

A broad range of professionals including psychologists, guidance officers, speech pathologists, social works and visiting teachers. Contact school based welfare officers, or swvr@edumail.vic.gov.au PH1300 333 232 (1300 DEECD 2): Footscray Office 8397 0300.

Local Government Family Support Services
Access to universal services that target the wellbeing of children and families including maternal and child health child care, kindergartens.

Child and Family Information and Referral Services
Targeted case management support for children's safety and support Western Melbourne (Hobsons Bay, Wyndham, Maribyrnong)
1300 138 180 Brimbank Melton 1300 775 160.

Other resources and services

2014 Immigrant and Refugee Health

Refugee health fellows support health providers to improve refugee and asylum seeker health care in all areas.
Fellows – Child and Adolescent
Dr Shidan Tosif and Dr Hamish Graham RCH 9345 5522 (pager 7142) or refugee.fellow@rch.org.au
Fellows - Adult
Dr Joanne Gardiner and Dr Nadia Chaves RMH 9342 7000
joanne.gardiner@mh.org.au / nadia.chaves@mh.org.au

Refugee Health Project (WEDNESDAYS)

Providing support and information to general practitioners about refugee and asylum seeker health care, and capacity building in the catchment. Dr Karen Linton GP Joslin Clinic Cohealth, West Footscray 9912 2000. Karen_linton@hotmail.com

Mental Health Carers Support

Carers Victoria offer carer support, respite, training, information and links to carer support groups 1800 052 222.
Tandem Carers offer the Carer Support Fund which can provide funding to assist carers in their role, including transport, respite, counselling and other expenses. www.tandemcarers.org.au or 8803

Access to Allied Psychological Services (ATAPS)

ATAPS enables GPs to refer consumers to ATAPS mental health professionals who deliver focussed psychological strategies services. ATAPS is managed through Medicare Locals.
Medicare Local for Maribyrnong, Brimbank, Melton, Hume 9689 4566 / 8379 9931. Medicare Local for Wyndham, Hobsons Bay 8371 6501

NB. The western catchment covers the LGAs of Maribyrnong, Brimbank, Melton, Hobsons Bay and Wyndham

This tool has been developed by HealthWest and its project partners (2014). Feedback can be provided to HealthWest via www.healthwest.org. au

Appendix 5

Evaluation summary: overall progress against objectives

Focus Area	Focus Question	Progress	Comments
Achievement against the project objectives	*In what ways has the project achieved the goals and objectives described in the project plan?* *Reflections on shortfalls and areas for improvement*	Satisfactory progress against the plan	The project was able to comprehensively identify and document the barriers and the enablers to better participation by refugees and asylum seekers in the public mental health system. The project established a model of building networks and collaborations through the Project Advisory Group. Our model focused on: • building capacity and relationships between the members of the Advisory Group and • networking and informing through membership of other relevant groups • presentations on resources to a variety of mental health and settlement services • consultation and liaison activities. The result of these activities is a better informed and more confident group of practitioners, and the emergence of new pathway opportunities. There is always a temptation to try to do too much – to diversify the ways in which a project such as this might operate. It is important to be realistic, and not raise expectations unnecessarily.
Governance	*In what ways has the project's governance arrangements (Advisory Group, management planning/administration) been effective?* *Reflections?*	Satisfactory progress against plan Reported effectiveness of governance	The HealthWest environment provided a strong administrative and planning environment for the project. The cross-agency project governance, implemented through the PAG fulfilled its role as both advisory body, and also in its provision of expert support and agency engagement. Difficulty in gaining the active participation of the acute mental health services was an issue highlighted by members of the PAG. Staff turnover in the PAG was an issue; perhaps a PAG orientation session might have been useful?

Project planning	*How effective have the project planning processes been in guiding and developing the project?* *Reflections on planning?*	Satisfactory progress against plan	HealthWest's strategic directions guided the overarching planning process. The early forum provided the opportunity to undertake an environmental scan and to recruit key stakeholders. Subsequent case study analysis enabled us to gain an in-depth understanding of the processes and issues that impact on the efficiency and effectiveness of case work. As opportunities for new initiatives arose they were discussed in PAG meetings. Planning papers were redeveloped accordingly. This work greatly facilitated the overarching project management and helped the group to remain focused on the actual project work. Sometimes planning might have appeared to be reactive in nature rather than strategic. The experience of the project was that the rapidly changing context of the work made it very difficult sometimes to do little more than *keep up* with the most recent program changes. Further there was a sense of the group constantly expanding its collective understanding of the service system – new opportunities for action presented themselves over the life of the project and became incorporated into our thinking in a somewhat organic fashion.
Partnerships	*What defines a successful partnership in this project?* *Reflection: How successful has the project been in creating and maintaining partners for the project?*	Partnerships developed and maintained	Stakeholders no longer feel the need to refer access issues to the project worker, but will approach the relevant service directly. Stakeholders ask for resources to distribute amongst their networks. Stakeholders build on the strategies of others - for example where ASRC became interested in orientation sessions as a result of sighting the model Mid-West Area –MHS model. Stakeholders proactively share information. In general, stakeholders have maintained their engagement with the project, attending meetings and participating in other aspects of the work. Consistently engaging the acute mental health services proved to be difficult with staff changes, and the challenges of working with a system where resources are very tight, and where there were not always commonly held goals between the project and those services. One partnership that did not progress as we might have hoped was a collaboration with the Victorian Transcultural Mental Health (VTMH) 3 year CALD organisational development project with North West Mental Health.

Partner Contributions	*What contributions have the partners made to the project?* *Reflections?*	Positive contributions	Information and expertise sharing; distribution of resources and materials; networking the project to new areas and contacts; facilitating the conduct of focus groups and meetings; contributing to planning and resource development; engaging with management to secure support for the project. In the mental health services the acute services might have drawn upon their own diversity work and diversity committees to build some stronger relationships and become more proactive in the project work.
Pathways	*To what extent have client pathways been defined and developed?* *Reflection: Where to from here?*	New pathways developed New partnerships Positive assessment of partnerships Reported improvements in sector pathways to support refugees and asylum seekers	*I had that situation where a (homeless) client was really unwell in the office and I rang the CAT (Crisis Assessment Team). They asked where the client lived and I said our office address. The CAT worker tried to argue with me but I insisted - so she went away to ask her supervisor and came back and said I was right. I wouldn't have done that if you hadn't told me….."(Case manager)* There is a much clearer and commonly held understanding of the structure of the service system and how services articulate from generalist low level need to emergency and acute level. However there remains a substantial amount of work that could be undertaken in the development of new pathways – both for selected target groups such as youth, and between community and existing mental health and specialist services.
Capacity building activity[18]	*What capacity building activities have been most productive?* *Reflection: Where might further progress have been made?*	Feedback re capacity building activities Reported benefit from workforce development activities Reported change in organisational capacity	Guest speakers and reports at the PAG meetings; specific workshops and seminars on topics such as the implementation of the new MHCSS; joint planning activities; resource development. Opportunities for partnership may have existed with the Victorian Transcultural Mental Health three year organisational development project undertaken with the North West Mental Health Service.

[18] In this context, capacity building refers to incorporating organisational and systematic change activities that strengthen the capacity of the RAS sector to respond to clients (this could include training, policy development, workshops etc).

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