Tabled - Pamela Curr 18/11/11.

12/09/2011

Toowong Private Hospital

Immigration Mental Health Service

Dear

Re:

This is to certify that the aforementioned has been an inpatient under my care at the Toowong Private Hospital since his admission on 29th August 2011. He has been treated for a post traumatic illness, depression and panic disorder with a mixture of medication and psychotherapeutic principles (delivered via interpreter).

It is our feeling that this man's condition is an understandable reaction to the difficulties/trauma that he has been subjected to in Iran/Afghanistan/Pakistan and during his detention in Australia. During his stay in hospital, he exhibited an observable improvement in depressive and anxiety symptoms. His panic symptoms are triggered by thoughts of his young family who remain living in dangerous conditions in Pakistan and by thoughts of returning to detention at Scherger.

It is our feeling that should he be made to return to detention at Scherger he stands a significant risk of rapid and full relapse of his conditions. Hence it is our strong recommendation that this man be considered for community detention. In addition, we request that all attempts be made to expedite the processing of this man's Visa Application. The delay in this process along with his family situation is undoubtedly having a detrimental effect on his mental state.

Yours Sincerely,

Consultant Psychiatrist

Toowong Private Hospital

Cc:

QLD IMA Case Management Team,

DIAC QLD.

17/10/2011

tph Toowong Private Hospital

Assistant Director QLD IMA Case Management Team
DIAC QLD

FAX: 07 3136 7581

Dear

This is to advise that the abovenamed has been an inpatient under my care at Toowong Private Hospital since his admission on 20 September 2011. He has been treated for an adjustment disorder with a combination of medication and psychotherapy.

condition is a reaction to the trauma to which he had been exposed in Afghanistan, his prolonged detention (>22 months) in Australia and the uncertainty about his future. During his stay in hospital, he exhibited an improvement in depressive and anxiety symptoms. The prospect of further detention in Australia and the uncertainty regarding the safety of his family, particularly his wife and four children in Afghanistan, have been persistent stressors.

mental health has improved sufficiently for discharge from Toowong Private Hospital. It is my opinion that returning him to a detention centre would be associated with a high risk of a relapse in his adjustment disorder. I therefore recommend that consideration be given to community detention.

Yours sincerely,

Consultant Psychiatrist

cc International Health and Medical Services,
Brisbane ITA, 100 Sugarmill Rd, Pinkenba, QLD 4008 Fax: 07 3637 9127

Email:

Investigations:
CT head: No specific intracranial CT abnormality to account for recent symptoms.

MRI knees

a. Right knee
   1. Ruptured anterior cruciate ligament, probably longer – standing.
   2. Subtle tear of the free margin of the body of the lateral meniscus. There is additional subtle fraying of the junction of the posterior horn and body of the lateral meniscus.
   3. Subtle signal abnormality of the posterior horn of the medial meniscus at the free margin.
   4. Focal cartilage ulcer at the central weight-bearing aspect of the lateral femoral condyle with focal reactive sub-chondral oedema.
b. Left knee: Oblique cartilage fissure at the lateral facet of the patella.

Hep B:
HepBsAg – positive.
HepB core antibody – positive
HepB core antibody (IgM) – negative
HepB e antigen – negative
Hep B e antibody – positive
Consistent with chronic Hepatitis B infection.

ELFT: Bilirubin 24 (no pain RUQ, no symptoms with fatty foods).
TFT: NAD
B12 / Folate: NAD
FBC: NAD

Diagnostic formulation:

asylum seeker presenting with depressed mood neuro – vegetative, dissociative, de-realisation and hallucinatory experiences on a background of exposure to trauma, a life marked by stress and fear, and aggravated by prolonged detention.

His response to the uncertainty, the loss of a purpose and tasks in life during the long detention process, and the guilt associated with having abandoned his family for so long has led to depression.

Axis I
Post Traumatic Stress Disorder
Major Depressive Disorder

DD: Adjustment Disorder

Axis II: Deferred.

Axis III

Axis IV
Long period in detention.
Loss of life tasks.
Guilt

Axis V

Toowong Private Hospital

DISCHARGE SUMMARY

Surname:
First Names:

DOB:

Date of Admission: 13/09/2011

Date of Discharge: /10/2011

Reason for admission: ,ear old asylum seeker, was referred by the Mental Health Team at the Scherger Immigration Detention Centre. He had been in detention since May 2010, and the experience had been difficult for him. The referral notes that he had arrived on Christmas Island with high expectations of a successful and swift visa process, but had been stressed, anxious and depressed throughout. He developed sleep and appetite disturbances, intrusive thoughts, and dissociative episodes. He disclosed a history of torture and/or trauma, and had been receiving QPASTT counselling which he had participated in enthusiastically. Questionnaires indicated his symptoms were consistent with Post Traumatic Stress Disorder. His feelings of hopelessness and helplessness were reinforced by a negative outcome in his visa application process.

It was also reported that became "disconnected" from his surroundings and began experiencing constant feelings of self harm; he felt his family would be better off without him. He had no intentions of acting on his feelings, and is not known to have attempted self harm.

On admission, was depressed, was experiencing nightmares, external auditory and visual hallucinations, and a sense of detachment from his body. He had intrusive thoughts, and he described thought blocking in the several languages he speaks, and episodes of panic. He reported that suicidal ideation had been present for two weeks; he had not acted on the thoughts, and had not formulated a plan.

Brief History of illness:
While in detention, reported trauma related symptoms, including intrusive thoughts and images of dead people surrounding him (primarily being hung). At times the faces of the people were his own. He was also hearing shouting and arguments. He was sleeping only 1 – 2 hours per night. reported he had always had a negative outlook on life, and he seemed to feel worthless and useless before his case was heard. Reports noted that he had seemed to suffer depression before being detained, although he did not support this..

reports that he has been in danger most of his life. He has been exposed to death and violence. He recalls one of the most traumatic experiences as exposure to many dead people, including a dead baby, when, at age 11, he and his family were escaping at night from a village under attack. At a later time, an uncle made threats to kill the whole family if he saw them in public. He and the family have spent long periods house bound for fear of being attacked or arrested.

On the boat trip to Australia, the boat sank and he had to stay in the water in a life jacket for some 2 hours before being rescued. He was scared of sharks, and this incident caused intrusive thoughts.

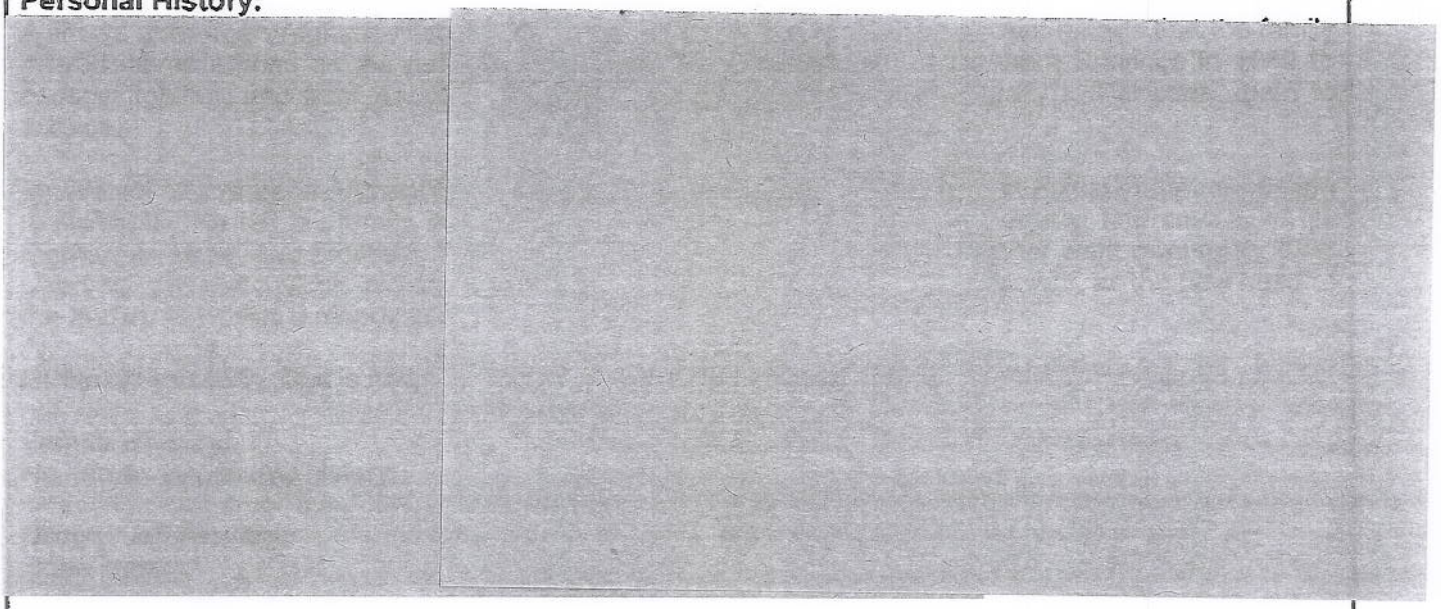
Medications on Admission:
Mirtazapine 45 mg nocte
Buspirone 5mg nocte
Diazepam PRN

Past Medical History:
has Hepatitis B, low infectivity, chronic carrier.

reported a twisting injury to his R knee while in detention; once in 2010, and again in Feb 2011. Has pain after exercise, in cold weather, some walking activities.

Past Medication Trials:
None before detention.

Personal History:



Forensic History:
None known.

Treatment and progress:
After several days observation, which confirmed neuro-vegetative disturbance, low motivation, and anhedonia, Venlafaxine was commenced at 75 mg and titrated to 150 mg. Quetiapine was added nocte to normalise sleep. He reported flashbacks to past trauma triggered by some movies, and by questions about his country.Asif presented with headaches but his CT head was normal.

Psychology input was supplied for behavioural activation, relaxation techniques, sleep strategies, motivational interviewing, distraction techniques and skills in challenging distorted thinking (e.g. "I have no control over these thoughts"). He was taken on outings to Southbank, Mt Cootha, a shopping centre, etc without incident.

On the ward he was prepared to help others; he kept good boundaries; and he was appropriate in dealings with staff and co-patients. His mood improved and he was observed to interact warmly with others. Anxiety significantly lessened and the perceptual abnormalities dissipated.

When discharge was discussed with him he became anxious about returning to any form of detention centre. Time was spent with him to prepare for this but he was reluctant to pursue this. He continued to express a belief that he would not be able to cope with the anxiety of detention and resisted strategies to address this. He was anxious when detention was broached and he was concerned about his family. Otherwise there was no evidence of ongoing pervasive depression.

Medication At Discharge
Venlafaxine 150 mg mane
Quetiapine 50 mg nocte

Follow up arrangement on discharge:

a. has been very compliant in the open hospital environment, and his behaviour to others has been exemplary. Security facilities are likely to re-traumatise him, and he identifies that it was the long period of detention which initiated his depression. He should be monitored for anxiety and depression.If he is to return to detention he should be immediately followed by mental health services. Psychiatric review should occur regularly.

b. He should continue trauma counselling post discharge.
c. If has to appear before a tribunal, he may be better served by making a written submission first (he has difficulty representing / explaining himself in formal situations).
d. Recommend continue the Venlafaxine for a period of 12 months before considering whether to trial ceasing it.

Case Manager where relevant:

Psychiatrist:

Date:

Copy to (include address):

Mental Health Team Leader. Scherger IDC: PO Box 848, WEIPA QLD 4874 Fax 07 40823348.