victorian refugee health network

Submission on behalf of the Victorian Refugee Health Network

The **Victorian Refugee Health Network** is grateful for the opportunity to make a submission to the Royal Commission into Victoria's Mental Health System.

The Network facilitated a **sector roundtable held on 30 April 2019** to consult on the development of this submission. In addition to the themes identified during the roundtable, this submission is also based on findings of a survey of Network members, and our collective experiences working with clients and communities over more than a decade.

About the Victorian Refugee Health Network

The Victorian Refugee Health Network (the Network) was established in June 2007 to facilitate coordination and collaboration among health and community services to provide more accessible and appropriate health services for people from refugee backgrounds. The Network has provided expert advice to the sector and to successive State and Commonwealth governments on refugee/asylum seeker health and values collaborative relationships developed over many years. We have worked with the Department of Health and Human Services (DHHS) on policy and service development in the areas of primary health and specialist services, maternity care, sexual and reproductive health, family violence, oral health, asylum seeker access to health care and catch-up immunisation. More information about the Network can be found on our website: www.refugeehealthnetwork.org.au

Language

Refugee – is someone who has been forced to leave their country due to a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or a membership of a particular social group, and who is unable to return to their country.

Asylum seeker – is someone who has applied for refugee status and is awaiting a decision on their application.

The term '**people from refugee backgrounds'** is used to refer to those who: have arrived in Australia with, or who have subsequently been granted, permanent or temporary humanitarian visas; people seeking asylum; and those who come from refugee backgrounds who have another visa type. Where the immigration status a person currently has or had on entry to Australia is significant (i.e. to service eligibility), this is noted.

Key messages

- **Victoria has a large number of people who arrived as refugees or seeking asylum** – there have been more than 40,000 refugee arrivals over the last decade, and we have at least 10,000 asylum seekers currently living in the community. Around half this population arrive as children or adolescents.
- People from refugee backgrounds have experienced forced migration, trauma, and disruption of health services – they may have **multiple and complex physical and mental health issues** arising from their pre-migration experiences, during their journey or after settlement in Australia.

- These communities have a **high prevalence of mental health issues related to past traumatic experiences.**
- **Asylum seekers have additional risk factors for mental illness** due to their uncertain migration status and asylum experience, including, in many cases, prolonged immigration detention and family separation. Immediate issues for this cohort include lack of welfare supports, variable Medicare access and destitution.
- **Most mental health consultations with people from refugee backgrounds require the assistance of an interpreter**, particularly in the early years after settlement. The need for language services adds complexity to service delivery, has broader implications for culturally and linguistically diverse communities, and needs careful consideration in mental health service planning.
- **Mental health promotion, prevention, early identification, and early intervention should begin early in the settlement process** and be integrated into settlement support and enabled through Victoria's Refugee Health Program.
- **Prevention of, and treatment for mental illness requires support for settlement and attention to the social determinants of health** – ensuring access to housing, welfare, education, work, family reunion, and meaningful community and economic participation.
- **The existing mainstream mental health service system is fragmented, difficult to access, and does not adequately consider trauma.** These issues apply to both child and adolescent, and to adult mental health services.
- **Mental health service intake restrictions based on diagnosis, location, age, severity or ability to engage effectively function to exclude patients, especially the most vulnerable.** People from refugee backgrounds often do not fit neatly into service categories and are frequently mobile in the months after arrival. New arrivals do not have experience of the Australian mental health care system, which, together with stigma, language barriers, and socioeconomic disadvantage are further barriers to accessing mainstream mental health services. Individuals with dual disability/diagnoses (e.g. mental illness and disability, mental illness and substance use) face even greater issues accessing holistic care.
- The **private mental health service system is generally not accessible for children or adults from refugee backgrounds** due to cost, and lack of associated language services.
- **There are limited data on access of people from refugee backgrounds to mental health services in Victoria** – addressing shortfalls in data is an essential component of evaluating service delivery and outcomes and will be instrumental in measuring reform.
- **Good mental health is an essential component of good health and good settlement** – integrated models of care that consider physical and mental health, the impact of trauma, social determinants of health, and coordinate care across the primary, secondary and tertiary sector are needed in meaningful redesign of the mental health service system to meet the needs of all Victorians.

Summary recommendations

That the Victorian Government Department of Health and Human Services (DHHS) support and resource Victorian mental health services to meet the needs of children and adults from refugee backgrounds by:

1. ***Expanding partnerships between communities, health services, mental health providers, refugee mental health specialists, educational welfare staff, community services and bicultural/multicultural workers.***

1.1. Expanding community engagement initiatives for refugee background communities, to increase understanding around mental health and mental health services as part of a broader mental health literacy strategy with a focus on prevention.

1.2. Developing and disseminating culturally appropriate psychoeducation about mental health symptoms, coping strategies, and supports that are available in Victoria to communities from refugee backgrounds.

2. Advocating for needs-based, rather than time-limited settlement support through the Commonwealth Settlement Support Programs.

2.1. Advocating for prompt resolution of migration status and needs based Status Resolution Support Services for people seeking asylum.

3. Providing integrated prevention and early-intervention focused mental health services within community health, primary care, and settlement organisations.

3.1. Extending and enhancing models from within the Refugee Health Program to ensure early screening and a proactive approach to early identification and preventive care

3.2. Supporting models combining health and mental health care, and community-based models of care that are co-designed and seek to integrate care across the spectrum of the health service system.

3.3. Ensuring access to culturally appropriate early intervention suicide prevention and post-vention care that specifically targets communities from refugee backgrounds.

4. Ensuring people from refugee backgrounds can access all elements of the mental health service system equitably.

4.1. Ensuring language service support is available for all elements of the mental health service system, including through the Better Access Initiative, Headspace, and school-based support systems.

4.2. Reducing barriers to access to mainstream mental health services – with a flexible approach to entry that places the individual and their support needs as the priority, avoiding layered exclusion criteria.

5. Ensuring that the mental health service system has the capability to work with children and adults from refugee backgrounds and those with low English proficiency.

5.1. Ensuring mental health staff have training in trauma informed care, cultural competency, and working with interpreters.

5.2. Ensuring all mental health services have a language services policy and access to appropriate training and provision of credentialed interpreters.

5.3. Supporting training for the interpreter workforce for work within mental health services.

6. Incorporating culturally relevant forms of mental health support alongside mainstream mental health services, using principles of co-design with communities.

7. Supporting key centres of expertise to deliver specialised care for children and adults from refugee backgrounds with mental disorders and to support their complex psychosocial needs.

8. Supporting mental health workforce development and capacity:

8.1. Through training placements for mental health clinicians within specialised refugee services and extending the DHHS refugee fellow program to include a psychiatry registrar position.

8.2. Through actively encouraging diversity within the mental health workforce, including through employment of bicultural and community liaison workers and enabling training pathways for people of refugee background.

9. ***Ensuring data on migration and refugee/asylum seeker status are collected as part of mental health reporting to allow meaningful evaluation of service access, outcomes, and implementation of the findings of the Royal Commission.***

10. ***Developing of a State best practice framework around mental health and early intervention for children, adolescents and adults from refugee backgrounds, building on the work of agencies with experience and proximity to communities, and proactively considering regional settlement.***

Background

Many adults and children from refugee backgrounds have experienced trauma, conflict, family separation and significant human rights violations, including physical or sexual violence. A meta-analysis found the population prevalence of reported torture was 21% in refugee adults,[1] and available Australian data suggest a high proportion of asylum seekers in detention disclose a history of trauma and torture.[2] Unaccompanied and separated children have specific risks and vulnerabilities.[3-7]

While **pre-arrival trauma is well recognised in refugee populations, settlement may also contribute to mental illness**, and is often associated with multiple stressors. Navigating life in a new country, language barriers, housing and financial instability, difficulty accessing employment, changes in family roles, and loss of community, country and cultural connections can have additive impacts in terms of risk for mental health. A meta-analysis of risk factors affecting mental health outcomes in refugee groups[8] found poorer outcomes were associated with institutional or temporary housing after settlement, restricted economic opportunity after settlement, ongoing conflict in the country of origin, *higher* education level and *higher* socioeconomic status pre-arrival, and coming from a rural area. Child and adolescent refugees had relatively better mental health outcomes than adults in this analysis, although parent mental health has a strong influence on child wellbeing.

Asylum seekers may face additional stressors related to their asylum experience – through perilous journeys, time in immigration detention, and living in a state of prolonged uncertainty. There is clear evidence that Australian immigration detention, especially long-term detention, is detrimental to health and mental health at all ages, in the short and long term.[9-29] Additionally, Australian temporary protection visas have been shown to be associated with worse mental health status when compared to permanent protection visas.[16 21 30-33] Many asylum seekers in Victoria have now been in Australia since 2013, and are still awaiting the outcome of their protection claim – precarious migration status and prolonged family separation have a cumulative impact on mental health. In addition, cuts to Status Resolution Support Services. (SRSS) initiated in 2018 have left many asylum seekers in increasingly vulnerable situations, with imminent risk of homelessness and destitution.

Widely variable rates of mental health issues are reported in refugee children (reviewed in [34], also [35-36]) and adults,[1 20 37-41] although there is more information available on the prevalence of Post-Traumatic Stress Disorder (PTSD), depression, and anxiety than other mental health diagnoses, and findings are typically specific to cohorts, conflicts and countries of settlement. Like any population, people from refugee backgrounds may have conditions such as schizophrenia or bipolar disorder; although there is little evidence these diagnoses are more frequent in refugee background populations in Australia. Data from the Building a New Life in Australia (BNLA) Study suggest refugee background populations have a high prevalence of mental health symptoms - with 46% females and 35% males reporting moderate-high levels of psychological distress, compared to the Australian-born populations (11% and 7% respectively).[42]

Intergenerational conflict is a common issue for young people from refugee backgrounds, with different expectations from parents and children, arising as young people navigate the space between two cultures. Parents and carers often lack the resources needed to resolve conflict and support their children in the Australian context, and may not be aware of supports to help them address these common challenges.[43]

Despite risk factors for mental illness relating to pre-arrival, migration, and settlement factors; **available evidence suggests that both refugees**[34 44-51] **and asylum seekers**[52-55] **face significant barriers to accessing health and mental health services**.

Consultation summary

The following section provides a summary of themes from consultation with the Victorian Refugee Health Network to inform the Network submission to the Royal Commission into Victoria's Mental Health System. This summary was derived from the following sources:

- Review of existing Network data sources, such as statewide meeting reports, project reports, and executive meeting minutes.
- Over 30 people attended a sector roundtable on 30 April 2019. Invitees included bi-cultural workers and community liaison workers, representatives from the Refugee Health Program, local refugee health networks, specialist services, mental health services, primary care, asylum seeker support agencies and other interested Network participants.
- A survey was sent to broader Network participants and feedback was also collected via email.

This submission draws on all of these sources.

Key themes

Community needs

People from refugee backgrounds are likely to have experienced disruption of basic services, poverty, food insecurity, poor living conditions and prolonged uncertainty; they may have experienced significant human rights violations, trauma or torture These circumstances place them at increased risk of complex physical and mental health conditions.[56] In addition to pre-arrival experiences, people from refugee backgrounds face numerous barriers to accessing health care after arrival in Australia. Many of these issues were raised during consultation with Network participants.

On arrival and early in settlement

People from refugee backgrounds can arrive with a variety of health and mental health conditions that may have been previously unmanaged as a result of disrupted access to services. In addition, people from refugee backgrounds arrive having experienced torture or other traumatic events, although it is important for service providers to recognise that they also experience a variety of other mental health issues, similar to those of the general Australian population.

Participants noted that there is an expectation within the Humanitarian Settlement Program (HSP) to meet immediate needs quickly and that often this means mental health assessments are rushed. Settlement services provide focussed support in the very early stages after arrival, however participants identified that supports are often needed for a longer duration to assist people with many of the determinants of health and mental health; such as finding appropriate housing, learning English and finding meaningful employment.

Recommendations included flexible services that support people from refugee backgrounds along their settlement pathway, beyond the supports offered in the first six to twelve months after arrival as part of the Humanitarian Settlement Program.

Settlement stressors contributing to poor mental health, including in the longer term

Participants highlighted that there is a need for health, mental health and settlement services to recognise and understand that specific stressors for people from refugee backgrounds and people seeking asylum that may not be trauma related, and may relate to broader settlement challenges.

It is important for those working with people from refugee backgrounds to recognise that some mental health issues may start in Australia or may be compounded as a result of a range of settlement stressors. These can include isolation and lack of support; housing and Centrelink issues; difficulties accessing employment, particularly meaningful employment; and experiences of racism, discrimination and bullying. Specific examples included individuals being a respected professional in their home country and having qualifications that are not recognised in Australia – which makes it difficult to find meaningful employment, causing stress and contributing to depression. Other examples included experiences of racism and discrimination, and more specifically bullying for children at school on the basis of their English language proficiency or accent. Young people/adolescents were identified as experiencing longer term settlement stressors relating to 'living between two cultures'. This included stressors and pressures from family, feeling lost, and the impact of the mental health of their parents, family violence, and their access to services.

Recommendations to address ongoing settlement stressors that contribute to mental health outcomes for people from refugee backgrounds – including through primary prevention that considers the social determinants of health and mental health. This will require engagement with refugee background communities, greater understanding of the ongoing settlement stressors and co-design of strategies. Systems to address recognition of prior skills and qualifications and support to find meaningful work are needed.

Suicide prevention

There are limited data on suicide in refugee background populations in Australia, although participants identified increasing concern about suicide in young people, including young people born in Australia to refugee background families. Centre for Multicultural Youth (CMY) has also noted an increase in suicide and suicide attempts in young people of refugee background. They report that the impact of a young person taking their life has a ripple effect, including negatively affecting mental wellbeing, and potentially triggering self-harm or suicidal ideation in other young people from within the same communities. Recent experience suggests families and community members have difficulty responding - early warning signs may have been missed; or people may have had concerns, yet they did not know where, or how to seek help. CMY have found that young people from migrant and refugee backgrounds had considerable feelings of shame associated with a young person taking their life. Sometimes, the event is covered up by the family or community leaders, resulting in anger and distrust amongst young people who want to discuss the issue more openly, including the impact of the loss on their own mental health and wellbeing, and how to better support young people in their communities. These differences in response can instigate or exacerbate intergenerational conflict between young people and their parents and community leaders.

Recommendations on ensuring access to culturally appropriate early intervention suicide prevention and post-vention care that specifically targets communities from refugee-like backgrounds.

Explanatory models of mental health and mental health literacy

Different communities have different perspectives and different ways of articulating and describing mental health and wellbeing. In addition, communities have differing levels of need and variable empowerment. People seeking asylum have particular vulnerabilities, and many of this cohort are highly disempowered as a result of the ongoing uncertainty of their visa status and within the current political and social context.

While mental health services need to consider different explanatory models of mental health within service planning and delivery, there is also a need for greater awareness and understanding within communities from refugee backgrounds around mental health, wellbeing and available mental health services. Participants identified a need for greater community awareness and understanding of depression, anxiety and more common mental health issues, and support for understanding that 'this [mental health] is a part of health'. Providers and bicultural workers identified a need for better access to information about mental health and mental health services, including preventative mental health care. Preventative health and early intervention were felt to be unfamiliar concepts in many communities.

A current project funded through Victorian DHHS models community engagement through bicultural workers working with community members to engage in mental health promotion and improving mental health literacy. Bicultural workers use conversations about mental health and wellbeing, increase awareness of services, and where needed, make supported referrals. This model was felt to be useful, engage new communities, and participants suggesting extending similar programs into more refugee background communities (currently funded only for communities from Syria and Iraq).

Recommendations that services need to be based within communities and build relationships in order to improve mental health literacy and awareness of available services.

Recommendations included a need for community involvement in designing education targeted to mental health literacy, and resources to promote understanding of the mental health system, how to access mental health services, and avenues available to raise concerns/make complaints when services do not meet individual needs.

Stigma

Stigma presents a significant barrier within refugee background communities to understanding mental health, talking about mental health and accessing mental health services. There is a lack of information within some refugee communities and there is misinformation regarding mental illness/health. There is a fear within some communities that mental illness means that you are "crazy" and that there is no "cure". This contributes to fear and shame relating to mental illness and accessing services for mental health concerns. A bicultural worker spoke of some families being reluctant to let their children follow through with mental health plans as these were perceived to have negative effects for a child's future, such as difficulty getting a job or into university. Fear and shame was also highlighted as something experienced by people seeking asylum when accessing services on the basis of their asylum seeking status.

There is a need for greater community awareness and understanding of depression, anxiety and more common mental health issues, and an understanding that 'this is a part of health'. Increasing awareness about mental health issues in communities requires working with communities about how to educate and address stigma relating to mental health appropriately and to ensure that mental health literacy and service navigation messages are tailored to the needs of particular communities.

Accessible resources - language

Many resources relating to mental health, including resources to improve mental health literacy and resources that provide service information, are not available in the languages spoken by people from refugee backgrounds. Information in community languages is a current gap within the mental health and broader health system. This requires working with communities to determine the most appropriate messaging relating to mental health and mental health services and also the most appropriate means of communication. For some communities, this means the provision of written materials in community languages, for others this may be audio or pictorial resources. However, this must be tailored based on consultation with communities about which resources work or make sense to them, how the messages can be shaped to better meet their needs, and the most effective means of communicating

information. It is important that information is not only provided through interpreters but through a range of other mediums.

Service access barriers

Lack of available services

People from refugee backgrounds have access to specialised torture/trauma counselling services, however Network participants identified that there is a shortage of specialist mental health services and that increasing access to psychiatric care for other mental health issues is a priority. Reductions in community mental health case management and support were also identified as an issue for people from refugee backgrounds and people seeking asylum.

Participants identified a range of overarching issues in the mainstream mental health system, many with specific implications for people from refugee backgrounds. General concerns included the impact of waitlists for services, a lack of available services, difficulty accessing services, fragmented and poorly linked services, and that in general, services did not adequately consider trauma. More specific concerns included decreasing numbers of community based mental health services with the transition to National Disability Insurance Scheme (NDIS), which has had a major impact on availability of services for people from refugee backgrounds. The NDIS is difficult to access for people with low English proficiency; and is not accessible at all for people seeking asylum or refugees with temporary protection visas (who are ineligible based on their residency status). Further, NDIS approaches mental health within a disability framework rather than a recovery framework, which is not well suited to work with people of refugee background.

Other concerns include a decrease in psychiatrists who bulk bill (including under MBS item number 291), making psychiatry services essentially inaccessible for people from refugee backgrounds. Private psychiatrists who are prepared to bulk-bill are simply not available and the perception from discussions was that clinicians working with people from refugee backgrounds ‘should not waste time on this [trying to refer to private psychiatry]’. The private mental health service system is generally not accessible for children or adults from refugee backgrounds due to cost, and lack of associated language services – for example while the Better Access Initiative supports access to psychologists, the lack of language service funding means this scheme is not accessible for people with low English proficiency.

Other gaps in services identified included limited access to appropriate psychoeducation, that is, psychoeducation tailored to the needs of refugee background communities that is available in relevant settings; decreases in access to complementary therapies; and decreased access to services providing appropriate community based support to people from refugee backgrounds. An example was provided about the decommissioning of the Personal Helpers and Mentors Service (PHaMs). This program previously provided a model of community support that was well accessed by people from refugee backgrounds, and specifically by clients of Foundation House. This program was noted as a good practice model that was accessible and helpful for people from refugee backgrounds, and which did not require a formal mental health diagnosis to obtain the service.

Entry criteria for mainstream mental health services

Entry criteria for a range of mental health services was identified as problematic for people from refugee backgrounds, contributing to barriers to access to services. Issues include rigid or restrictive entry criteria that are often dependent on a formal mental health diagnosis, severity of presentation, or restricted by geographic, age-based or other funding constraints, or an individual’s ability to engage with, or attend services. People from refugee backgrounds often do not fit neatly into service categories and are frequently mobile in the months after arrival – multiple and layered exclusion criteria often function to prevent the most vulnerable people accessing the mental health service system.

While these issues within the mainstream system affect the broader population, this is compounded for people from refugee backgrounds who often struggle to navigate a complex health system and amplified for asylum seekers without access to Medicare. People from refugee backgrounds and people seeking asylum can therefore 'get lost or forgotten' if they are not eligible for a service.

In addition to entry criteria, there are also barriers for people from refugee backgrounds who would like to self-refer to mental health services, due to many referral forms or systems being online. For people with low English proficiency, online self-referrals are inaccessible. There is a need for simplified referral processes and forms that allow people with low English proficiency to understand referral systems and self-refer when needed.

Interpreters and language service support

Access to interpreters was raised as a significant issue impacting on access, appropriateness, effectiveness and cultural safety of mental health and other services for people from refugee backgrounds. Participants noted that there was a lack of language services and a lack of uptake of language services. Private psychiatrists were identified as frequently not working with interpreters. Some participants identified that when language services were utilised, they were not always utilised in a culturally appropriate manner. Issues included accommodating gender preferences or cultural background when requesting interpreters for clients. Working with interpreters who speak the same language as the client, but who are not from the same cultural background, was also identified as problematic. This was felt to be particularly important for interpreters working in mental health, where some concepts are unfamiliar or stigmatised in communities and consultations need to be interpreted carefully with these aspects in mind.

Participants placed value on considering interpreters as part of the therapeutic team - reporting that working with a different interpreter each time you see a client is 'counter-therapeutic' and that interpreters are part of the team providing care. Consistency when working with interpreters was felt to be essential to building strong therapeutic relationships and trust.

Other issues raised relating to language services included lack of access to interpreters with higher level training. Participants noted the importance and benefit of being able to access interpreters who have had specific mental health training and training relating to work with people from refugee backgrounds who may have experienced torture and other traumatic events.

Approach to service delivery

Appropriateness of mental health services

A consistent theme identified related **to concern around the appropriateness of mental health services and the mental health system for people from refugee backgrounds**. This included the clinical and often diagnosis-focussed orientation of mainstream mental health services, as well as the lack of services delivering mental health care in culturally appropriate ways. Mental health services and their underpinning frameworks were noted as being very 'western' in their approach, particularly in reference to the language they use to talk about mental health and wellbeing. Participants reflected that communities frequently perceive mental health services as being only for people with hyper-acute mental illness and that perceptions around acuity (and that "I'm not crazy") affect access to mental health services. Individuals with dual disability/diagnoses (e.g. mental illness and disability, or mental illness and substance use) were felt to be particularly vulnerable, and face substantial issues accessing appropriate care.

Participants noted that torture and trauma services provide very specific care and are not always needed, or appropriate, for people who have other mental health problems (i.e. unrelated to torture or prior trauma), or for those who are experiencing mental health issues as a result of their settlement experiences. A gap was identified between mainstream services and torture and trauma services and

participants felt that the '**majority of people from refugee backgrounds need something between mainstream mental health and torture and trauma counselling'**.

Additionally, it was noted that some refugee-like communities are 'very protective' and may be unwilling to engage with mainstream mental health, or drug and alcohol services. Two factors were felt to be critical to addressing this issue: i) services building relationships with communities to address pre-conceptions, and ii) the willingness and skills of service providers to work with people from refugee backgrounds and their beliefs.

Other issues with service delivery

While there are specialised services for people from refugee backgrounds and people seeking asylum, including specialised torture and trauma services, it was noted that **services are 'scattered' and that there was not a 'statewide approach' to delivering good mental health services for people from refugee backgrounds**.

General mental health services, including child and adolescent mental health services (CAMHS), area mental health services, and acute/inpatient services, were reported as seeing small numbers of people from refugee backgrounds. Initiatives to support education for providers around working with interpreters, providing trauma informed care, and understanding the refugee/asylum seeker experience were identified as beneficial and likely to impact positively on the approach to service delivery for these populations.

A range of challenges relating to service models were identified for people from refugee backgrounds, including problems arising when services 'assess and refer'. For people from refugee backgrounds this is problematic, as it relies on people telling their story, often of torture or other traumatic events, as part of the intake process, and then being referred to see someone else, where this story may need to be told again. This is re-traumatising, and functions as a barrier to engaging with mental health services.

Good practice service models

Good practice approaches to the delivery of mental health services for people from refugee backgrounds included integrated services, interdisciplinary teams, and co-located services; services that take a broad approach to recovery; services that are willing to engage in broader advocacy; working within an integrated trauma framework; and services that build local relationships with refugee background communities. Family based care and ensuring family and community support for people who are experiencing mental illness was identified as an essential part of recovery for people from refugee backgrounds. Primary health care providers were identified as critical in supporting access to mental health services for people from refugee backgrounds and providing follow-up care – essentially step-up and step-down care within an integrated system.

Co-location of services was identified as particularly beneficial for people from refugee backgrounds. Developing a trusting relationship with a health provider then provides a greater chance of engagement with other services, including mental health services, when these are based on site and recommended by the trusted service provider.

Community health services often have a good model of integrated service delivery, with access to counsellors and social workers, mental health nurses, and physiotherapy within the one service, although participants also reported that access to psychiatry was previously in place within this model (and felt to be highly beneficial) and has now been defunded.

Co-location and integration of mental health services within generalist settings, such as general practice (GP) clinics, was identified as a good way for mental health services to be "normalised" – recognising that 'mental health is part of health' and that such strategies help address stigma around mental illness. Co-location also was identified as having the potential to increase uptake of mental health services, as a trusted GP or service provider could make a 'warm' referral to mental health

services. The physical location and accessibility by public transport were also identified as important factors for access to services.

Two key examples of good practice working to identify people with mental illness and link them with early treatment and support were the Refugee Health Program (RHP) and models of integrated service delivery.

Refugee Health Program

The RHP is a targeted service for refugees and asylum seekers in Victoria, established in 2005. The RHP is funded by the DHHS and delivered through community health services in Victoria. The RHP has three aims – these are to:

- Increase refugee access to primary health services.
- Improve the response of health services to refugees' needs.
- Enable individuals, families and refugee communities to improve their health

The program works with individuals and families, delivering direct services, as well as providing training and other capacity building activities to the broader primary health care system to build understanding of the unique needs of people from refugee backgrounds.

In 2014, the Victorian Auditor General's Office (VAGO) reviewed Access to Services for Refugees, Migrants, and Asylum Seekers including timeliness of the services, service coordination and the ability of the service to respond to client's identified needs. The RHP played a large part in the Auditor General's conclusion that "only the Department of Health can demonstrate at a strategic level that it understands the complex and multiple needs of migrants, refugees and asylum seekers."[57]

In general, the RHP staff, mostly Refugee Health Nurses (RHN) are based within community health, supporting clients in the initial months after settlement, coordinating the post arrival health assessment and linking people with appropriate services. Case workers regularly refer into the RHP when clients are in need of support and the RHP assist in 'holding' the clients, while helping them access services.

Within the RHP there are three Settlement Health Coordinator (SHC) positions – based within settlement services and working closely with settlement providers (AMES Victoria). Over the period July 2017 - December 2018, 4,598 clients came through the Footscray and Dallas AMES offices, where the co-location of SHC has been piloted. The SHCs provided 2,200 clinical care contacts within this cohort. The SHC work to bridge the gap for settlement caseworkers - supporting the triage of clients and assisting in the casework referral process so clients are linked to appropriate services. Early settlement support could be enhanced by investing in services that support care coordination and early screening, enabling early identification of mental illness and early intervention for people of refugee background. Models which augment the RHP, improve referral pathways for newly arrived refugees, support early mental health promotion and access to mental health services where required, should be explored.

For clients who have been settled for longer periods, and who are no longer receiving post-arrival settlement support, the RHP are a useful referral point for other services, such as housing and employment services. Settlement stressors can be cumulative, and the impacts of un- or under-employment, discrimination and social isolation can compound pre-settlement challenges and prior trauma.

An integrated service system where multiple services are on-site and the RHN can work across the services and/or seek advice or advocate for mental health care alongside addressing social determinants of health is felt to be a good example of a system that is working well, and can support individuals to get early treatment if needed.

Integrated Services

Five models within Victoria have been raised as a good practice examples of integrated health and mental health services:

- **Cohealth -** clients have access to counsellors and social workers, mental health nurses, and physiotherapists in the one service. In the past, there was also access to psychiatry, which has now been defunded. This model was identified as having the potential to increase uptake of mental health services, as people from refugee backgrounds often have a trusted GP or service provider who could make a 'warm' referral.
- **Monash Health Refugee Health and Wellbeing -** integrates tertiary and primary care services within a community setting, and is linked to acute services, including Area Mental Health Services. This model ensures services are optimally located within a community setting whilst also structurally supporting the transition of patients across the spectrum of care. The physical location and accessibility of public transport are important factors for service access.
- **Cabrini Asylum Seeker and Refugee Health Hub** is a philanthropically funded organisation providing primary care and specialist mental health services for asylum seekers, including those without Medicare. The service provides care for some of Victoria's most vulnerable asylum seekers, and integrates services, including mental health casework.
- **Royal Children's Hospital Immigrant Health Service** provides an integrated model of physical and mental health for infants, children and adolescents, with psychiatry and mental health nursing embedded within the clinic model.
- **Asylum Seeker Resource Centre (ASRC)** a philanthropically funded organisation that provides a culturally attuned response to people seeking asylum. The ASRC provides primary care, psychiatry and counselling services; prioritising people without Medicare. The service addresses the social determinants of health through extensive housing, foodbank and casework programs. Additionally, the ASRC provides access to legal, employment and education programs, which provides a holistic and supportive service delivery model.

Need for flexible, connected services

There was consensus on the need for service models to be more flexible. This includes wait times for services and prioritisation of wait lists, and flexibility for services that are geographically bound. People from refugee backgrounds often move in the early years of settlement, disrupting access to services. **Flexible service models were identified as particularly beneficial when they had the ability to respond to 'high prevalence, low impact' mental health conditions, alongside work with 'low prevalence, high impact' conditions.** This was particularly important for people from refugee backgrounds who may be experiencing mental health issues such as depression or anxiety that are related to settlement stressors such as learning English, finding work, parenting in a new country, or access to affordable housing.

Flexible service models should be able to accommodate movement of people from refugee and asylum seeker backgrounds. One example provided was a 'dynamic hub and spoke' model, which may include a virtual hub of expertise that can provide services that are not bound to a physical location, and exploring innovative use of technology, such as telehealth.

Workforce

A number of workforce issues were identified to support accessible, appropriate and culturally safe provision of mental health services. Workforce issues were felt to extend across the range of mental health clinicians, including psychiatrists; psychologists, GPs, nurses, mental health nurses, those working in settlement services, interpreters and bicultural workers. This included the need for

increased workforce funding as well as increased diversity, training and upskilling within the workforce.

Training and upskilling

There is a need for greater training and upskilling for generalist and specialist health care providers to work with people from refugee backgrounds. This includes training and skills related to working with interpreters, culturally competent/appropriate delivery of services, understanding refugee and asylum seeker specific context, and trauma informed care. GPs were identified as a critical workforce given their role in primary care, and as 'gatekeepers' to services. GPs provide a large amount of day-to-day mental health care, yet this work is often under-recognised, and they are often under-resourced to do so.

Psychiatrists were identified as a workforce requiring education and training relating to working with interpreters, and child protection workers were also identified as requiring upskilling and training about working with families from refugee backgrounds.

Workforce diversity

A lack of diversity within the health and mental health workforce was noted as a longstanding issue. This includes a lack of cultural diversity in the broader health and mental health workforce, as well as a lack of diversity of disciplines within clinical teams. Bi-cultural workers embedded in organisations can be an important bridge to enable communities to access services, particularly mental health services, where stigma is a barrier to access. Teams working with people from refugee backgrounds in mental health need to be diverse, with a diverse set of skills.

Recommendations include employing bicultural workers and community liaison workers specific to refugee background communities - for both mental health roles and general support roles. **Other recommendations included rotating placements for mental health clinicians within specialised refugee services; extending the refugee fellow program to include a psychiatry position; and increasing access for community to access Certificate III and IV courses relevant to mental health, so that people from refugee background can contribute to delivering mental health services in culturally appropriate ways, and access education and employment pathways to build diversity within the mental health workforce.**

Particular issues for people seeking asylum

The issues raised and recommendations made in this submission relate to people from refugee backgrounds, including people seeking asylum. There are, however, unique challenges facing people seeking asylum in relation to their mental health and mental health service access.

People seeking asylum are experiencing poorer mental health as a result of the duration of uncertainty related to their protection claim, their ongoing uncertainty, and more recently, due to changes in policy and the provision of Status Resolution Support Services (SRSS) program that significantly increase their risk of homelessness, and destitution. They face multiple, additive, and ongoing stressors, often including family separation; with little chance of resolution within the next three years, and cumulative impact on mental health. While the Victorian State Government has been proactive and supportive, the impact of these issues will be ongoing, and there is a need for greater advocacy by the sector and State Government at a Commonwealth level in relation to these issues.

People seeking asylum who are coming off SRSS frequently have multiple, and complex needs, and providers are seeing high frequency of serious mental illness, and escalating suicidality. There is a lack of accessible mental health services in Victoria that are able to address these needs, with a large burden falling to ASRC, Monash Health and Cabrini Hub. In addition, people seeking asylum may live far from the services that can provide multidimensional support. Specific examples reported to the Network include people seeking asylum living in Tarneit and Brookfield.

Participants noted that there is a lack of understanding within services about the particular needs of people seeking asylum, and widespread confusion about their eligibility for services. Key issues include the need for greater awareness about the experiences of people seeking asylum, including the impact of prolonged uncertainty, delays in processing, and diminishing welfare support; the increasing risk of destitution; and the implications for mental health.

For many people seeking asylum, the Refugee Status Determination (RSD) is lengthy. At the primary stage of this process, people can experience waiting times of up to a year for an initial interview with the Department of Home Affairs (DHA), with another one to two years being an average duration for those appealing for review of immigration decisions - to either the Immigration Assessment Authority (IAA) or the Administrative Appeals Tribunal (AAT). Waiting times become progressively protracted as a person seeking asylum moves through the various stages of appeal, with current waiting times for a Federal Circuit Court (FCC) hearing (directional only) being approximately two years. This influences life planning, employment prospects, housing stability and access to Medicare due to constantly changing Bridging Visa status, and the rights attached to this form of visa. A person experiencing this level of uncertainty for such protracted periods, almost always experiences deterioration in their mental health, and frequently develops mental illness.

Recommendations on advocating for prompt resolution of migration status and needs based Status Resolution Support Services for people seeking asylum; support for access to mainstream mental health services; and support for specialised services to deliver care for asylum seeker children and adults with mental illness and support their complex psychosocial needs.

Thank you for the opportunity to contribute a submission to the Victorian Royal Commission on Victoria's Mental Health System – we are keen to contribute to the work of the Commission and look forward to the Commission's findings and reform within mental health in Victoria.

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