Dear Prof Robson

Consultation Draft - Culturally responsive clinical practice: Working with people from migrant and refugee backgrounds

Thank you for the opportunity to provide feedback on the Consultation Draft - Culturally responsive clinical practice: Working with people from migrant and refugee backgrounds. The Migrant and Refugee Women’s Health Partnership is to be commended for its commitment to improving clinical practice in relation to migrant and refugee health through such a broad consultative and collaborative process.

The Australian College of Mental Health Nurses (ACMHN) wishes to make the following suggestions:

- That the document expand on the impact of social determinants at page 18 to provide context about how migrant and refugee experiences/issues with housing, employment, education, income etc may contribute to poor/deteriorating physical and mental health outcomes over time, even if they have been granted a visa. It would also be useful to emphasise the importance of these indicators being monitored over time as indicators of overall health and wellbeing.

- That the document provide more specific context for clinicians on the impact of particular experiences on mental health based on the current evidence base (Commonwealth of Australia, 2017; AHRC, 2014; Newman et al 2013; Triggs 2013; Coffey et al 2010; McLoughlin & Warin, 2008; Cohen 2008):
  - People currently in immigration detention: While they may have left held detention, these individuals remain severely restricted in their movement - they cannot be reunited with their family and have little or no prospect of economic and/or social participation. The nature of the detention is indefinite; many have given up hope and openly talk of killing themselves as a way of bringing an end to their suffering and excruciating distress and despair. Cumulative trauma is endemic.
  - People with a history of being held in immigration detention (Increased risk of experiencing cumulative trauma, Complex PTSD)
  - People who have been granted temporary visas – do not have same benefits, recognition or support as Australian citizens and face the continuous uncertain prospect of being forced to return to their country of origin or to detention when visa expires.
  - Migrants and people on temporary protection visas who are isolated and perhaps do not have the power to bring their family to Australia, but have family that may be
living in poverty, poor or dangerous conditions overseas (feelings of isolation, guilt, developing tension in relationships with family still overseas).

The potential impact of each of the above circumstances on the mental health and wellbeing of the people affected needs to be taken into account by all clinicians – regardless of whether the clinician is a specialist mental health clinician or other health professional.

- Adjust language to reflect a more competency-based approach, rather than deficit based (e.g. “some people may need assistance to find and understand information” rather than “people with an inability to find or understand information…”).

The ACMHN sought input from one of its members, Prof Nicholas Proctor, who is Chair of Mental Health Nursing at the School of Nursing and Midwifery, University of South Australia. Prof Proctor provided specific comments on these areas at Appendix A.

Thank you again for the opportunity to provide feedback. We are happy to be contacted if you have any further enquiries.

Yours sincerely

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Appendix A – feedback from Prof. Nicholas Proctor

It is really pleasing to see great effort being made to promote best practice for people of refugee and asylum seeker background, as well as for people who are migrants more generally. While the health systems in Australia and other developed countries are regarded as some of the finest in the world, there is an ever-present need to ensure flexibility regarding cultural competence and cultural inclusivity across a range of practice settings. Australia, for example, has one of the most diverse populations in the world, with more than 25 per cent of its current population being born overseas. If current rates of immigration to Australia continue to grow, it is estimated that by 2050 approximately one-third of Australia’s population will be born overseas.

The document does well to promote key considerations, however there is one group that require special attention. I would strongly encourage the writing team to take account of the powerful impacts of current government policy upon asylum seekers on temporary protection visas (some 30,000 of these are part of the legacy caseload).

In Australia, asylum seekers who arrive by boat who are found to be refugees are mostly granted a visa that entitles them to temporary residency. This may be a Temporary Protection Visa (TPV) or a Safe Haven Enterprise Visa (SHEV). These visas are granted to people who arrived in an ‘unauthorised way’; that is, without a valid visa. TPVs were granted to people who arrived in Australia by boat between 1990 and 2001. They were abolished and then reintroduced in 2014. These temporary visas entitle a person to live in Australia for three to five years. For a TPV to be renewed, the applicant’s circumstances are re-assessed to determine whether it is safe enough for the person to return to her or his home country. The granting of a SHEV is for asylum seekers who have lived in a designated ‘regional’ area and may be entitled also to apply for a permanent work visa or partner visa in limited circumstances.

The impermanent nature of these temporary visas and the processes associated with their renewal – such as the lack of certainty about when interviews to re-assess claims would occur and how the safety of the person’s homeland would be assessed, or whether they can apply for another visa – mean that TPV and SHEV holders face considerable mental distress, mental deterioration and anxiety marked by uncertainty about their continuing personal circumstances. This uncertainty, coupled with strongly held beliefs that it is unsafe to return to their country of origin, results in substantial psychological and physical effects in some visa holders. There have been many suicides among this group and many more ‘near misses’. The document should specifically address this issue in a practical and applied way. This means at the very least, in a more substantive way as several studies have suggested that temporary refugee protection contributes substantially to the risk of depression, post-traumatic stress and problems related to mental illness in refugees including intrusive, anxiety based symptoms in the form of constant worrying about the possibility of being deported. Asylum seekers’ marginalised status arising from TPVs reinforces a sense of insecurity, powerlessness and helplessness that characterises previous experiences of held detention.

Studies investigating the effects of temporary protection on the mental health of refugees and asylum seekers have concluded strong associations with daily stresses related to financial and
work difficulties, and problems in accessing health care, language classes and other opportunities. Clinician who use this document should know about these issues. Additionally, since temporary visa holders are unable to sponsor close family members to Australia and to re-enter Australia if they travel overseas, without seeking express permission from the Department of Home Affairs, they are unable to assist family members to flee dangerous situations, thereby reinforcing feelings of guilt and powerlessness.

On this basis more needs to be done to this document to fully inform clinicians of this as well as to ensure clinicians understand and consider the associated states of those feeling marginalised and disenfranchised.

I strongly recommend that the document authors revise the emphasis within the text that refugees and asylum seekers ‘lack the knowledge and skills to navigate the health system’. The document mentions this as ‘the person’s inability to location necessary information’. Taking a deficit approach is something the College should recommend be revised. A strengths based approach would be a better way to go. After all, many mainstream physical and mental health services do not fully embrace cultural competence, empowerment and advocacy towards decision making. Moreover, as outlined above, there are wider political processes and power relationships in health and immigration settings that actively prevent empowerment and self-determination.