

# **Making Mental Health Programs Accessible & Effective for People of Culturally & Linguistically Diverse Backgrounds**

## **Introduction**

A coalition of Queensland non-government and government multicultural health and mental health services have come together to consider the barriers our clients currently experience in accessing mainstream Mental Health programs including Better Access, ATAPS and Headspace. Nationally, there appears to be an increasing emphasis on mainstream mental health services with a move away from community based mental health services to a privatised model of health service delivery. This is fundamentally altering the parameters of service delivery and is having a dramatic impact on access to services for people from culturally and linguistically diverse (CALD) backgrounds.

The Access to Allied Psychological Services or ATAPS Program was developed as an alternative program to Better Access for people from vulnerable groups needing access to mental health services. However, many of the same barriers that exist within mainstream service models such as Better Access also exist in ATAPS and this has resulted in people from CALD backgrounds not being able to access needed services. Data provided by the University of Melbourne in September 2010 to General Practice Queensland has identified that less than 1% of referrals to ATAPS in Queensland are people from CALD backgrounds compared to 18% of the population. The coalition of services working together in Queensland has sought to identify needs and barriers in accessing mainstream health services including ATAPS and to propose alternate strategies. These strategies are necessary to ensure that mental health services including ATAPS can provide adequate and equitable services for people of CALD backgrounds, prioritising those who are most vulnerable.

A number of important issues impacting on our clients were not included as part of the recent review of the ATAPS program and are now translating into further mainstreaming of mental health programs for these groups. Our organisations wish to engage more effectively with the Department of Health and Ageing and others to ensure that community based services and people from CALD backgrounds accessing services are considered in current policy development.

Coalition members work with people who are of diverse cultural backgrounds including people who have come to Australia as migrants and refugees. Barriers to effective service delivery include 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. Within this group are people who have come to Australia as refugees and survivors of torture and trauma. This group of vulnerable people have particular needs due to the

persecution they have endured and these can have long term physical and psychological impacts on individuals, families and communities (sometimes lasting multiple generations). This in turn has short and long term social and economic consequences.

Organisations who have contributed to this discussion paper are provided in Attachment 1.

## **Summary of Issues & Recommendations**

### **1. *Service Model & Intervention Issues***

- a) Business/Profit based models of service delivery offer few incentives or requirements for the necessary flexibility and quantity of service support required for cross-cultural interventions and complex/high needs.
- b) Inconsistent models of implementation for ATAPS across GP Divisions (and in the future Medicare Locals) mean that service delivery results are inequitable or non-existent for people of CALD/refugee backgrounds
- c) Limited capacity of health professionals to assess/diagnose presenting issues in a cross-cultural context and relating to refugee experience.<sup>1</sup>
- d) Lack of knowledge and confidence of health professionals to work with interpreters, particularly within a counselling context.
- e) Lack of partnership arrangements with community based health and mental health services to offer holistic and flexible services.
- f) Lack of consultations with the sector regarding new models of service delivery (such as Medicare Locals and Headspace) and no requirements to do so mean that the needs of this client group are not included.

### ***Recommendations:***

- a. That people from CALD backgrounds and in particular vulnerable sub groups (such as refugee survivors), should be considered as a priority target group for Tier 2 under ATAPS.
- b. That future development of Medicare Locals be required to be inclusive of both community based services and of people from culturally and linguistically diverse backgrounds.

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<sup>1</sup> We are aware that there are many examples of good practice and that there are health professionals who possess a good understanding of working within a cross-cultural context, however it is our experience that this is not consistent or necessarily a common feature.

- c. That the development of new Headspace and Sub-acute services need to be inclusive or alternatively specialised services funded.
- d. That greater flexibility to treatment options be built into any service delivery models to allow for: tailored promotion and explanation of services, and specific types of support including wrap around services and interventions suitable to the client. This includes the adoption of culturally appropriate models inclusive of bi-cultural health professionals where appropriate
- e. That people from culturally and linguistically diverse backgrounds and people from refugee backgrounds be considered as a special needs group and eligible for specific funding. Given the reluctance of GPs and the Divisions of General Practice to prioritise service delivery for culturally and linguistically diverse populations, that funding be specifically allocated to community service agencies who can provide both mental health counselling, case management and support along with needed wrap around services.
- f. Allocate funds to community services with expertise in working with target groups for direct service delivery, capacity building, cross-cultural training and development for mainstream providers and community development programs.
- g. Allocate funds to increase rural and regional services for people of CALD and refugee backgrounds
- h. That Divisions of General Practice, Medicare Locals and other regionally based mainstream service providers be required to justify their primary targets groups to local communities and be able to provide an evidence base for these decisions. This includes increased accountability about how GP Divisions respond to the needs of CALD communities within their catchment areas.

## **2. Access to services**

- a) Data from the University of Melbourne shows that less than 1% of consumers who accessed ATAPS services in Queensland spoke a language other than English at home or spoke English “not at all” or “not well”.
- b) Lack of funds for, and experience in, working with interpreters
- c) Diversity in service capacities and models according to individual GP Divisions

- d) Knowledge and expertise in cross-cultural assessments and interventions
- e) Ability to provide what clients are seeking which is a broad range of counselling, advocacy and social support as well as taking time to build trust
- f) Ability to provide services to people who do not “conform” to mainstream service provider frameworks, for example bring their children with them to counselling

### ***Recommendations***

- i. That dedicated interpreter budgets are allocated and policies that assist with take-up of interpreter services are developed.
- j. That training in relation to the use of appropriate interpreters is provided and accessed.
- k. That flexible referral pathways into a range of mental health services including community health services be allocated i.e. that referral via a GP be one option not the only option.
- l. In order to increase the capacity of General Practitioners and Allied Health Practitioners to work with CALD clients and to appropriately identify and refer clients with a mental illness, that specific funds are allocated for the delivery of capacity building programs (including ongoing cross-cultural training and development) for mainstream providers.
- m. Ensure the adoption of culturally appropriate models inclusive of bi-cultural health professionals where appropriate
- n. Encourage the use of existing multicultural counselling/case management services as ATAPs providers

## **Background – ATAPS as an Example**

The Access to Allied Psychological Services (ATAPS) Program has been purposely designed to address the needs of populations not well serviced by mainstream Mental Health programs such as the Better Access initiative. The ATAPS guidelines specifically state that the program focuses “on service gaps and populations not well serviced by other mental health programs” and that a “targeted and potentially flexible approach is required... to ensure that vulnerable underserved populations receive mental health services” (p2, ATAPS Guidelines). As such, ATAPS should be able to address the access and service intervention issues that exist within the Better Access Initiative including where people from CALD and refugee backgrounds.

According to the current ATAPS guidelines (p3-4, ATAPS Guidelines) two categories of service provision currently exist within the ATAPS program:

- (a) Tier 1 which includes “other hard to reach groups including youth, Indigenous Australian, people from culturally and linguistically diverse backgrounds”; and
- (b) Tier 2 which provides additional capacity to target particular groups through “innovative and flexible means of delivery”. This does not currently specifically target people from culturally and linguistically diverse backgrounds

## **Limitations of ATAPs Model**

The experiences of our organisations are that the same barriers that exist in the Better Access Initiative also persist within the ATAPS Tier 1 program and will not be overcome unless people from CALD backgrounds are able to be provided for under the Tier 2 system.

The inability of the mainstream mental health system (including Tier 1 within ATAPS) to accept referrals and work with people from CALD backgrounds has led to a number of multicultural services in Queensland working together to identify and document specific barriers and potential strategies to address these.

Recent discussions with the Queensland Division of General Practice have highlighted both the issues identified by service providers and the general reluctance by both individual Divisions and individual GPs to respond to and look at strategies to improve access. This includes questions in relation to why GPs and Divisions should be responsible for servicing a group that is more costly and complex to work with when fixed resources can be easily used elsewhere. Comments received have included the observation that these groups should be going to community based services as GPs have too much to do and cannot be expected to meet everyone’s needs. However, the current system and funding guidelines is dependent upon the involvement of both GPs and Divisions of GP so it is vital that these groups take up this responsibility.

General Practice (and private Allied Health model) is based on a business model which does not fit with the needs of many people from CALD backgrounds. Where there is an undersupply of resources or where the prime motivation is to make money, and you have a client group that require more complex responses and resources, these groups 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. The current business model is not based on equity but on financial return. For example individual Allied Health Practitioners are telling us that they would prefer not to work with clients from culturally diverse backgrounds as (1) interpreters are not funded and (2) even where they are, sessions with an interpreter take twice as long for the same rebate.

Within ATAPS, the decision to prioritise people from CALD backgrounds is made at the local GP Division level and only some Divisions in Queensland have prioritised this group. Among these Divisions a number of models for working with this group have been developed and in some cases only one or two ethnic groups have been prioritised resulting in inequitable access to the ATAPS program across the state

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, particularly those who adhere strictly to western, medical models of mental health recovery.

## **Data**

Data provided by the University of Melbourne in September 2010 to General Practice Queensland has revealed that of the 37,926 consumers that were referred to ATAPS at least once in Queensland, 332 (0.9%) spoke a language other than English at home or spoke English “not at all” or “not well”.

A profile of these 332 consumers reveals 73% were low income earners, 60% had not used psychiatric services previously, and 66% were diagnosed with depression.

With 18% of the Queensland population being overseas born of which around half are born in non English speaking countries, the access rate to ATAPS being less than 1% for people who were identified as speaking a language other than English is of a major concern.

A recent article in the Canberra Times (9.4.10) identified concerns in relation to whether all consumers are able to take up GP referrals to ATAPS. The article identified that “between July 2003 and March 2009, GPs referred more than 153,000 consumers to ATAPS, but only 116,000 consumers accessed these services”. It is our assumption that people who did not take up services were those who face barriers in doing so such as the clients we are discussing in this paper.

## **Barriers to Access**

1. Interpreters: The inability of allied health services to access free interpreting services is a major problem; financially it is not viable for private practitioners to meet the expense of an interpreter. Given that there are so few bilingual private practitioners and that not all people wish to use a person from their own language group, language barriers exclude many CALD people from services. The use of professional interpreters and the selection of the right interpreter is critical to good mental health outcomes – this is not just about the right language but the right interpreter taking into account ethnicity and gender issues. Issues surrounding the use of interpreters by Allied Health Practitioners are exacerbated by the low take up rates of interpreters by General Practitioners (GPs) during appointments/consultations. Issues include:
  - (a) GPs are unable to identify mental health issues where people are unable to express their needs in a language or cultural framework that is understood by the GP. For example clients from refugee backgrounds may present with psycho-somatic symptoms that are the result of trauma and long term hardship. These are often treated as physical ailments rather than mental health issues due the inability of clients and GPs to reach an understanding of their symptoms;
  - (b) Where mental health issues are identified and referred, unless the local Division of GPs has prioritised CALD the Allied Health Professional is unable to access free interpreters;
  - (c) If an inappropriate interpreter is used mental health outcomes may be exacerbated rather than assisted, for example trauma may be re-triggered by using an interpreter from an ethnic group associated with persecution;
  - (d) Where a local Division of GP has prioritised clients from CALD backgrounds, they need to use funding allocated for service delivery to meet the cost of interpreters – this means that the funding runs out quickly and those who are referred early in the year will be serviced rather than those most in need. This also means less clients can receive a service when compared to clients who do not need interpreters.
2. Assessments/Interventions: Both ATAPS and Better Access are based on a Western model of interventions and there needs to be greater flexibility in

treatment modalities including a model of supportive and practical components in the service delivery. Many of the people from CALD backgrounds that we work with are unlikely to have a diagnosed mental illness and any model based on a concept of a “diagnosed mental health illness” or mental health plan may be problematic. Clients may have moderate to high level symptomatology consistent with depression, PTSD, complex grief, anxiety etc but they are unlikely to access a system which includes a formal diagnosis. Many clients do not view themselves as having a mental illness and the need for diagnosis is a barrier to seeking assistance.

3. Even where people from CALD backgrounds have been prioritised by a local Division of General Practice the model used varies between each Division thereby creating quite different accessibility issues between each Division area, for example some Divisions have no model, some directly employ one or two psychologists and others may use a brokerage model. In some cases where only one or two psychologists are employed they are employed because they come from a particular cultural group (eg a Vietnamese psychologist in a region with a large number of Vietnamese clients) however in practice this means other cultural groups are likely to miss out.
4. Access to ATAPS and Better Access is dependent on GPs:
  - (a) appropriately identifying the need in CALD clients;
  - (b) recognising that the individual or family requires additional support;
  - (c) having access to a culturally competent workforce to refer to and able to refer appropriately;
  - (d) knowing that their Division of General Practice has a program that suits that particular client; and
  - (e) being prepared to do the paperwork (including a Mental Health Plan) to make the referral to the GP Division or the Allied Health Professional
  - (f) that the client has a regular GP and discusses their mental health issues with the GP
5. Individual Divisions of General Practice have the freedom to develop their own ATAPs model and the different models across the state results in inequitable access to services. If you live in one part of the Brisbane you may be able to access quite different services to someone from the same cultural backgrounds who lives in a different suburb (and whose GP falls within a different Division). While in theory this is based on community need there are no requirements to evidence this. For example: some GP divisions are funding interpreter services for ATAPS clients when required but this seems to be the exception rather than the rule. We are aware that a couple of Divisions have prioritised CALD groups but have quite different ways of meeting this need with some services employing specific registered professionals from particular cultural backgrounds and others use a brokerage model. The quality and quantity of service provided is highly



variable depending upon this and the Division's ability to attract appropriate professionals.

6. The bilingual/bicultural workforce in private practice is minimal in Queensland with the majority of bilingual allied health workers being located in the public and NGO sector. Bilingual/bicultural workers are employed specifically to provide cross-cultural support to therapeutic interventions. Research demonstrates that bilingual/bicultural workers are an important component to service delivery facilitating access to services as well as improved health outcomes. Access to such a workforce is possible through various partnership arrangements but this rarely occurs (eg the current SEA-GP Division and the Queensland Transcultural Mental Health Centre arrangements where SEA-GP contracts the Transcultural Mental Health Centre to deliver ATAPS services via its bilingual allied health staff).
7. Access to ATAPS is inequitable as it depends on each Division to work out how to respond to demand for services. Current demand doesn't accurately reflect current need and there is little or no guidance and support for Divisions to provide access to and culturally appropriate service delivery. Using interpreters, engaging bicultural staff and employing professionals of diverse cultural backgrounds are all viable strategies. However, further training and support is also required to ensure high quality assessments and interventions are also responding to the needs of people from CALD backgrounds no matter which health region they live in.
8. We are aware of cases where people from CALD backgrounds have seen a private provider but have dropped out as they are not getting their needs met. A number of GPs have contacted the Queensland Transcultural Mental Health Centre for referral options stating that things did not work out with the referral to a private provider, usually due to cultural and language issues.
9. The experience of the Queensland Transcultural Mental Health Centre as an ATAPS provider [with SEA-GP Division] is that people from CALD backgrounds often need more support than just one monthly appointment which is ideally provided in partnership with a multicultural sector organisation (wrap around services). This supports the need to work at the Tier 2 level.
10. Multicultural sector organisations are well placed to identify people from CALD backgrounds requiring assistance via ATAPS and could facilitate appropriate referrals. The current Tier 1 system is too restrictive and does not allow for flexibility in the referral process. As counselling and psychologically based intervention strategies are often new concepts for people in this target group, these organisations are well placed to discuss these with their clients and facilitate appropriate referrals via GPs that will have a successful outcome.
11. Better Access and ATAPs are strongly tied to particular therapeutic outcomes, in particular CBT, and there are a number of concerns regarding

the validity of this therapy with clients from CALD backgrounds, and in particular with refugee survivors of torture and trauma. Additional information in relation to these concerns is contained in Attachment 2.

12. Refugee Survivors of torture and trauma present with multiple and complex issues of which mental health may be only one. Providers need to be able to work across all of the presenting issues and provide “wrap around services” to support wellbeing and recovery. This may include support to attend sessions, providing health education, advocacy and referrals.
13. Many people from CALD backgrounds have a different understanding of mental health and counselling and have a low level of knowledge about the Australian mental health system. This includes awareness of services as well as the importance of early intervention and prevention strategies, now more common in mainstream population
14. People from CALD backgrounds often seek help at a later stage of mental distress or in a crisis situation. People affected by the emotional/mental condition, their family and carers have to endure and tolerate high levels of mental distress without professional help.
15. The stigma and shame associated with mental illness is a great contributor to people’s reluctance to look for help. This can result in family breakdown, alienation and isolation from family members and general community.
16. People from CALD backgrounds may experience fear or discrimination when accessing services. People who have endured torture at the hands of government services maybe be highly fearful and suspicious of professionals. The physical environment as well as the approach adopted by professionals is important to building the necessary confidence and trust with CALD individuals. Simple factors within the physical environment, such as a reliance on an automatic phone system will make the service inaccessible to someone needing an interpreter.
17. Referrals under a GP model are usually made via connections between the GP and the allied health professional – the allied health professionals working with the GP Practice may or may not have the expertise need to work with this group, in particularly for refugee survivors of torture and trauma. Many mental health professionals have little/no understanding/or interest in the mental health issues in other cultures. This may have the following consequences:
  - (a) Assessments may be flawed from the beginning of an intervention, because there is no culturally appropriate assessment process. (See Case Study Two)
  - (b) Mental health professionals may interpret social, cultural norms or language norms as mental illness and pathologise behaviour that is culturally normed
  - (c) Mental health professionals in private practice frequently lack information and do not utilise community-based treatments and support options.

- (d) There is often little acknowledgement that people from CALD backgrounds have the right to practise their culture (within legal norms). Culture impacts on mental health issues and it needs to be recognised that cultural practices, religious observances, multicultural celebrations and/or participation in culturally appropriate support/activities need to be included in the support and treatment plan.
- (e) People have the right to have information in their own language and information needs to be provided and explained in a language that can be understood and acted upon.
- (f) The referral pathway is complex and provides multiple barriers for people from culturally and linguistically diverse backgrounds including refugee survivors of torture and trauma. Attachment 3 outlines the referral pathway and potential barriers.

### **Case Studies**

The following are a number of specific examples of the lack of success in using mainstream mental health programs such as Better Access and ATAPS:

- (i) A 16 year old pregnant girl from a refugee background was admitted to hospital after trying to commit suicide. She had been seeing a private Allied Health professional (psychologist) for over 1 year who had been working on her “self esteem” issues but who had no idea that she was pregnant, what the possible family and community impacts of this may have been or of the trauma implications of her refugee experience. In short the practitioner had been unable to establish a sufficiently therapeutic relationship with the young woman to enable her to discuss any of the issues impacting on her life or that she had suicidal tendencies. The young woman was subsequently referred to a community based agency which specialises in this area.
- (ii) A Chinese man with depression was keen to receive counselling and was referred to his doctor. While the GP division provided ATAPS not all GPs in the division were signed up and this man's regular GP was one of the GP's who could not refer to ATAPS - so he was unable to receive counselling via ATAPS. Because of the language barrier he could not be referred to a private psychologist through Better Access as no private psychologist could afford the interpreter costs. This man could not afford the costs of the gap fee for a private Cantonese psychologist.
- (iii) A GP seeing a Laotian woman with depression and PTSD was keen to refer to ATAPS. The client did not speak enough English for counselling to be provided in English. The GP Division had used their ATAPS money to employ part time psychologists including a Vietnamese speaking psychologist (as a large portion of their community profile was Vietnamese, while the Laotian community was small). The Division said

that they sometimes could afford interpreters but could not this time as they only had limited funds available; it was about 4 months before new funding would become available under ATAPS and they said they would consider it then. The woman could not use Better Access as there are no Laotian speaking psychologists and no psychologists who could afford an interpreter. She was not from a refugee background and her PTSD was about trauma experienced as a result of Domestic Violence in Australia. She was eventually linked into a community based mental health service for practical assistance and provided with medication by her GP.

- (iv) An Ethiopian woman was suffering from depression and anxiety resulting from a history of trauma in a refugee camp, acculturation stress and caring for a sick son. Her GP and an advocacy agency were keen to arrange ATAPS counselling for her but the GP division were unwilling to use ATAPS money to pay for interpreters or set up a contract with QTMHC to provide the counselling. She was on the wait list for a community based Torture and Trauma service but it is currently about 8 months long. She still currently needs therapeutic input and options have been discussed but nothing is really available. Better Access is not an option because of the language barrier.
- (v) A CALD woman accessing a community based mental health service was referred to a Psychologist with experience working cross culturally under the mental health plan. The woman did not speak any English and the psychologist liaised with ATAPS to explore if they were able to make a referral to him or to any other psychologist under their program. The Psychologist was told that a referral to him could not happen as ATAPS has its own psychologists and they will assess the person's situation to be referred to an ATAPS Psychologist. The woman has reported that no service was provided to her.
- (vi) A psychologist working in private practice has publically stated that you do not need to use interpreters when working with people from refugee backgrounds as you can rely on non-verbal assessments. Even if a non-verbal assessment could be considered sufficient within a give set of circumstances, the different social and cultural norms surrounding non-verbal behaviours could make any such assessment questionable.

## Recommendations

1. That people from CALD backgrounds, should be considered as a priority target group for Tier 2 under ATAPS.
2. That people from culturally and linguistically diverse backgrounds and people from refugee backgrounds are considered as a special needs group and eligible for specific funding. Given the reluctance of GPs and the Divisions of General Practice to take up service delivery for culturally and linguistically diverse populations, that funding be specifically allocated to community service agencies who can provide both mental health counselling and support along with needed wrap around services.
3. That any future development of Medicare Locals be required to be inclusive of both community based services and of people from culturally and linguistically diverse backgrounds.
4. That Divisions of General Practice be required to justify their primary targets groups to local communities and be able to provide an evidence base for these decisions. This includes increased accountability about how GP Divisions respond to the needs of CALD communities within their catchment areas.
5. That greater flexibility to treatment options be built into any service delivery models to allow for: tailored promotion and explanation of services, and specific types of support including wrap around services and interventions suitable to the client. This includes the adoption of culturally appropriate models inclusive of bi-cultural health professionals where appropriate
6. In order to increase the capacity of General Practitioners and Allied Health Practitioners to work with CALD clients and to appropriately identify and refer clients with a mental illness, that specific funds are allocated for the delivery of capacity building programs (including ongoing training and development) for mainstream providers.
7. That funding be allocated to increase rural and regional services for people of CALD and refugee backgrounds
8. That dedicated interpreter budgets are allocated and policies that assist with take-up of interpreter services are developed.
9. That flexible referral pathways into a range of mental health services including community health services be allocated i.e. that referral via a GP be one option not the only option.

## **Attachment 1 – Participating Services**

- Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)
- Multicultural Development Association (MDA)
- Multicultural Centre for Mental Health & Well - Being Inc (Harmony Place)
- ACCES Services Inc
- Multilink Community Services
- Ethnic Communities Council of Queensland (ECCQ)
- Multicultural Communities Council Gold Coast
- Queensland Transcultural Mental Health Centre

## **Attachment 2 – Appropriate Therapeutic Interventions with Refugee Survivors of Torture and Trauma**

The Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder (Australian Centre for Posttraumatic Mental Health, 2007) recognises that in treating refugees and asylum seekers (p137) a “practitioner is faced with a number of complex factors over and above the individuals’ traumatic experiences, including language, ethno cultural, socio-political and community issues, as well as the persons’ current clinical and psychosocial situation.” The experiences of each person and the way that they are reacting to these experiences are unique. It is important for many refugee survivors to be able to see what is happening to them as normal reactions to abnormal experiences rather than being individually pathologised.

The Australian Guidelines go on to recommend that “practitioners working with refugees and asylum seekers need to be culturally skilled including having awareness of biases, awareness of values, avoidance of stereotyping, the capacity to respond to potential conflicts between traditional values and values of the dominant culture and the ability to choose the appropriate approach. Practitioners should also recognise that cultural factors interact with...social factors – class, education, social status, rural or urban background.”

Traumatic experiences of refugee survivors need to be understood within socio-political factors of the country of origin. Practitioners need to have an understanding of the nature and history of these factors and the impact that these have had on individuals, their family and their communities.

The Australian Guidelines (p133) go on to recommend that practitioners should be aware that once people have settled in Australia, other factors can also impact upon the mental health of people from refugee backgrounds including:

- ongoing fear and concern over the safety of family and friends left behind;
- loss and separation from family and friends;
- settlement challenges such as learning a new language, employment, adjusting to new cultural norms and changing family relationships; and
- discrimination

In seeking to understand the needs of people from refugee backgrounds practitioners need to be able to acknowledge the impact of these traumatic experiences and recognise that past experiences may lead to current issues such as:

- Ongoing danger in country of origin, new unfamiliar environment, fear about the future and of not coping may lead to anxiety, feelings of helplessness and perceived loss of control;
- Continuing separation from family members and loss of belonging may lead to changed relationships, reduced capacity for intimacy, grief and depression

- Devaluing of a person in the new culture, injustices and exposure to ignorance and lack of understanding may lead to a shattering of previously held assumptions, a
- loss of trust, meaning & identity destroyed and altered views of the future
- Racial prejudice and new humiliations may lead to guilt and shame

The Australian Guidelines recommend that a number of considerations are considered when working with this group such as:

- The building of trust and rapport is important and appointments may need to be longer and there may need to be more sessions;
- Comprehensive assessments may require specific appointments;
- Clients need to be seen in a “safe” place which will not trigger traumatic memories;
- Use of authoritarian behaviours may cause re-experiencing of interrogations and other traumatic experiences;
- Medical settings may act as reminders of torture/trauma;
- The gender of the practitioner (and interpreter) is important particularly if working with survivors of sexual assault
- Client hostility may be a reaction to fear and uncertainty;
- Care should be undertaken to promote a sense of control for the client;
- Some concepts need to be explained in culturally sensitive and appropriate ways eg confidentiality, counselling
- Intrusive questioning may be frightening and cause re-traumatisation
- Anticipation of factors affecting “non-compliance” eg knowledge of and misunderstanding of medications

When working with refugee survivors of torture and trauma it is critically important to provide a safe environment where integration of traumatic material can occur at the right pace (so re-traumatisation does not occur). Containing overwhelming affects and supporting the inevitable grieving process bit by bit to allow the processing of trauma is vital.

Therapeutic interventions like Cognitive Behaviour Therapy (CBT) are not always appropriate for use with this client group. CBT in particular “aims to help the client to become aware of thought distortions which are causing psychological distress, and of behavioural patterns which are reinforcing it, and to correct them. In the main clients who have experienced trauma are needing support to work through and integrate what were real and horrifying experiences not thought distortions. In particular where there are traumatic re-experiencing, flashbacks, nightmares, dissociation or a person is not readily able to access cognitions that effectively counteract these states, CBT is not recommended. CBT attempts to correct distorted thoughts at a purely cognitive level which does not address the integration of traumatic material. Nor does it take into account the broader context in which traumatic experiences need to be understood.



- Attachment 3 – Current Referral Pathway

