Queensland Mental Health Commission

Queensland Mental Health Commission Strategic Planning Issues Papers

Prepared and Submitted by:
Queensland Program of Assistance to Survivors of Torture and Trauma

Refugee Mental Health

- **Topic**
  Brief description of topic to be addressed

Current access to mental health services in Queensland for people from refugee backgrounds

- **Current Situation**
  Brief analysis of the current issues, data or other evidence as relevant to Queensland

In 2011, 20% of the population in Queensland was born overseas and almost 10% speak a language other than English at home. Immigration is the main source of population growth in Queensland. As part of this, Queensland settles approx 13% of the annual national refugee intake of 20,000 per year. The refugee population in Queensland is growing increasingly diverse and geographically dispersed. Pre-migration torture and trauma and post-migration acculturation stress are recognised as risk factors to poor mental health outcomes in this population group.

Data from Department of Immigration and Citizenship (DIAC) indicates that as of the end of March 2013, 1430 people had come to Queensland in that financial year as refugees (ie as permanent residents) and were settled across Queensland. The largest group (829) came from the Middle East, followed by Africa (322) and Asia (238). Brisbane and Central Coast settled the largest number of people (679), followed by South East Queensland (562) and South West Qld (107). Smaller numbers settled in far North Qld (39) and North West Qld (43). The number settled each year means a cumulative increase with approximately 2000 people being settled in Queensland each year.

A number of key community support services which have previously provided preventative wellbeing support for vulnerable groups within the general population but also for people from refugee and asylum seeker backgrounds, have recently lost funding. This includes areas such as housing and homelessness support and youth service.

People from refugee backgrounds are generally considered to be a sub-set of the CALD community, there are, however, important differences including:

- Refugees face a suite of issues and while some may be common to people from CALD backgrounds, others may not;
- Refugees do not chose to leave their country, do not chose where they are settled and are unlikely to be able to return. They have experienced persecution and displacement and generally have experienced torture and extreme trauma which has had a profound and long term impact on health

and wellbeing. Access to services is impeded by the impact of these experiences as well as those related to language and cultural views surrounding health. This may be further exacerbated if the person is still seeking asylum and is not in a place of "safety".

Community Mental Health Services (NGO sector)

The resource allocation to the multicultural mental health non-government sector has remained relatively unchanged in the past 18 years despite the significant growth in numbers (over the past 10 years approx. 15,000 people from refugee backgrounds have settled in Queensland). The Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT), Harmony Place (Multicultural Centre for Mental Health and Wellbeing) and the Townsville Mental Health Awareness Project, are funded via the Queensland Government mental health non-government funding program, and have been in receipt of the same amount of funding (with CPI) since 1995.

The lack of resources available in the multicultural mental health non-government sector to provide culturally appropriate mental health support programs across the state is of concern. National data shows low rates of access by CALD communities to mental health services despite evidence showing that the prevalence of mental illness being higher in refugee communities. Mainstream health care providers are not routinely trained to identify and deal with refugee survivors and QPASTT routinely works with clients who fall outside of the public health system. Refugee survivors have issues with trust and are reluctant to re-tell their stories; this, along with specialised skills required to adequately address recovery for this client group, means that specialised services are necessary to enable access and recovery.

Specialist serviced based within Queensland Health

The Queensland Transcultural Mental Health Centre is based in Metro South Addiction and Mental Health Services. It provides specialist state-wide consultation and assessment services for CALD individuals, families, communities, and organisations but does not provide ongoing services.

In addition Multicultural Mental Health Coordinator positions were based within acute mental health services across 8 Hospital and Health Services. Their roles are focused on ensuring culturally responsive acute service delivery to CALD consumers and their families, however in a number of regions these positions have recently been re-allocated to other areas of priority by the relevant Hospital and Health Service.

Funding Allocations

Since 2007, recurrent funding dedicated to multicultural mental health sat around $3m per annum as follows:

$2.3m*	Queensland Health	. To deliver the state-wide Queensland Transcultural Mental Health Centre and multicultural mental health coordinator positions
Approx $500,000* to the Community Mental Health Services including	• QPASTT (non-government sector) – Statewide service • Harmony Place (non-government sector) • Townsville Mental Health Awareness Project • (non-government	. To deliver torture and trauma counselling and support services. This includes services across Queensland; however is pre dominantly funded by the Federal Government. . To provide non clinical mental health support to CALD consumers in the Brisbane region . To conduct non clinical mental health support and awareness activities in multicultural communities

	sector)	

* These are approximate figures from 2010. These have potentially been reduced since that time and are no longer easy to determine as some of the funding is now incorporated into core funding for Health and Hospital budgets and not quarantined. Current NGO funding agreements are only until December 2013

Prevalence and ethnicity

National data shows the persistent low rates of access by ethnic communities to mental health services despite Australian and international evidence showing that levels of mental illness may be higher in immigrants and refugees than in the host community due to pre-migration, migration and settlement stresses.

Data Collection

A key issue is data consistency and quality as "overseas born" data (collected by Queensland Heath Services) does not capture rates of people from refugee backgrounds accessing services.

Service access and utilisation

Various Queensland and national studies have consistently shown that people from CALD backgrounds are under-represented in mental health services.

Explanatory models of mental illness

A key challenge in multicultural and refugee background mental health is in relation to the many different cultural explanations of mental illness across cultures and the need for clinicians to understand when unfamiliar traits, behaviours, thoughts and emotions in patients are a result of psychopathology, or simply cultural explanations as these issues impact on assessment, treatment and care.i

The Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder recognises that in treating refugees and asylum seekers practitioners are faced with complex factors over and above the individuals' traumatic experiences, including language, ethno cultural, socio-political and community issues, and the individual's current clinical and psychosocial situation. The impacts and legacies of refugee related trauma span psychological, social and existential domains. The experiences of each person and the way that they are reacting to these experiences are unique.

For professionals working in the specialised field of torture and trauma counselling, they need to consider the way that the clients explain their presenting issues and work with their understanding of what they bring to us. In assessments, what clients bring from their cultural and personal point of view plus their own professional assessment of the client's presentation needs to be taken into account. Barriers arise when clients are referred to mainstream mental health services where staff are not culturally competent in working with people from different backgrounds and may not have an understanding of what the client is experiencing. Once this occurs clients are reluctant to re-present.

Pathways to access

It is not surprising that if ethnic groups have differing beliefs about mental health problems and mental illness that means they will not necessarily access a mental health service. Internationally, it has been shown that the differences between native born and immigrants entering mental health care involuntarily arise out of a dynamic interaction between family choice, cultural values and beliefs regarding mental health services and help seeking, and contextual factors such as availability of services and social networks that can refer to such services. People from ethnic communities most often prefer to seek help via community leaders and their informal networks. In addition, the stigma and shame associated with mental illness is a great contributor to people's reluctance to look for help.

People from refugee backgrounds may experience fear of discrimination when accessing services. People who have endured torture at the hands of government services maybe highly fearful or suspicious of government services and

professionals. The physical environment as well as the approach adopted by professionals is important to building the necessary confidence and trust with CALD individual.

Access to Primary Health and Mental Health Services (eg via GPs, Better Access & ATAPS)

People from refugee backgrounds face considerable barriers to accessing the primary health care system including language and cultural difference; understanding of the healthcare support and service systems; and lack of confidence within both professionals and clients to seek out and develop mutual understanding of issues, interventions and treatments. An important part of the recovery model for this client group is that it is recognised that they are experiencing normal reactions to abnormal experiences rather than being individually pathologised and given a mental health diagnosis. Funding in the primary health care system is predominately based around a diagnosis and while this may be appropriate for some it is a barrier for others.

General Practice (and private Allied Health) models are based on business models where the inequity that already exists to health care for some population groups such as CALD people is amplified. Client groups with complex health needs that require more complex responses and resources are unlikely to be prioritised or offered services. Examples of the additional resources required includes more time to: explain service systems; explain health conditions and treatments; organise and work with interpreters; and address a range of issues for all presenting family members.

Access to primary care services for people from refugee backgrounds is difficult. Practices turn away clients, citing they have too much to do and cannot be expected to meet everyone's needs. Yet the current system and funding programs is dependent upon the involvement of both GPs and Medicare Locals. In addition:

- GP services are reluctant to and frequently do not use interpreters;
- Allied health practitioners in private practice are not able to access fee free interpreting from TIS;
- ATAPS programs which are supposedly about addressing these barriers via offering interpreter funding are being inconsistently implemented and accessible.

- ### Models and Precedents for Innovation and A Better Way Forward

  Brief analysis of solutions or approaches relevant to the topic, with reference to 'better resources; better services; better accountability and transparency; better engagement'.

  - Good quality data is critical for appropriate resourcing, better services, better accountability and better engagement. The fact that Queensland Health does not collect specific data on people from refugee backgrounds only overseas born is a limitation on planning for this client group. We recommend that the data variable "ethnicity" be included to provide more useful information for service planning and service accountability purposes.

  - People from refugee backgrounds tick all the boxes in terms of risk for poor mental health outcomes. However their resilience in surviving and making it to Australia demonstrates their strengths and capacity to overcome such experiences. If this group is supported at critical points in their settlement process we are able to arrest a decline in mental health rather than issues becoming more acute. By the system enabling services to deliver high quality appropriate and targeted recovery services rather than focusing on acute services, people from refugee backgrounds may never need to engage in acute services.

  - Community based services have a strong relationships with this client group, their families and their communities. National and international evidence based research supports the delivery of primary care mental health services in local, well connected community organisations. These services are often not

recognised by medical practitioners as equal partners in the recovery from mental health problems, and there is a lack of partnership arrangements with community based health and mental health services to offer holistic and flexible services. Community Services are able to provide wrap around services which enable the development of trust and enable needs which impact on mental health and recovery to be addressed. It is important that these services are continued in order to allow for better services and appropriate engagement.

- Investment in building the capacity of mainstream services to enable asylum seekers to receive appropriate services is critical. This is also a better use of resources than the provision of inappropriate services which fail to enable positive outcomes.

- People from refugee backgrounds struggle to access sub-acute mental health services (particularly around crisis care). New service models to address this are needed and in particular services around triage and assessment and short term after hours interventions.

- There is a need to build specialist capacity within the public mental health system to assess and triage this client group including increased skills around contextual issues surrounding the refugee experience, language, cultural context and referral pathways

- **Implications for the Reform and Change Agenda in Queensland**
  Three or four key implications

While the reform agenda in Queensland is looking at recommissioning and tender, it is important that the specialist and intensive nature of work in this field is recognised. It is also important that services able to work with people from refugee backgrounds continue to be funded and tender processes recognise and take into account the vulnerability of this client group. This could include a requirement that successful tenders are able to demonstrate that they:

- understand the differences required in service frameworks and delivery in order to enable access by people from refugee backgrounds;
- have the capacity to ensure the needs of refugee survivors are able to be met;
- are able to establish trusting and positive relationships with refugee survivors of torture and are able to engage this group in an ongoing manner;
- are able to deliver a comprehensive and appropriate service for torture and trauma survivors that acknowledges the diverse needs of different cultural groups;
- are able to build the capacity of other (mainstream) services to work with refugee survivors;
- recognise and build into their service delivery frameworks the use of interpreters; and
- recognise the clinical nature of services currently located within the NGO community mental health sector.

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[i] Stern, Lara & Kirmayer, Laurence J. (2004) 'Knowledge Structures in Illness Narratives: Development and Reliability of a Coding Scheme', *Transcultural Psychiatry*, Vol. 41, No. 1, pp.130-142.