Case Studies:
Improving mental health pathways for people from refugee and asylum seeker backgrounds
WARNING:
Please note this is an educational resource intended for a professional audience. Some of the content within this resource relates to mental health, self-harm and suicide. It could be distressing for some readers.

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Introduction

About this resource

This resource has been created as an educational resource for staff from organisations whom work with people from refugee and asylum seeker background who are experiencing mental health difficulties. This resource was designed for staff from:

- settlement services;
- refugee and/or asylum seeker support services;
- acute mental health services;
- community mental health services; and
- NDIS providers.

These case studies explore some of the challenges and practical solutions for improving access, service coordination and care. It is recommended the case studies be used in training, team meetings and supervision as a reflective exercise to develop awareness and improve practice.

These case studies are fictional, they have been drawn from the lived experiences of staff working with people from refugee and asylum seeker background who are experiencing mental health difficulties. These staff strive to deliver the best possible services to this client group.

These case studies are drawn from the western metropolitan region of Melbourne. However it is hoped that the material included in this resource will have wider applicability.
Jean Paul arrived in Australia by plane in his early twenties and was seeking asylum from Sudan. Jean Paul needed support to apply for a protection visa. Jean Paul presented at The Hub, a local organisation that supports people seeking asylum. As Jean Paul had not yet applied for a protection visa, he was not eligible for support through The Hub. There were other services which could support Jean Paul. A caseworker at The Hub provided Jean Paul with information about these services.

When Jean Paul presented at The Hub he self-harmed and expressed suicidal ideation. The caseworker contacted the local mental health triage service and discovered that Jean Paul was an existing involuntary client. An ambulance was called and Jean Paul was taken to hospital to treat the impact of his self-harm.

The caseworker from The Hub advised the mental health service that Jean Paul was not eligible for support through The Hub and provided information about services which could support Jean Paul with applying for his protection visa.

Over a period of ten days Jean Paul presented at The Hub each day whilst on day leave from the mental health service. Jean Paul said staff at the mental health service advised him to go to The Hub. Each day the caseworker spoke with a different staff member at the mental health service to explain where Jean Paul could get the support he needs. Each day the staff at the mental health service were unaware of the information provided on the previous day/s. Each time Jean Paul presented at or called The Hub he either self-harmed, or expressed an intention to self-harm.

The caseworker from The Hub offered to visit the mental health service to attend a case conference to support the staff in Jean Paul’s care and discharge planning. This did not happen. Jean Paul has now applied for his protection visa and is receiving support through a settlement service provider.

Discussion Topic: Inter-agency communication

Q  What could have been done to prevent Jean Paul from re-presenting at The Hub?
Q  What could be done to improve the inter-agency relationship between The Hub and the mental health service?
Q  Now Jean Paul has a protection visa and is receiving support from a settlement service, how can the agencies work together to support Sanjeev’s recovery?
Q  What changes need to be made to policies and/or procedures at each service to improve outcomes and the system for Jean Paul?
Case Study #2 – Sanjeev
Topic: Barriers to access

Sanjeev arrived in Australia by boat from Sri Lanka as an unaccompanied minor five years ago. He made the journey on his own. Sanjeev has been in detention for almost five years.

Sanjeev currently lives in community detention and receives a basic living allowance through the Status Resolution Support Services (SRSS). Sanjeev is restricted from working and study, unless it is English classes or an approved course. He has access to International Health and Medical Services (IHMS) in place of Medicare. Sanjeev can only go to an IHMS provider and any medical treatment beyond a general GP appointment or dental check-up requires pre-approval by IHMS.

Sanjeev has experienced long term trauma. Sanjeev has significant difficulty managing new relationships and change. While living in community detention he experienced a breakdown in his mental health, including paranoia, psychosis, hallucinations, suicidal and homicidal thoughts. He was admitted to an in-patient unit for approximately four weeks.

The following year Sanjeev’s visa status changed suddenly, he was no longer able to access SRSS. He also received news a family member was arrested in Sri Lanka. He experienced a significant deterioration in his mental state. Sanjeev contacted the local mental health triage service who arranged for Sanjeev to be transported to the Emergency Department of the local hospital. Upon arrival Sanjeev was refused treatment as he did not have a Medicare card and could not pay for the service. Sanjeev was eligible for care through IHMS, but because of his distress and low English literacy he was not able to explain his situation. Sanjeev was not offered an interpreter and sat outside the emergency department for approximately six hours.

Sanjeev’s mental health continues to deteriorate.

Discussion topic: Barriers to access

Q  What factors might have impacted Sanjeev’s ability to advocate for himself?
Q  How could the mental health triage service support clients like Sanjeev to access the hospital?
Q  What changes need to be made to policies and/or procedures at the hospital to improve access?
Case Study #3 – Mahmoud

Topic: Living with uncertainty

Mahmoud migrated from Afghanistan via Pakistan to Australia 4 years ago leaving his children and wife behind with plans to bring them over once he had settled. Mahmoud was living with a friend in shared accommodation where they both shared a small room. Mahmoud was on a bridging visa and received a basic living allowance through the Status Resolution Support Services (SRSS). He was not eligible for accommodation or employment supports. Mahmoud wanted to find employment so that he could send money back to his family in Pakistan. Mahmoud could understand basic English but needed an interpreter for in depth conversations.

Mahmoud experienced psychosis associated with psychosocial stressors and was admitted to a psychiatric inpatient unit. Shortly after discharge Mahmoud stopped taking the prescribed medication.

Mahmoud was linked with two settlement services, a trauma support service and also a Personal Helpers and Mentors Service (PHaMs). Mahmoud had ceased appointments with the trauma support service.
Mahmoud’s GP noticed a decline in Mahmoud’s mental state and referred him to a local mental health service. He was experiencing auditory and visual hallucinations, his mood appeared low, he was mildly agitated and expressed some suicidal thoughts.

Mahmoud commenced on a different antipsychotic medication which assisted with some of his symptoms. Mahmoud had limited insight into his mental health. He was provided with ongoing education about the need for medication and he continued to take medication whilst with the service.

When asked about further psychology work Mahmoud said he did not want to continue to reflect on the past but wanted to look to the future. Over a period of time, through the use of an interpreter, further information was gathered about Mahmoud’s mental state and the symptoms he had experienced in the past. Mahmoud’s thoughts appeared disordered, with interpreters finding him difficult to follow.

Mahmoud found some employment but there was concern that he was being financially exploited. Mahmoud moved into a large share house with other refugees. The caseworker tried to support Mahmoud but it was difficult as he had been discharged from the settlement services. Mahmoud found new accommodation, but it was in a different area. The caseworker decided to refer Mahmoud to a mental health service in his local area.

Discussion Topic: Living with uncertainty

- What psychosocial stressors could be impacting Mahmoud’s mental health?
- How could the caseworker support Mahmoud to manage these stressors better?
- How could the caseworker support Mahmoud to live with the uncertainty he is experiencing?
- What improvements could have been made to the service system to improve Mahmoud’s pathway?
Case Study #4 – Raheem

Raheem is an Iraqi male in his 50s living in Melbourne’s west. Raheem came to Australia as a refugee three years ago after residing in Jordan and Syria. Raheem currently holds permanent residency.

Raheem lives in a private rental with his family, which includes his wife and children. None of the family members are employed at present. As a result they are under significant financial stress. Raheem has no other family or personal supports in Australia.

Raheem has a diagnosis of depression, anxiety and post-traumatic stress disorder. All members of the family have significant histories of trauma. His son also has mental health problems.

Raheem speaks very little English, and is reluctant to engage with the local Arabic community due to perceived stigma about his and his son’s mental health diagnosis. This also makes Raheem reluctant to use interpreters.

Raheem is currently accessing support through a caseworker at a local community mental health service. In two month Raheem will no longer be able to access support through the local community mental health service. Raheem will need to access support through the new National Disability Insurance Scheme (NDIS).

Discussion Topic: Transitioning to the NDIS

Q. What steps will Raheem need to take to access the NDIS?
Q. What challenges might Raheem experience in trying to access the NDIS?
Q. How can the caseworker support Raheem to understand and access the NDIS?
Q. How can the caseworker support Raheem’s continuity of care when he transitions to the NDIS?
Managers from a number of mental health services met to discuss the transition to the National Disability Insurance Scheme (NDIS). One of the key priorities identified was workforce development. They identified the opportunity and need to develop a more culturally responsive and suitably trained workforce that could provide high quality NDIS services to people from refugee background.

The workforce required to service this demand in Victoria was estimated to grow from 19,550-23,900 to 34,400-42,000 jobs (full time equivalent). Changes to the local workforce were inevitable, including new staffing structures, new roles and the recruitment of many new workers. It was important to develop a strategy so that it would be considered in the planning and rollout of these changes.

The managers decided to work together to develop a workforce development strategy. They mapped out what types of services would be provided under NDIS, what roles they would likely need to be able to provide these services, what competencies would be needed and what training could be provided.

### Growth in Workforce at Full Scheme

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<th>19,550 – 23,900 (FTE range)</th>
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<td>Current Workforce</td>
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<td>Future Workforce</td>
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Source: NDIS Ready – Communications Toolkit, August 2016, NDIS.
Discussion topic: Workforce development

Q What core competencies will be required to ensure staff are culturally responsive and suitably trained to provide services to refugees?

Q What training could be offered to staff new and existing staff?

Q How could bicultural peer support workers be integrated into the new staffing structure and services?