victorian refugee health network

Foundation House
The Victorian Foundation for Survivors of Torture Inc.

Key Issues in Access to Mental Health Care for Refugee Background Communities

A SECTOR CONSULTATION TO INFORM VICTORIA'S MENTAL HEALTH REFORMS

ACKNOWLEDGEMENT OF COUNTRY

The Victorian Refugee Health Network acknowledges the Traditional Custodians of the lands on which we work across Victoria and that the lands were never ceded. We recognise the resilience, strength and pride of Aboriginal and Torres Strait Islander communities and pay our deepest respects to Elders past, present and emerging leaders.

ABOUT THE VICTORIAN REFUGEE HEALTH NETWORK

The Victorian Refugee Health Network (VRHN) was established in June 2007 to facilitate greater coordination and collaboration amongst health and community services to provide more accessible and appropriate health services for people of refugee backgrounds.

The VRHN brings together a wide range of representatives from the health, settlement and community sectors who actively participate in projects and initiatives of the VRHN. This work builds on the many activities and programs around the State that support refugee health and wellbeing.

Informed by sector engagement and consultation, the VRHN focuses on several key project areas. This includes refugee and asylum seeker health, mental health, language services and interpreters, immunisation, disability, primary care and access to specialist services, and resource development.

ABOUT THE PROJECT

In 2022, the Victorian Refugee Health Network and the Victorian Foundation for Survivors of Torture (VFST), also known as Foundation House, established the Diverse Communities Mental Health and Wellbeing project, funded by the Victorian Department of Health. The project aimed to enhance the capacity of refugee and asylum seeker background communities to engage in and promote Victoria's mental health reforms and initiatives.

The project objectives were:

- to understand the needs of refugee background communities and the barriers they experience in accessing mental health services in Victoria, through engagement with two Community Advisory Groups, from Syrian and Iraqi communities, and communities from Afghanistan.
- to understand the challenges that services experience in engaging with and providing care to refugee and asylum seeker background communities through sector consultations utilising a survey, a workshop, and in-depth interviews with service providers.

ABOUT THIS REPORT

This report provides a summary of findings from a series of consultations conducted with mental health and other services about access to mental health services for clients from refugee and asylum seeker backgrounds. The consultations started with a survey, which was complemented by a workshop with Refugee Health Nurses, interviews with services in rural and regional areas, and interviews with General Practitioners specialising in refugee health. Owing to the significant overlap of responses from the consultations, the discussions under each theme were not segmented according to consultation groups, except where specified.

The first section of the report outlines the methodology for the consultations, including information about the respondents and the type of services they offer. The second section provides a summary of the challenges that services face in providing support to clients of refugee and asylum seeker backgrounds reported by the respondent. The final section of the report provides recommendations that would improve access to mental health services at sector, workforce, and community levels.

VRHN and VFST would like to thank everyone who took part in the survey consultation or who provided feedback in other ways on the key themes identified. We appreciate and value the input to this project and the contributions to improving service access for people of refugee and asylum seeker backgrounds.

Prepared by Ambreen Mirza and Mursha Dalay-on and the Diverse Communities Mental Health and Wellbeing Project Team from the Victorian Refugee Health Network and Victorian Foundation for Survivors of Torture.

The Victorian Refugee Health Network and Foundation House acknowledge the support of the Victorian Government for this project.

December 2023

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Executive Summary

In 2022, the Victorian Foundation for Survivors of Torture (VFST) and the VRHN established a project to enable refugee background communities and the service sector to provide feedback into the Victorian mental health reforms, with the vision of improving mental health service access for people from refugee and asylum seeker backgrounds. To achieve this, the Diverse Communities Mental Health and Wellbeing project leveraged VFST's community capacity building work with community advisory groups with lived experience and VRHN's expertise in advocacy and refugee and asylum seeker health service sector engagement.

A series of consultations were conducted with mental health and *other services* (which include primary care services, allied health, settlement services, humanitarian support programs, and community organisations) to understand the challenges services experience in engaging with and providing care to refugee and asylum seeker background communities.

From November to December 2022, a survey was disseminated via email to VRHN members and services who were part of existing networks, as well as organisational and professional contacts. A total of 91 survey responses were received from respondents working for mental health services and from other services. Most of the respondents were from Metropolitan Melbourne, with some from regional and rural Victoria.

The survey was complemented by a workshop with 46 nurses working with the Victorian Refugee Health Program, interviews with three General Practitioners specialised in refugee health, and interviews with six respondents from services based in rural and regional areas.

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KEY FINDINGS

Participants in the consultations identified key issues specific to mental health services and *other services,* as well as challenges experienced across the sector. These are consolidated into the following themes:

- Limited capacity of services to work with and provide trauma-informed care to refugee and asylum seekers
- Issues related to use of interpreters
- Fragmented mental health system
- Long wait times and implications
- Limited options for clients in rural and regional areas
- Limited options for clients accessing mental health support
- Financial costs of accessing mental health support
- Other client level barriers
- Lack of awareness and understanding of Victoria's mental health reforms and newly established initiatives and services.
- Lower levels of understanding of the mental health reforms amongst 'other services' (i.e. referring agencies, allied health), and a very low level of awareness of the mental health reforms amongst GPs consulted.

In this report, *other services* refer to non-mental health services, including primary care, allied health, settlement, humanitarian support, local government, and community organisations.

RECOMMENDATIONS

To address the issues and challenges identified in the consultations, below is an outline of the key recommendations for consideration in the mental health service system reforms.

- Institute workforce development across the service sector, with a strong focus on developing culturally safe and trauma-informed practice.
- Equip services with resources to effectively work with refugee and asylum seekers, including communication in community languages, increased funding for bi-cultural workers and improved use of interpreters.
- Integrate mental health and wellbeing within a holistic and coordinated health system through improved linkages across sectors and with specialist refugee health services to ensure continuity of care, and integration of family-centred services and the NDIS in the reformed mental health system.
- Develop effective strategies to reduce long wait times and ensure prompt access to mental health support, including improving service capacity, increased funding for thorough mental health assessments, and simplified referral process.
- Build the capacity of services and communities in rural and regional areas to promote mental health and wellbeing by increasing the number of services, expanding eligibility criteria for intake and access, and providing no-cost support for high-risk clients.
- Increase access options for refugee and asylum seekers needing mental health support, particularly those with limited digital literacy and/or those needing urgent support.
- Review and amend restrictions to accessing mental health care arising from residency status of clients.
- Implement and resource community-based programs to address client-level challenges to accessing mental health support.

Many recommendations pertain to the development of a holistic system of health and community services. On this basis, the capability to respond to the mental health and wellbeing needs of refugee and asylum seeker clients should be built into both organisational policy and practice.

Introduction

One of the recommendations of the Royal Commission into Victoria's Mental Health System is to work in partnership with and improve accessibility for diverse communities.[1] In response, the Victorian Foundation for Survivors of Torture (VFST) and the Victorian Refugee Health Network (VRHN) established a project to facilitate the integration of community voices into the reform process. The Diverse Communities Mental Health and Wellbeing project aimed to leverage VFST's community capacity building work with community advisory groups combined with VRHN's expertise in advocacy and refugee health service sector engagement.

The main objectives of the project were:

- **to understand the needs of refugee background communities and the barriers they experience in accessing mental health services in Victoria, through consultation with two Community Advisory Groups from Afghan and Syrian/Iraqi communities, and**
- **to understand the challenges that services experience in engaging with and providing care to refugee and asylum seeker background communities through service sector consultations utilising a survey and in-depth interviews.**

This report outlines the findings from a series of consultations conducted with mental health and *other services*, and complements other reports produced within the broader scope of project.

1 Royal Commission into Victoria's Mental Health System – Recommendations. Available at **https://finalreport.rcvmhs.vic.gov.au/recommendations/**

The consultations

SURVEY

From 4th November to 6th December 2022, the Victorian Refugee Health Network undertook a survey consultation with service providers working with people of refugee and asylum seeker backgrounds. The survey aimed to seek feedback from service providers on their understanding of key issues impacting access to mental health services for people from refugee and asylum seeker backgrounds.

The purpose of the survey was to:

- understand service and system gaps and challenges in offering services to individuals from refugee and asylum seeker backgrounds, and
- understand the barriers that individuals from refugee and asylum seeker backgrounds face when accessing mental health services

The survey was disseminated via email to VRHN members and services.

A total of 91 survey responses were received. These were categorised into responses from participants in mental health services and from those working in *other services*.

The *mental health services* included mental health advocacy services, paediatric mental health services, child and adolescent mental health services, and mental health clinicians for people seeking asylum.

In this report, *other services* refer to non-mental health services, including primary care services, allied health, settlement services, humanitarian support programs, local government services, and community organisations. They are also sometimes referred to in the succeeding discussion as *referring services*.

Profile of survey respondents

FIGURE 1

LOCATION OF RESPONDENTS

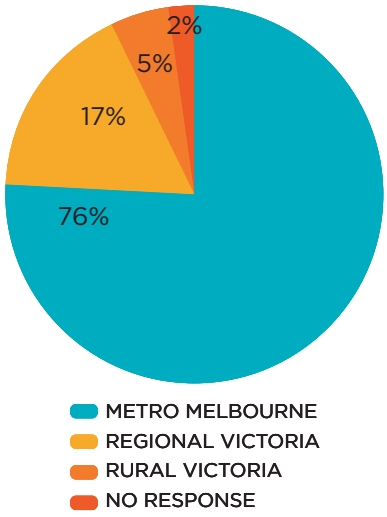
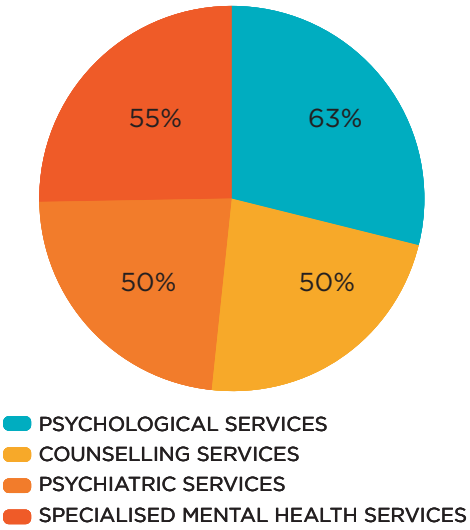


FIGURE 2

MENTAL HEALTH SERVICES OFFERED



How services identify clients from refugee and asylum seeker backgrounds

Respondents reported several methods to identify clients from refugee and asylum seeker backgrounds. These include:

- Directly asking clients if they are of refugee or asylum-seeker background: via intake forms (enrolment or registration forms) or at intake assessment or interview.
- Information from a referring agency (e.g. GP, health provider, support worker) indicating the client has a refugee or asylum-seeker background.
- Visa status or other documentation requested from clients for identification purposes or indicating client is from a key refugee-source country.

Responses indicated a lack of consistency in the way services identify refugee and asylum seeker background clients. This warrants the need to improve methods to identify, collect and report on migrant and refugee background in Victorian health data as well as the accessibility and responsiveness of services to people of refugee background.

WORKSHOP WITH REFUGEE HEALTH NURSES

As follow-up to the survey, a workshop was facilitated with nurses from the Victorian Refugee Health Program. The 46 nurses represented the following services and LGAs:

- Cohealth (Moonee Ponds, Footscray, Maribyrnong)
- EACH (Manningham, Maroondah, Whitehorse, Yarra Ranges)
- Monash Refugee Health and Wellbeing (City of Greater Dandenong, Casey, Cardinia)
- IPC Health (Brimbank, Melton, Wyndham)
- DPV Health (Hume, Whittlesea)
- Sunraysia Community Health Services (Mildura)
- Swan Hill Community Health Services (Swan Hill)
- Bendigo Community Health Services (Bendigo)
- Primary Care Connect (Shepparton)
- Latrobe Community Health Services (LaTrobe)

INTERVIEWS WITH SERVICES IN RURAL AND REGIONAL AREAS

Three dyadic interviews were conducted with services working with refugee communities in rural and regional areas to further understand the challenges they face in engaging and providing mental health care to this group. The six respondents were based in the areas of Mildura, Shepparton, and Nhill. They represented organisations that provide settlement services, community health services, mental health support via torture and trauma counselling, and an English language school.

INTERVIEWS WITH GENERAL PRACTITIONERS (GPs)

For many, GPs are the first point of contact for people accessing mental health support and a main source of referrals. This theme consistently surfaced from the project team's community engagements and sector consultations. Recognising this critical role, interviews with GPs were included in the series of consultations to understand the challenges they experience in facilitating access to mental health support for patients from refugee and asylum seeker backgrounds. Three Melbourne-based GPs working in refugee health participated in the interviews for this project.

Mental health concerns of clients from refugee and asylum seeker backgrounds

The survey consultation asked respondents to identify the common mental health concerns experienced by their clients from refugee and asylum seeker backgrounds.

More than 80% of respondents working in *mental health services* reported providing services to refugee and asylum seeker clients for trauma-related concerns, anxiety, and other psychological issues. Others reported attending to clients for depression, support for children (ADHD, autism spectrum, cognitive assessments), suicidality, and addiction related concerns (see Figure 3). Family violence is another issue that results in clients being mandated to attend behaviour change programs. Some of the respondents have also seen clients with psychiatric concerns, distress related to uncertainty and other issues related to the visa process, as well as other situational crises such as grief and loss, financial pressures, and homelessness.

Figure 3 presents the common issues based on the percentage of responses from those working in mental health services.

For respondents from *other services*, the most common reasons for referral to mental health services were anxiety, trauma related concerns, and depression. A significant percentage also referred clients for support for children (e.g., autism, ADHD, cognitive assessments), suicidality, medication or psychiatric support, addiction concerns, and behavioural change programs due to family violence.

FIGURE 3

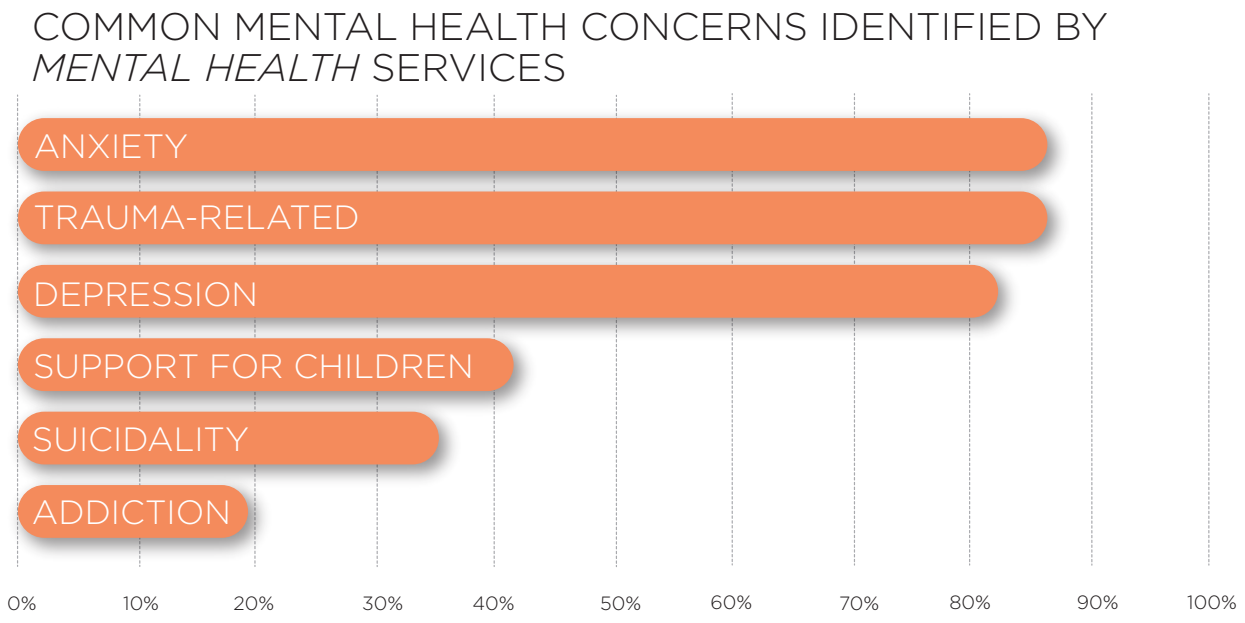


FIGURE 4

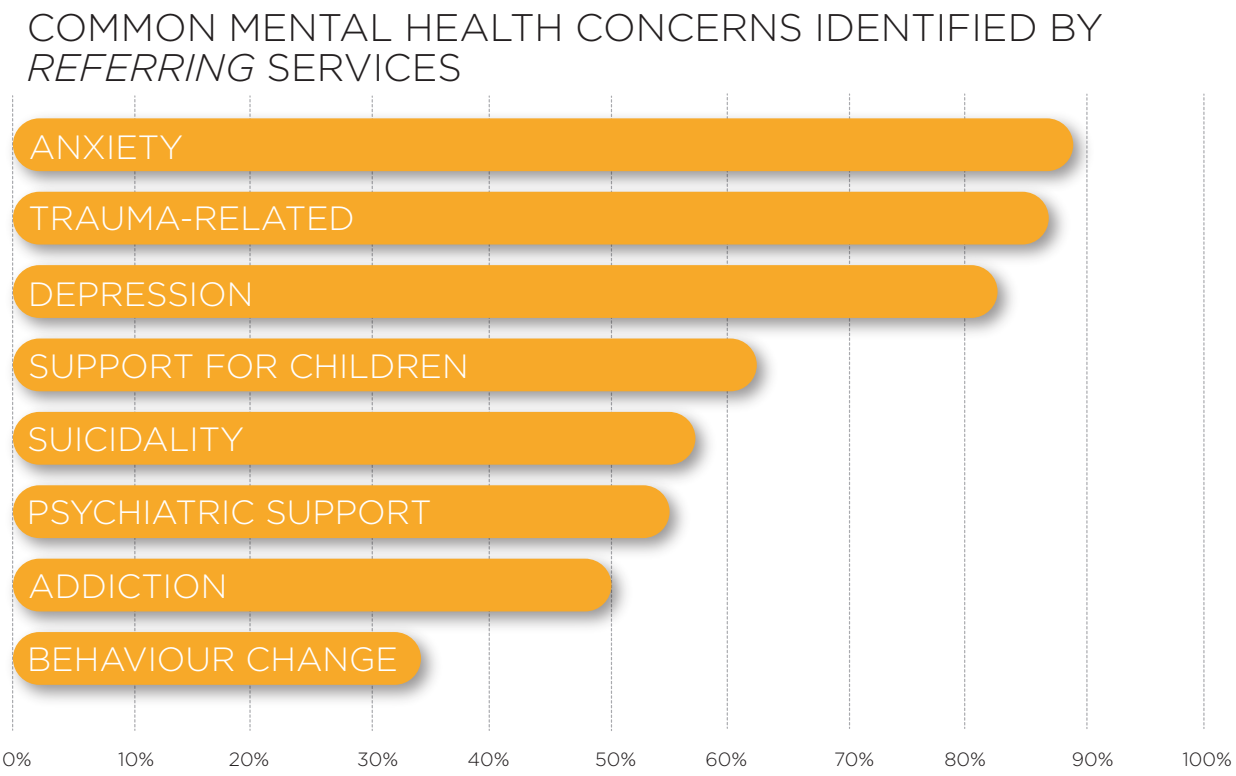


Figure 4 shows the common mental health concerns identified by respondents working in other services who are referring clients onto mental health support services.

Other reasons for referral include family violence support, gender identity related concerns, perinatal mental health, admission into mother-baby unit, bed-based mental health services, obtaining mental health reports to access the disability pension, behavioural difficulties in disability, child protection, and settlement difficulties.

From the survey responses, the majority of refugee and asylum seeker clients attending mental health services were self-referred.

The remaining referrals were from community health services, family and friends of the client, GPs, and other services (i.e., legal, housing, employment).

Issues and challenges in delivering mental health support to refugee and asylum seeker clients

At the consultations, the respondents were asked about the challenges they face when providing mental health care to clients from refugee and asylum seeker backgrounds, or when referring clients to mental health services. Respondents from mental health services acknowledged that refugee and asylum seeker clients are confronted by significant barriers when accessing their service. Respondents also noted organisational limitations that impacted their capacity to promote their service to these client groups.

For respondents working in *other services*, a significant challenge identified was progressing referrals to mental health services. Many respondents indicated that clients did not want to be referred.

From the survey consultation, about 86% of the respondents from *other services* have referred clients to mental health services, while 14% have not made referrals. The most common reasons cited for not referring were that the service was not funded as a referral agency. Some services opted to refer to social workers or provided clients with information for self-referral.

The following sections outline key barriers and limitations in accessing mental health support.

> “Emergency services for people in acute distress are not easy to access. Even if they are seen by the Area Mental Health Services, refugees and asylum seekers are still considered to have a personality disorder rather than acute trauma. They are labelled as such and are referred to the GP without any active treatment.”
>
> (General Practitioner)

> “A child client had symptoms of anxiety, was selectively mute, and had difficulty interacting with other students. He was referred to a local community service, but they were unable to provide a therapist who could speak the child’s language. Even after two years the child continues to not have any psychological support.”
>
> (Nurse Practitioner)

1. LIMITED CAPACITY OF SERVICES TO WORK WITH AND PROVIDE TRAUMA-INFORMED CARE TO REFUGEE AND ASYLUM SEEKERS

Limited capacity of services to provide trauma-informed care

At the consultations, service providers who completed referrals for their clients reported their observations about the limitations of *mental health services* in providing care for people from refugee background. Among these observations are limitations of mental health services in the following areas:

- knowledge about the experiences of refugees and the complex impact of these experiences to their mental health and wellbeing,
- training on working with clients who experience torture and trauma,
- capacity to build rapport with clients from refugee backgrounds, and
- awareness of culturally informed health beliefs, including the cultural implications of a mental health diagnosis.

Further, some respondents from *non-mental health services* reported feeling unprepared and uncomfortable talking to clients about their mental health, particularly for clients from refugee and culturally diverse backgrounds. This is due to these providers not knowing how to start a conversation about mental health, fear of offending the client, and perceived inability to provide information in a culturally appropriate and trauma-informed way. This apprehension often causes delays for services to provide appropriate and timely referrals.

Respondents from *other services* also heard from their clients about previous experiences of racism and trauma when they tried to seek support from mental health services. Such experiences help to explain why clients refuse to be referred to mental health services even when assistance was offered.

For clients and providers, these limitations result in:

- mental health services and practitioners unable to provide culturally safe, trauma-informed, and appropriate care and treatment to clients from refugee background,
- other service providers deterred from making referrals to mental health services for their refugee background clients, and;
- refugee background clients not receiving appropriate treatment and care even from specialist mental health professionals, re-traumatisation, non-disclosure of actual mental health concerns, and delayed treatment.

Lack of translated information/forms

Many mental health services do not have translated materials or forms in community languages available for clients. Also, materials that in English are often too advanced for clients who are beginners of the language.

As a result, clients with limited English proficiency may have limited understanding of the services offered, and treatment that may benefit them.

Shortage of GPs and mental health workers

There are not enough GPs, mental health workers and advocates for refugee and asylum seeker clients, in particular torture and trauma counsellors. This shortage is especially acute in rural and regional areas where there is high settlement of refugee background communities.

Lack of connections with refugee and asylum seeker communities

Respondents from mental health services acknowledged that they do not have working relationships with refugee and asylum seeker communities to effectively promote access to their services.

There is also an apparent need for a bicultural workforce, whether as mental health professionals or community support and liaison providers. Bicultural workers are particularly important where access to interpreters is limited.

2. ISSUES RELATED TO USE OF INTERPRETERS

Practitioners not engaging interpreters

Interpreters are useful in facilitating effective communication with health providers and their non-English speaking clients about mental health. However, as respondents from referring services noted, many mental health services and GP clinics do not engage interpreters during consultations.

GPs also noted that only a few psychologists use interpreters, which leaves limited options when referring clients from refugee backgrounds. Mainstream psychologists are less likely to use interpreters or are not experienced in working with interpreters. This results in significant delays in finding an appropriate psychologist for refugee background clients.

> There should be a way to register complaints with AHPRA... GPs refusing to use interpreters can be dangerous, it is a medico-legal issue.
>
> (General Practitioner)

Instead of utilising professional interpreters, many services use family members to interpret for their clients. This can be an ethical issue especially when children are asked to interpret for parents who have mental health conditions or are in distress.

One respondent also expressed concern that the refusal of practitioners to use interpreters could result in consequences that pose further harm to clients.

Limited funding for interpreters

According to respondents, only a few mental health services have access to a free interpreting service. As a result, there are often unacceptably long wait times for clients with limited English.

Respondents from mental health services reported that funding available for interpreters is limited and could only be used for psychological sessions. Hence, they do not employ interpreters for bookings or scheduling appointments, which often leads to client non-attendance due to miscommunication. Missing appointments due to language barriers also often occur when clients receive appointment reminders in English via text messages.

For GPs, they can access free interpreting service for medical practitioners. However, the use of interpreters means more time allocation and clients requiring interpreters need to be booked for 'long consultations,' increasing the out-of-pocket costs for clients.

Limited interpreters available from small language groups

Another challenge experienced by respondents that used interpreters is the limited availability of interpreters, particularly from smaller language groups such as Tibetan, Rohingya, Chin, Karen, and Karenni. While phone interpreting can be accessed interstate, some interpreters and clients find remote communication challenging due to several reasons, such as inability to detect non-verbal cues, clients having hearing difficulties and needing to lip read, or clients in distress unable to engage through the phone.

Interpreting services unable to meet requests

Limited interpreter availability also means that interpreting services are unable to meet client's gender preference for the interpreter or requests for the same interpreter. This poses a challenge since mental health consultations involve discussions that are sensitive, and this requires a trusting environment with the interpreter. It can be difficult to establish trust when the option provided is not suitable, such as when a male interpreter is provided instead of a female, and the client may be unable to fully convey their concerns.

Ethical issues and practice concerns with interpreters

While there are services that use interpreters for their clients, respondents mentioned some ethical issues they have observed. For example, clients are asked to make critical decisions without an interpreter present even if the situation calls for interpreting to be provided.

Another significant issue identified is that interpreters are often not briefed beforehand about the purpose of and context where the interpreting is to be provided. Sometimes interpreting services send out an interpreter who has not agreed to interpret for counselling. This results in disruptions of the sessions.

> My client was at the hospital and had suffered a miscarriage. When asked if she wanted an interpreter, she said, 'I can speak only very basic English.' They then asked her if she wanted a social worker, and she did not understand but said 'no.' They then asked her about the baby's body, and again, she did not understand. When they asked her about cremating the body, she agreed at the time, but the client wanted the body buried. So, sometimes acknowledging a duty of care when their spoken English isn't great, and these sorts of conversations, need interpreters.
>
> (Torture and Trauma Counsellor)

> I have had a couple of times when interpreters shut down a session when they realise it's actually a counselling session... They've chosen not to do that kind of interpreting.... I've been in the middle of a session and have been told 'Sorry, I have to stop this right now. I don't interpret for trauma or for counselling. You shouldn't have been allocated to me.' So, I have to get another interpreter and start all over again.
>
> (Torture and Trauma Counsellor)

Also, there are interpreters who offer opinions and judgment while interpreting for clients, which the respondents see as a breach of the interpreters' professional code of conduct.

> Sometimes clients face stigma not only from the community, but also from the interpreters. They talk back in the session, break their role, and give their opinion.
>
> (Torture and Trauma Counsellor)

3. FRAGMENTED MENTAL HEALTH SYSTEM

Lack of efficient coordination and linkages across sectors

Respondents from referring services reported that they have limited knowledge of mental health referral pathways and often need to advocate for their refugee background clients at GP clinics and hospitals. At the time of the consultations, they were not aware of an updated and centralised mental health services website that can be accessed for referral information.

Also, specific information about services pertinent to their client cohort (e.g., services for school aged children or trauma-based services) are not readily accessible. This has lead to significant time spent trying to find the information before clients can be referred.

Referring services find that the referral process is complicated and vague, that clients have to repeat their story multiple times but end up not receiving consistent care. It can be difficult and time-consuming to find services with mental health professionals who have experience working with refugee and asylum seeker clients and also work with interpreters or have bi-cultural workers.

Lack of wraparound support for clients with complex needs

The lack of coordination among services also means that clients with complex needs do not receive coordinated support.

Clients with mental health concerns which are compounded by other health conditions require continuous case management. However they are often sent back to their GP after receiving a diagnosis from a mental health service provider, without ongoing mental health support arranged for them.

> “A woman in her 40s was referred for treatment of depression and health anxiety, in the context of complex post-traumatic stress disorder (CPTSD). She was living in a two-bedroom government-provided home with her five children. She described black mould on the internal walls and the family slept on mattresses on the floor as she couldn’t afford beds. She struggled to deal with her children’s behaviour. Her CPTSD symptoms were triggered by seeing the face of her child that resulted from rape, as he grew to look more like his father. She had numerous somatic complaints which had been investigated and no physical cause was found.”
>
> (Mental Health Professional)

Access to support is also difficult for refugee background clients who have disability as a result of their mental health condition. Psychological reports are required to access NDIS support and Disability Support Pension. However, refugee background clients often experience significant delays acquiring psychological or psychiatric reports due to the limited options of mental health professionals who are able to work with them.

> Client is a 67-year-old Karenni man who is isolated and lives with severe PTSD. He has no means of transport and doesn't speak English. He lives in poverty. He is unable to access transport to see a psychologist. He is unable to access NDIS because that requires evidence from a psychologist, and he is unable to find a psychologist who is willing to provide a report for NDIS.
>
> (General Practitioner)

Lack of family-centred services

Respondents reported that services for refugee and asylum seeker communities should focus less on individual care, and more on family-centred care, to meet the needs of and improve outcomes for the whole family. They also articulated the need for a model where several services are working together, such as parenting support, family therapy, case workers, and housing support services working together.

> Client is a 19-year-old female with severe antenatal depression and anxiety. She has a history of early childhood trauma and sexual abuse. The antenatal clinic does not identify mental illness as a problem and referrals are not responded to. The pharmacist has told her to stop the antidepressant as they are unsafe in pregnancy (not true). She has no engagement with any local psychologist despite multiple referrals and has difficulty engaging on the phone. She has ended up in being admitted to hospital and is not allowed to have visitors on the ward. Stable housing is a huge issue for her. The independent model of care and response does not work for clients like her, services need to involve her partner and family.
>
> (General Practitioner)

4. LONG WAIT TIMES AND IMPACT

The long wait time to see a mental health professional is a very common challenge for referring services and their clients. Mental health services have very long waitlists and clients have to wait for months before they receive mental health support. This is linked to the problem of staff shortage recurrent across the health services sector.

Delayed assessments for proper diagnosis

Respondents from referring services reported long waitlists for their clients who need neuropsychological assessments. They noted that many child clients are living with undiagnosed learning disabilities while waiting to see a specialist for cognitive assessments.

The long wait time increases clients' distress. Some eventually cease their relationship with the referring service well before they are allocated a consultation with a mental health professional. Other clients go back to the referring service, including their GPs and support workers, because they are not given meaningful support while they wait. This places undue burden and emotional strain on these workers.

Moreover, patients with chronic mental health problems who are unable to access meaningful support from other services or are put on long wait lists often revert to their GPs. This adds to the already full loads of GP clinics.

> "Client arrived by plane in 2018 with experience of trauma and torture. Over years of waiting for his protection claim to be assessed, his mental health deteriorated. He had issues with sleeping, eating, and unexplained physical health symptoms. Treatment from the GP is inconsistent due to only accessing bulk-billing GPs who are very busy. We attempted to communicate with his GP about his current treatment but with no response. The client deteriorated rapidly due to changes in his country of origin. He attacked his loved ones and is now involved with the criminal system."
>
> (Mental Health Professional)

> "Client is a 47-year-old asylum seeker who is living with a psychotic illness. He has made multiple suicide attempts over the past three years. He could not afford a private psychiatrist. The public mental health team saw him for 2-3 weeks following a suicide attempt and then discharged him. The lack of psychiatric services resulted in him repeatedly presenting in crisis after every few months."
>
> (General Practitioner)

5. LIMITED OPTIONS FOR CLIENTS IN RURAL / REGIONAL AREAS

Lack of services in rural/regional areas

The inadequate number of mental health services has been identified as a major challenge across the state, but even more so for those residing in rural and regional areas. The mental health services available are limited in their capacity to provide culturally appropriate and trauma-informed support for refugee and asylum seeker clients, even in high settlement localities.

There is also a general shortage of GPs in rural and regional areas, which means limited options for people needing support through a mental health care plan or referral.

The limited availability of in-person interpreters is also apparent in rural and regional areas. While remote interpreting may be available, this also poses additional challenges for refugee background clients who may have difficulty engaging by phone.

Distant location of services

As there are limited mental health services available in the area, clients have to travel considerable distances to access a service in other towns or in Melbourne. This is not sustainable in the long term for clients who do not have their own transport.

In addition, there are not enough services for clients who are facing family violence and need to speak to a mental health professional. They often must travel far distances at the risk of their safety and the safety of their children.

> “Client is a 25-year-old Karen woman with five children who lives with a partner who is exercising coercive control. She has attended the emergency department 3-4 times per month with mental health crises. A mental health service allocated her to a psychologist who is located 24 km away from where she lives, and she does not have a car. The emergency department booked her in with a psychiatrist and she had multiple appointments cancelled due to the unavailability of a psychiatrist [in her area]. It has been six months since her last suicide attempt, and she is still not yet on medication.”
>
> (General Practitioner)

6. LIMITED OPTIONS FOR CLIENTS ACCESSING MENTAL HEALTH SUPPORT

Clients are only offered telehealth

Referring services reported that some mental health services only offer virtual consultations. This is considered a barrier to many of their refugee background clients who are unable to access telehealth due to limited resources, lack of digital literacy, and lack of awareness about the telehealth system and what to expect from remote consultations.

Restrictive criteria for accepting clients

Respondents reported that mental health services have specific criteria for accepting clients. For example, presentations must be directly caused by torture and trauma experience. Many clients referred by other services are found not to meet those criteria, and therefore unable to access specialist mental health support.

Lack of childcare options

Another significant challenge that prevents clients, particularly women, from accessing mental health support is the lack of childcare options. Those who have no other option but to bring their children to their appointments are often unable to focus during consultations with their mental health professional.

Some support workers go beyond their duties by babysitting so their clients can attend much needed counselling sessions.

> “Whenever one of the women has a phone counselling session, she comes into my office, and I lend her my laptop. She leaves her children with me and goes into the other room, and I babysit her children for that time. That’s the only way she can receive counselling.”
>
> (Rural Area Settlement Worker)

> “Often, psychology and counselling services are targeted at the 'worried well', not for people in severe distress.”
>
> (General Practitioner)

7. FINANCIAL COSTS OF ACCESSING MENTAL HEALTH SUPPORT

Costs of consultations and medication

Financial constraints are a barrier to accessing critical mental health assessments and treatment, particularly for those who cannot afford out of pocket payments. GP respondents noted that 'long consultation' allocations are required for a thorough mental health assessment to be made for clients who need mental health support. However, long consultations are not adequately funded, and consequently, fees need to be shouldered by clients.

Also, while there is mental health support available for free, specialist mental health services, such as counselling and psychology involve fees. Clients from refugee backgrounds often need multiple sessions resulting in cumulative costs that are too high.

In addition, costs of medication can be prohibitive. Respondents reported that asylum seekers and low-income clients would rather spend money on food and needs of their children than on medications.

Lack of access to bulk-billing mental health services and rebates

As Medicare is dependent on type of visa and residency status, many refugee background clients and asylum seekers are unable to access bulk-billing mental health services and rebates. Respondents also identified a challenge that only few bulk-billing mental health services are available in Metro Melbourne, and none in rural and regional areas. This leaves many seeking mental health support to pay out of pocket.

Some specialised service providers do not offer Medicare rebates for clients even if they are eligible. This limits the number of visits that clients can make to these services.

Services are unaware of visa categories

Respondents reported that there is a lack of awareness amongst services about the different visa categories and the rights and limits attached to them. If services are not across the different categories, it is harder to inform clients and clarify what they are entitled to in terms of accessing mental health support.

Travel costs

Another challenge for refugee background clients who are unable to receive support through telehealth is the cost of travel to be able to attend in-person appointments with their GPs and mental health services.

As previously noted, clients who live in rural and regional areas often incur additional costs to travel long distances to access appropriate treatment.

Considerations for asylum seekers

Asylum seekers commonly do not have work rights and have limited social and financial support which, respondents have reported, greatly affects their mental health. As they have limited access to Medicare, they are not entitled to mental health support offered through Medicare, such as the mental health care plans, and subsidised mental health treatment.

For asylum seekers who have been in detention, there are no financial provisions to seek support for the psychological harm that has been caused by their experience in detention.

8. OTHER CLIENT LEVEL BARRIERS

Clients' mental health literacy

One common issue observed by respondents among clients from refugee and asylum seeker backgrounds is low mental health literacy. Clients are often unaware of what constitutes a mental health issue, when to seek treatment, and the types of treatment available. In addition, they are often unaware of the nature and process of mental health support and treatment in Australia and require more psychoeducation around treatment and support options.

Mental health stigma

Respondents shared that clients are often unwilling to seek mental health support due to stigma around mental health and the implications for accessing services on the individual, their family and community.

Clients' understanding of service navigation and entitlements

Another significant barrier to accessing support for clients from refugee and asylum seeker backgrounds is limited understanding of how to access services within the mental health system and their entitlements under Medicare. This results in limited help-seeking behaviour for mental health issues.

> "There was a child in school who was having some difficulty, and we asked the parents if they would like to refer their child for a cognitive learning assessment. The father's response was 'Do you think my child is crazy?' It's important to remember that it can take a long time to build trust with parents and to explain why they need to refer their children for mental health support."
>
> (Principal, English Language School)

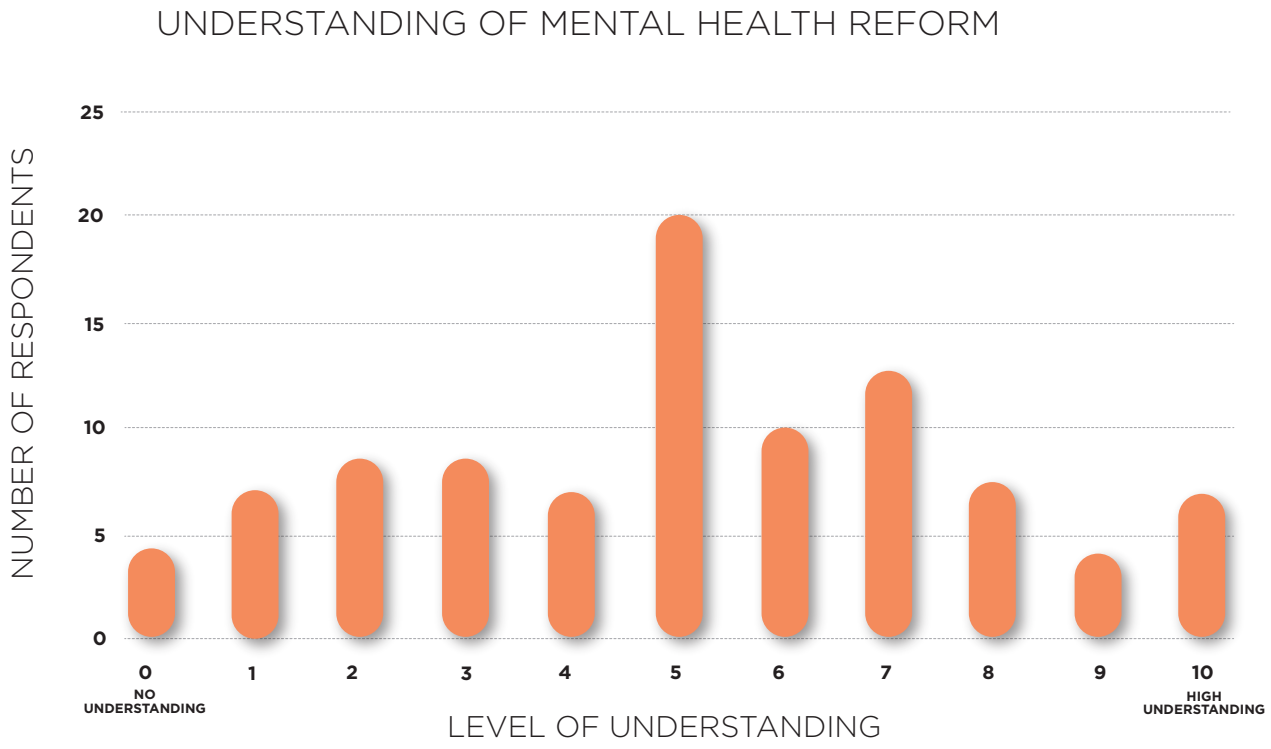
Sector awareness of the Victorian mental health system reform

Survey consultation respondents were asked how they would rate their level of understanding of the Victorian mental health reform agenda (0 = no understanding, 5 = some understanding, 10 = high understanding). The average level of understanding was 5 with 60% of respondents rating their understanding of the process as a 5 or below.

The level of understanding varies between Metro Melbourne and rural/regional-based respondents, as well as between respondents from mental health services and those from *other* services. There are more service providers in rural and regional areas (75%) who have low level of understanding about the reforms (self-rating of 5 or below) compared to those in metro Melbourne (21%). There is a higher level of understanding about the reforms (self-rating of 5 or above) among respondents from mental health services, than those from *other* services (57%).

A low level of awareness about the mental health system reforms among GPs was also reflected in the survey and interview consultations. Respondents reported having little to no knowledge about intended changes in the mental health system. For those who do, their main source of information has been through presentations at the VRHN State-wide meetings. Other sources of information were from publications such as the Australian Journal of Family Practice and other industry magazines. However, some respondents noted that while these materials may be utilised, other channels may need to be explored to inform and update practitioners and health professionals about the reforms and intended changes, for example, to referral pathways.

FIGURE 5



Recommendations

Drawing on the insights from the consultations about service gaps and challenges in delivering mental health support to clients from refugee and asylum seeker backgrounds, below are key recommendations to improve access.

Many of these recommendations pertain to the development of a holistic system of health and community services, where the capability to respond to the needs of people from refugee and asylum seeker backgrounds should be built into both organisational policy and practice.

1 INSTITUTE WORKFORCE DEVELOPMENT ACROSS THE SERVICE SECTOR

- Training for mental health services on:
  - culturally safe and trauma-informed practice, including an understanding of the experiences and challenges of refugee and asylum seeker clients.
  - usage of interpreters at mental health services for appointment bookings and sessions with counsellors and clinicians.
  - understanding different cultural views of mental health and the importance of a community/family approach when working with clients.
  - the various visa categories and the rights and limits attached to them.
- Training for non-mental health services to identify when to refer clients for mental health support, as well as to equip them to effectively provide information and psychoeducation on mental health.
- Training across the health sector, including within academic curricula in tertiary level institutions (i.e., psychology and social work departments), to increase understanding of the 'refugee experience' and advocacy for trauma-informed practice in the promotion of refugee and asylum seeker mental health.

2 EQUIP SERVICES WITH RESOURCES TO EFFECTIVELY WORK WITH REFUGEE AND ASYLUM SEEKERS

- Availability of translated forms and other informational material for clients in various community languages and in plain English.
- Increased funding for mental health services to improve access to interpreters.
- Increased funding and employment of bi-cultural workers in mental health services.

3 INTEGRATE MENTAL HEALTH AND WELLBEING WITHIN A HOLISTIC AND COORDINATED HEALTH SYSTEM

- Improved coordination and linkages across sectors to ensure continuity of care, including building capacity of all health sector services to create and maintain linkages to specialist refugee health services.
- Increased communication of the mental health reform process, and initiatives, especially for services in rural and regional areas, as well as with GPs.
- Development of a centralised mental health services website to access services and relevant information about specific client groups.
- Integration of family-centred services in the reformed mental health system.
- Efficient and timely processes for clients seeking mental health services to access the NDIS.

4 DEVELOP EFFECTIVE STRATEGIES TO REDUCE LONG WAIT TIMES AND ENSURE PROMPT ACCESS TO MENTAL HEALTH SUPPORT

- Increased service capacity to improve current wait times so that clients can access mental health support sooner. High-risk clients should be given priority.
- Increased funding for GPs to provide thorough mental health assessments.
- Inclusion of psychologists within GP clinics for easy referral of clients needing mental health support.

5 BUILD THE CAPACITY OF SERVICES AND COMMUNITIES IN RURAL AND REGIONAL AREAS

- Increased number of mental health and specialist mental health services in rural and regional areas.
- Expansion of criteria and eligibility in terms of catchment areas for clients seeking mental health services, particularly specialised mental health services in rural and regional areas.
- Consider no-cost mental health support for the most at-risk clients regardless of local area.

6 INCREASE ACCESS OPTIONS FOR REFUGEE AND ASYLUM SEEKERS NEEDING MENTAL HEALTH SUPPORT

- Increased availability of options for clients seeking mental health support who are unable to utilise telehealth due to lack of digital literacy.
- For mental health services to review and expand their process for intake and assessment to adequately respond to clients needing urgent access to mental health support.

7 REVIEW AND AMEND RESTRICTIONS TO ACCESSING MENTAL HEALTH CARE ARISING FROM RESIDENCY STATUS OF CLIENTS

- Review of Medicare eligibility to include all visa categories and asylum seekers to access subsidised mental health support.

8 IMPLEMENT AND RESOURCE COMMUNITY-BASED PROGRAMS TO ADDRESS CLIENT-LEVEL CHALLENGES TO ACCESSING MENTAL HEALTH SUPPORT

- Implement effective community initiatives to enhance mental health literacy and awareness of mental health service navigation.
- Improved mental health promotional activities by community liaison health workers to promote health seeking behaviour, foster community well-being and reduce stigma in client communities.

Contact

The Victorian Refugee Health Network is funded by the Victorian Government's (Department of Health) and auspiced by The Victorian Foundation for Survivors of Torture.

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Our mission

Collaborating to create health equity for people from refugee and asylum seeking backgrounds in Victoria.

Our vision

Victorians from refugee and asylum seeker backgrounds have timely access to appropriate services and other resources required to build and maintain their health and wellbeing.

victorian refugee health network


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