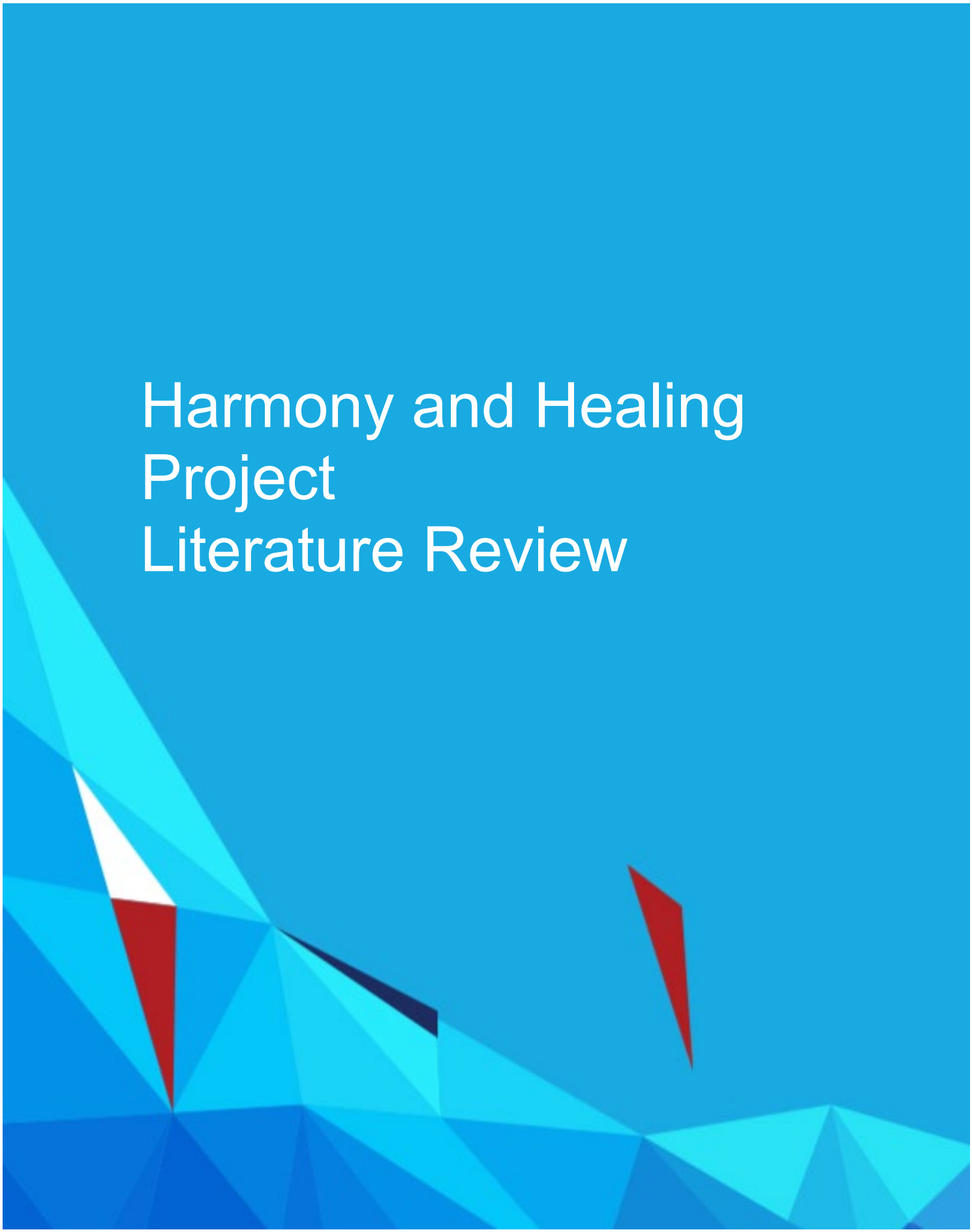
NSW GOVERNMENT
Health
Justice Health and
Forensic Mental Health Network

Harmony and Healing Project Literature Review



Contents

1 Summary

This paper is one of three steps in the first phase of the Justice Health and Forensic Mental Health Network (JHFMHN) Harmony and Healing Project. The aims of this phase of the project are to:

- Organise and summarise the current knowledge and experience that informs the care of adult refugees and migrants
- Add to the evidence base regarding experiences of adult refugees and migrants in secure settings, excluding immigration detention, who have been psychologically impacted by traumatic events and torture; and
- Identify gaps in service provision, address access barriers and make recommendations to the Net regarding its delivery of healthcare to people from refugee backgrounds.

The purpose of this literature review is to explore white and grey literature on the topic of refugees and migrants' experiences in the custodial and forensic mental health settings who have been psychologically impacted by traumatic events and torture. This is because torture and trauma can negatively impact people's mental health with depression, anxiety, Post-Traumatic Stress Disorder (PTSD), Complex PTSD (CPTSD) and protracted grief, commonly being experienced. While this is more prevalent among refugees and asylum seekers, other migrants have also been shown to be at a higher risk and symptoms can persist for many years post migration (Blackmore et. al., 2020; Kaplan, 2020; NSW Health, 2019; Lineth et al., 2018; Nickerson, et al., 2017 RANZCP, 2017; NSW Health 2011).

The Australian Bureau of Statistics (ABS, 2021) reported that between June 30th, 2020, and June 30th, 2021, 20% of prisoners in Australia were born overseas. In NSW, data available through the JHFMHN Culturally and Linguistically Diverse (CALD) Mapping Project Report (2019) shows that 18% of patients identified as CALD. It is not possible however, to state how many of these people in Australian prisons broadly or NSW specifically are from a refugee background. What is clear is that many refugees, asylum seekers and migrants (RASM) have experienced inhumane treatment along their journey to settlement in Australia including persecution, violence, torture and other human rights violations (de Silva et al., 2021; Kaplan, 2020; Wylie et al., 2018). As a result, many RASM are survivors of torture, trauma, and complex trauma (Kaplan, 2020; NSW Health, 2019; Lineth et al., 2018).

Research shows that people from different cultures can experience, respond to, and be impacted by trauma differently (Kaplan, 2020; Wylie et al., 2018). To provide effective care to people who have experienced trauma, it is necessary for mental health services who care for refugees and traumatised migrants to have the capacity to treat trauma (Kaplan, 2020). At the same time, it is important for all health workers to be informed about the impact of trauma as it applies to cultural differences and how to respond to a range of potential trauma reactions among patients (Kaplan 2020; NSW Health, 2019; Wylie et al., 2018). To do this, care must be both trauma informed and culturally responsive. There is, however, a paucity of data about refugees and migrants' experiences of health care in secure settings (except for immigration detention) globally and in Australia.

The identified gaps in knowledge include:

- Demographic information
- Information about refugee and migrants' trauma history
- Prevalence of mental and physical health issues pertaining to traumatic migration experiences
- Health protective factors and risk factors for custodial and forensic patients who have experienced trauma and complex trauma
- Health seeking behaviours and barriers
- Health literacy and barriers

- How best to apply cultural responsiveness and Trauma Informed Care (TIC) principles to health care delivery with refugee and migrant trauma survivors in secure custodial settings across primary and specialist care including “drug and alcohol, dental care, midwifery, optometry, allied health services, pharmacy services, radiology, orthopaedics, ophthalmology, dialysis, podiatry and population health services including hepatology, sexual health and harm minimisation services.” (JHFMHN, 2019, p.13).
- How best to apply cultural responsiveness and TIC principles to health care delivery with refugee and migrant trauma survivors in Forensic Mental Health settings
- Health staff capability to respond to refugees and migrant’s trauma survivors in a trauma informed and culturally responsive way
- The level of competence of health staff in both trauma informed care (TIC) and cultural responsiveness in NSW broadly and in secure settings specifically.

(Kaplan, 2020; Justice Health and Forensic Mental Health Network, 2019; Justice Health and Forensic Mental Health Network, 2018; Justice Health and Forensic Mental Health Network, 2017; Minas et al., 2013)

The data gaps identified through this review highlight the need for more information that pertains to the NSW custodial and forensic settings that focuses on health care delivery to refugees and migrants in the context of torture and trauma. A consultation with key staff from JHFMHN and Corrective Services NSW (CSNSW) is recommended, followed by the development of a position paper.

2 Key Terms

Acculturation
Acculturation is the cultural and psychological change that occurs as a result of contact between cultural groups and the people within them and the host culture, following migration. Berry (2017) describes four different ways this can happen. The first of these is assimilation, which is a complete adaptation to the new culture and relinquishing of values related to the culture of origin. Second is integration, the combination of adjusting and adapting to a new culture and maintaining norms and values of the culture of origin. Third is separation, a maintenance of all things related to the culture of origin and separation from the new culture. Fourth is marginalisation where a person is cut off from both culture of origin and the new culture.

Asylum seeker
An asylum seeker is someone who is "seeking to be recognised as a refugee but have not yet had an official determination of their claims" (Kaplan, 2020, p. 25). In other words, they have requested sanctuary, but this has not yet been processed (UNHCR, 2022). In Australia, refugees who are seeking asylum arrive either with or without a valid visa. Those with a valid visa can apply for a protection and live in the community with full access to community and health services until their request for sanctuary is determined. Those without a visa are held in immigration detention onshore in the community, or in detention centres in Australia, or offshore (Kaplan, 2020).

Culturally and linguistically diverse
Definitions that describe culturally and linguistically (CALD) diverse people in Australia vary. For this paper, to be consistent with the literature, CALD includes people who were not born in an English-speaking country and /or the predominant language spoken at home is not English. (Pham et al., 2021). It is important to note however, that while this acronym is commonly used, some stakeholders consider it to be problematic in that it doesn't include "consideration of race or ethnicity" (FECCA, 2022, p.4).

Cultural competence
Cultural competence is defined by NSW Health as "a set of behaviours, attitudes and policies that come together in a system or agency or among health professionals that enables them to work effectively in cross cultural situations" (NSW Health, 2019, p.3).

Culturally responsive care
Culturally responsive care is therapeutic person-centred care that incorporates consideration of both the social and cultural aspects of a person (NSW Health, 2019).

Cultural safety
Cultural safety is a concept that, in Australia is commonly discussed in the context of providing care for Aboriginal and Torres Strait Islander peoples. It has a focus on inequities in determinants of health, and the systemic bias and barriers to care inherent in the health system that affect people who have a different world view and communication requirements to the prevailing culture (Curtis, 2019)

Forced migrant
Unlike the term refugee, the term forced migrant is not a legal description. It is often used to refer to any type of displacement or involuntary movement within or outside of countries (UNHCR, 2016).

Health
The World Health Organisation (WHO) in 1946 defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, n.d. para.1). Health is determined by a range of factors that include lifestyle, environment, genetics,

and resources in the context of individual choices and behaviours (Australian Institute of Health and Welfare, 2020).

Health literacy
"The cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health" (WHO, n.d.a). People with low health literacy are at higher risk of worse health outcomes and poorer health behaviours." (Australian Institute of Health and Welfare, 2020a).

Humanitarian Program
"Australia operates a dedicated Humanitarian Program that offers resettlement for refugees and others overseas who are in humanitarian need, and protection for people who arrive lawfully in Australia and engage Australia's protection obligations." (Australian Government Department of Home Affairs, 2022, para.1).

Humanitarian Visa
This visa is granted "for people who are 'subject to substantial discrimination amounting to gross violation of human rights' in their home country. Substantial discrimination involves a lower threshold than persecution" (Parliament of Australia, 2011, p. 12).

Refugee
Article 1 of the United Nations Refugee Agency (UNHCR), Convention "…defines a refugee as a person who is outside his/her country of nationality or habitual residence; has a well-founded fear of persecution because of his/her race, religion, nationality, membership in a particular social group or political opinion; and is unable or unwilling to avail himself/herself of the protection of that country, or to return there, for fear of persecution." (UNHCR, 2001, para. 4).

Migrant
"An international migrant is someone who changes his or her country of usual residence, irrespective of the reason for migration or legal status. Generally, a distinction is made between short-term or temporary migration, covering movements with a duration between three and 12 months, and long-term or permanent migration, referring to a change of country of residence for a duration of one year or more." (United Nations [UN], n.d., para.2). Migrants and refugees share, as a direct result of migration, many of the same disadvantages, difficulties, and health issues (WHO, 2021).

Mental health
The WHO (2018) defines mental health "as a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to contribute to his or her community. Mental health is fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living, and enjoy life. On this basis, the promotion, protection, and restoration of mental health can be regarded as a vital concern of individuals, communities and societies throughout the world." (para. 2 and 3). The determinants of a person's mental health include the things that happen to them, their environment, having a family history of mental health problems or for a biological reason (WHO, 2018).

Torture

Torture was defined in 1984 by *United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment.* It remains a current definition and is currently cited on the Australian Human Rights Commission Website as a human rights violation that "means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him (sic) or a third person information or a confession, punishing him (sic) for an act he (sic) or a third person has committed or is

suspected of having committed, or intimidating or coercing him (sic) or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions" (n.d., para.1).

Secure Settings
In the context of this paper, the term secure settings includes both adult custodial and forensic contexts and excludes immigration detention and juvenile detention. People detained through immigration detention are not included because their care is beyond the jurisdiction of Corrective Services NSW (CSNSW) and JHFMHN. Young people detained in juvenile detention are not included because the focus of this review is adults.

Transcultural approach to care
Transcultural care originated from nursing theory and is the provision of care that incorporates knowledge and understanding of differences between cultures in the way members hold and express their values and beliefs and how these impacts their view of health, illness and care. Transcultural care requires nurses to apply their knowledge of cultural differences in the context of respectful and sensitive care giving (Ulutasdemir Ed., 2021).

Traumatic events
These are events that "pose a serious and major threat to a person's life or self. This includes exposure to actual or threatened death, a serious injury, losses in violent circumstances and/or witnessing such events. Traumatic events include war, torture, rape, violent assault and serious accidents. The demarcation between traumatic events and other adversities is not clear cut and refugee survivors have usually experienced multiple traumatic events as well as adversities". (Kaplan, 2020, p.4).

Trauma can impact people both socially and psychologically creating feelings of fear, helplessness breaking of bonds, disrupted connections with people and community and destroyed core beliefs. People can also feel emotions of humiliation and degradation. These impacts affect mood and behaviours resulting in reactions like anxiety, avoidance, hypersensitivity to threat, questioning meaning purpose and identify and a focus on injustice. Psychologically, people can experience grief, depression, problems with attachment and connections with community (Kaplan, 2020).

Trauma Informed Approaches to Care
Trauma informed approaches to care are based upon an understanding of how traumatic events and their impact affect people lives, their service needs, how they can best access and use the service, and how the service and the people within it can best respond to them. The foundation of TCI is person centredness, collaboration, respect and fostering of trust (Agency for Clinical Innovation, 2019).

3 Introduction

3.1 Harmony and Healing Project Overview

This paper is one of three steps in the first phase of the Justice Health and Forensic Mental Health Network (JHFMHN) Harmony and Healing Project. The aims of this phase of the project are to:

- Organise and summarise the current knowledge and experience that informs the care of adult refugees and migrants
- Add to the evidence base regarding experiences of adult refugees and migrants in secure settings, excluding immigration detention, who have been psychologically impacted by traumatic events and torture; and
- Identify gaps in service provision, address access barriers and make recommendations to the Net regarding its delivery of healthcare to people from refugee backgrounds.

In this paper, existing data and knowledge will be used to develop an understanding of refugees and CALD patients in the NSW custodial and forensic mental health environments. Following this, a consultation will be undertaken with key stakeholders in JHFMHN and CSNSW, to explore the whether the reported data is reflective of what is observed clinically in these settings.

The final part of this initial phase of the project is to develop a position paper documenting recommendations for best meeting the care needs of people who have a lived experience as refugees or come from a refugee like background and who have experienced trauma including torture as a result of migration, in line with the organisations vision of partnering with stakeholders, including patients, and working together towards a healthier future.

3.2 Purpose of the Literature Review

The purpose of this literature review is to explore white and grey literature on the topic of refugees and migrants' experiences in custodial and forensic mental health settings, who have been psychologically impacted by traumatic events and torture.

The review will describe and discuss the impact of these experiences on people's mental and physical health and how that can manifest in relation to emotional responses and related behaviours in the context of being a health care consumer broadly. How the care needs of refugees and migrants in both the custodial and the forensic mental health contexts could best be met will also be discussed. The reason for including migrants in addition to refugees is because:

- The World Health Organisation (WHO) views refugees as a subset of migrants and addresses the health needs of both in their *Global Competency Standards for Health Workers* (2021)
- Migration can be voluntary or involuntary
- Migrants who are not classified as refugees also commonly also experience the impact of trauma because of migration
- Due to gaps in data in Australia and in NSW it is often difficult to identify whether people are refugees or migrants
- Health issues related to trauma and torture can persist for many years after settlement for both migrants and refugees.

(WHO, 2021; Kaplan, 2020; NSW Health, 2019; Lineth, et al., 2018; Matlin, et al., 2018)

4 Background

Refugees, asylum seekers and migrants are amongst the most vulnerable in their new societies, both because of difficulties they may have faced during migration as well as their experiences upon and after arrival, such as discrimination, social exclusion, stereotyping, and stigmatisation. A significant difficulty people face following settlement, is having their health needs met because of challenges related to accessing health care services. The most obvious of these are cultural and language differences (WHO, 2021; NSW Health, 2019). However, institutional discrimination and health systems that do not specifically respond to or cater for the health needs of refugees and migrants, also play a significant role. These factors are the rationale behind the recent WHO Global Competency Standards for health workers who provide services for refugees and migrants (WHO, 2021). The preamble to this document states that refugees and migrants "have the fundamental right to the enjoyment of the highest attainable standard of health" (p.vii).

NSW settles the largest number of migrants in Australia including refugees, with 69,244 people settling in the 2020 to 2021 financial year. Five hundred and forty-three of these were categorised under the heading "humanitarian". Australia granted many more "humanitarian" visas than this in previous years. In addition to these numbers, there are generally many people in detention, who are waiting for their refugee or humanitarian claim to be processed. These people are in community detention or held in detention centres either on shore or offshore and are collectively known as asylum seekers (AS) (Australian Government, 2021; Kaplan, 2020; URBIS, 2019; Mental Health Commission of NSW, 2014).

Among the total NSW settled population, the 2016 census showed that 28% of people in this state were born overseas and 25% spoke a language other than English at home, including sign language. In addition, 47% of people in NSW had one or both parents born overseas (NSW Health, 2019). This means that nearly a third of the population of NSW are directly from CALD backgrounds and half of all NSW residents have a close connection to cultures and languages other than English. Some of these people who are residing in NSW, will be from refugee backgrounds through either first or second-generation migration. It is however difficult to identify how many, because data collection about CALD populations, including refugees, is generally inadequate and inconsistent (FECCA, 2022).

In the Australian custodial context, the Australian Bureau of Statistics (ABS, 2021) reported that between June 30th, 2020, and June 30th, 2021, 20% of prisoners in Australia were born overseas. In NSW, data available through the JHFMHN Culturally and Linguistically Diverse Mapping Project Report (2019) shows that 18% of patients identified as CALD. It is not possible however, to state how many of these people in Australian prisons broadly or NSW specifically are from a refugee background or were involuntary migrants because this data is not specifically collected from a health or custodial perspective (outside of a CALD census conducted by the Department of Justice as part of their Multicultural plan 2015-18 (2015). This is consistent with other health services in NSW and across Australia (FECCA, 2022). Despite these gaps however, it is clear there are a significant number of people from CALD backgrounds in secure settings in NSW and it is likely that a percentage of these will have a refugee background.

This is important from a broad health service delivery perspective because RASM are more vulnerable to having complex medical issues including chronic diseases, tropical diseases, and vaccine preventable diseases. Migration to a new country can also negatively impact people's mental health with depression, anxiety, Post-Traumatic Stress Disorder (PTSD) and grief, commonly experienced by RASM. While this is more prevalent among refugees and asylum seekers, other migrants have also been shown to be at a higher risk of mental health issues than the non-migrant population and these can persist for many years post migration (Blackmore et. al., 2020; Kaplan, 2020; NSW Health, 2019; Lineth et al., 2018; Nickerson, et al., 2017 RANZCP, 2017; NSW Health 2011). Interestingly, this health profile of RASM is similar to the overall mental

and physical health status of prisoners, who are at higher risk of poor physical and mental health outcomes than the general population (NSW Health, 2018).

Although AS are mentioned along with refugees in much of the health-related literature, they have not been specifically included in the scope of this paper. This is because there is a paucity of literature about AS in relation to incarceration. The last mention of AS and State custody was in 2004 (Groves, 2004). This may be because AS visa and detention status is federally controlled, so they are unlikely to enter a State Correctional or Forensic System. Also, it could be because a breach of the code of conduct implemented in 2013 for AS released into the community, can lead to visa revocation, which results in people being sent back to detention and not to gaol (Vogl and Methven, 2020). The focus of this paper, therefore, is migrants and refugees.

5 Data and Methods

Search Strategy

An initial brief search of the literature related to the topic of refugees and migrants' experiences in the custodial and forensic mental health settings who have been psychologically impacted by traumatic events and torture, revealed very little relevant literature with few articles specific to the custodial and forensic setting. It also revealed that most of the articles are narrower in focus than the broad aim of this review. These findings informed the inclusion and exclusion criteria and search terms below:

Inclusion Criteria

- Refugees and migrants' experiences in the custodial and forensic mental health settings who have been psychologically impacted by traumatic events and torture
- Torture and trauma
- Torture and trauma prevalence among RASM
- RASM and PSTD and CPTSD
- Prevalence of mental health disorders among RASM
- Predictors of mental health disorders among RASM
- Trauma informed Care in the context of CALD people and refugees in Australia
- Cultural competence and culturally responsive care in the context of CALD people and refugees in Australia
- Health literacy and social determinants of health in the context of CALD people and refugees in Australia
- RASM and criminogenics

Exclusion Criteria

Papers on the following were excluded because they were very specific in terms of people, context, health issues and impact and therefore, too narrow for the aims of this paper:

- Children and Youth
- Specific ethnicities and associated atrocities experienced by RASM related to country of origin
- Screening and treatment for mental health disorders among specific RASM groups including directly related to specific atrocities and harms
- Management of specific physical health issues for example, obstetrics, surgery, COVID and chronic disease
- Contexts that are not applicable to the aims of this paper including conflict affected settings, complex emergencies, RASM in developing countries and in countries with internally displaced persons and asylum seekers held in detention in Australia or oversees.

Using these criteria, a number of search terms were identified for use search that included the following including using Boolean operators:

- RASM and health
- RASM and mental health
- RASM and post-traumatic stress
- RASM and Complex PTSD and mental illness
- RASM and healthcare
- RASM and torture and trauma
- RASM and forensic mental health and Australia
- RASM and prison and Australia
- RASM and custodial and forensic mental health services and Australia

- RASM and crime statistics and Australia
- RASM and health literacy
- RASM and social determinants of health
- RASM and criminogenics
- Trauma informed care
- Culturally responsive care

Because of the breadth of this subject, for practical reasons, the search was limited to five years and the search terms: review of literature, and meta-analysis or systematic review; were also included.

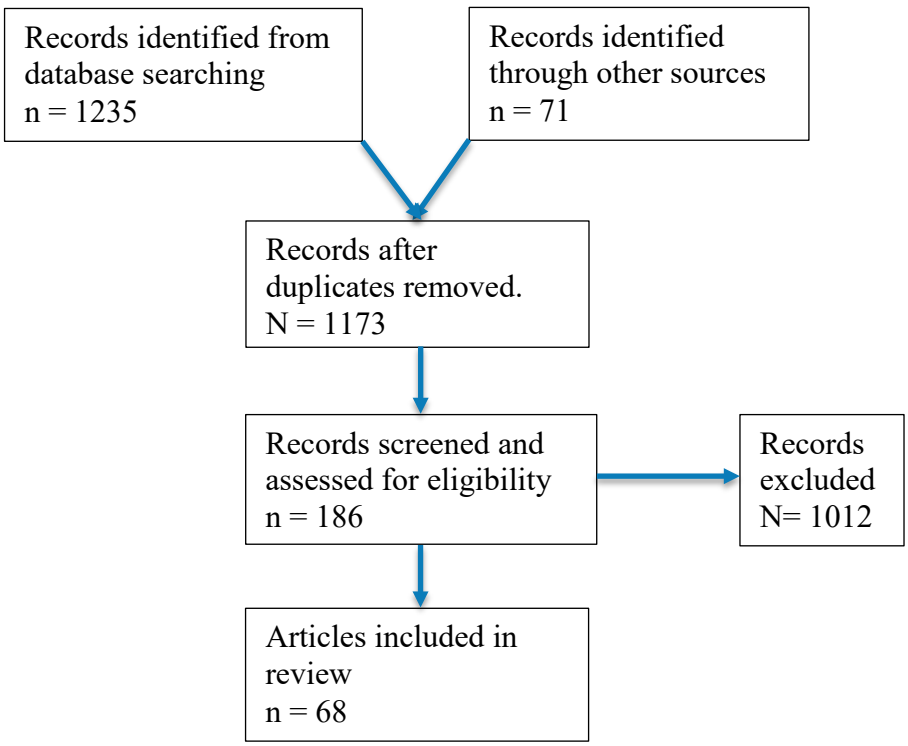
Databases searched using these terms include CINAHL, Psychology and behavioral sciences collection; ebook collection; ebook nursing collection, MEDLINE and the State Library Catalog Collection. Electronic databases were accessed via the Australian College of Nursing Library and the NSW State Library.

The results of this search revealed a number of gaps related to the aims of this review. For this reason, subsequent searches were carried out with the above terms using Google. These returned articles and documents relating to the gaps identified above and including the:

- Australian and NSW Policy and Strategic Context
- NGO organisations and services
- Refugee and migrant specific experiences and services available to them in Australia and in NSW.

Search Results

The result of the search is summarised in the chart below



It is important to note that in addition to the articles and documents reviewed and selected through the conducted search, a number of other documents and texts were also used to further inform the findings in this very specialised area of healthcare. These included:

- Two textbooks: *The Principles of Trauma Therapy: A Guide to Symptoms, Evaluation and Treatment* (Briere and Scott, 2015) and *Rebuilding Shattered Lives* from Foundation House (Kaplan, 2020).
- Several national and state and organisational documents that are relevant to refugee health and to the health of people detained in secure settings in NSW who are under the care of JHFMHN. These policies and strategies provide national and state policy and strategic frameworks that together provide context and direction for the provision of health care for refugees and migrants in secure settings in NSW. These are documented on p.15.

Key Findings from the Search Results

Key findings from a review of articles, texts and documents are summarised below:

- Trauma can occur at many points during the migration journey for RASM including prior to leaving country of origin, along the way and during and after settlement in the new country
- Torture has a specific definition and is common among refugees and asylum seekers. The prevalence of torture, however, varies across countries of origin. Refugees and asylum seekers can also experience atrocities, that do not meet the definition of torture, but which are nonetheless traumatising
- Complex trauma is recognised as causing specific and mental health symptoms that are more severe and impactful than those related to Post Traumatic Stress Disorder. These are treatable, but treatment is very specialised
- A range of physical and mental health disorders, including comorbidity are more prevalent among RASM in Australia than the general population and impact quality of life and wellbeing
- Social determinants of health are an important factor in RASM health
- Cultural responsiveness improves health care experiences and outcomes for RASM and reduces barriers
- Trauma Informed Care improves health care experiences and outcomes for RASM and reduces barriers.

(de Silva et al., 2021; Mellor et al., 2021; Janesari, 2020; Kaplan, 2020; Parajuli et al., 2020; NSW Health, 2019; Lineth, et al., 2018; Wylie et al., 2018; Nickerson et al., 2017)

Through this review process, it became clear that there were some unanswered questions and gaps in the literature related to the aims of this review. These included:

- The impact of immigration policy on refugee and migrant health
- The important role or potential role of Non-Government Organisations (NGO) in refugee and migrant healthcare
- The role of health policy in refugee and migrant health care delivery and culturally responsive care
- The human aspect in the lived experience of refugees and migrants
- The extent and impact of trauma for survivors of torture and for those who have experienced trauma through being a refugee and migrant
- Refugees and migrants experiences of health care in the custodial and forensic mental health settings
- Refugees and migrant health in the custodial and forensic mental health settings
- Mental Health and its connection to criminogenic tendencies

- A recovery framework for managing patients in secure settings who have experienced past trauma and have PTSD, CPTSD and comorbidity
- The role of culture, acculturation, and the social determinants of health in refugee and migrants' experiences broadly and in secure settings and how culturally responsive care can help
- Protective and risk factors for recovery from trauma and how this can be applied to secure settings

Data Synthesis and Analysis

The intention of this review was to explore the literature on the topic of refugees and migrants' experiences in the custodial and forensic mental health settings who have been psychologically impacted by traumatic events and torture. As described, there is a paucity of literature that directly relates to the custodial and forensic mental health contexts, and it became necessary to look broadly across the literature for information that can be applied to the NSW forensic and custodial environments. For this reason, the synthesis and analysis was conducted across both the white and grey literature taking a broad and high-level approach in order to identify that which is most relevant to the context as well as salient for and applicable to the population to which it is being applied. The results from the data synthesis and analysis are presented in the next section under the following headings:

- National and State Frameworks, Plans and Strategies
- Organisations that Support Refugees, Asylum Seekers and Migrants
- Evidence Relating to what is known about RASM Experiences, Health and Health Care Needs in Australia and NSW
- Knowledge Gaps

6 Review Findings

6.1 National and State Policy, Planning and Strategic Context

There are several national, state, and organisational documents that are relevant to refugee health and to the health of people detained in secure settings in NSW who are under the care of JHFMHN (listed below). These policies, plans and strategies provide a national and state policy and strategic framework that together provides context and direction for the provision of health care for refugees and migrants in secure settings in NSW.

Australian Government Department of Health

- National Women's Health Strategy 2020-2030

  Builds on the National Women's Health Policy 2010, to inform evidence-based actions at a national level to improve health outcomes for women and girls (Australian Government Department of Health, 2018)

- National Men's Health Strategy 2020-2030

  A "framework for action" at a national level to support men and boys to achieve the best outcomes "to live a long, fulfilling and healthy life" (Australian Government Department of Health, 2019. p. 6).

NSW Health

- Future Health, Guiding the next decade of care in NSW 2022-2032

  This framework replaces the *NSW State Health Plan: Towards 2021*. It is a strategic framework that describes a roadmap that will achieve the vision of "A sustainable health system that delivers outcomes that matter most to patients and the community, is personalised, invests in wellness and is digitally enabled" (NSW Ministry of Health, 2022, p. 10).

- 20-Year Health Infrastructure Strategy

  To inform and develop health infrastructure across NSW Health over the next 20 years, with a focus on facilities, services, workers, and consumers (NSW Health, 2020)

- NSW Plan for Healthy Culturally and Linguistically Diverse Communities: 2019-2023

  This is the "strategic statewide policy for meeting the health needs of culturally and linguistically diverse consumers for the next five years" and is to be used to develop local plans for each Health District (NSW Ministry of Health, 2019, p.1).

- NSW Women's Health Framework 2019

  "Framework applies across the NSW Health system and across the intersections with the broader health and wellbeing system including private sector organisations, not-for-profit organisations, and other government agencies. It recognises and provides an overarching perspective and principles to combine and apply the wide range of frameworks, strategies, policies, and plans that seek to improve or affect the health and wellbeing of women and girls." (NSW Ministry of Health, 2019, p. 2)

- NSW Men's Health Framework 2018

  "The Framework will act as a reference document and also guide the continuing actions of Ministry branches, local health districts, and other health agencies when considering the key health and wellbeing needs of boys and men." These organisations can use the Framework for planning, delivery, and evaluation of relevant activities. (NSW Ministry of Health, 2018, p. 4).

- NSW Health Literacy Framework A Guide to Action

  This framework provides guidance for action across NSW Health, with stated priorities "to create sustainable system level change and improve safety and quality of care." (Clinical Excellence Commission, 2019).

- NSW Health Refugee Health Plan 2011-2016

  This is a policy directive and "the state-wide plan for improving the health and wellbeing of refugees and people with refugee-like experiences who have settled in New South Wales. This Plan seeks to ensure the delivery of safe, high-quality services to refugees through both refugee-specific health services and through accessible, culturally and linguistically competent mainstream health services." (NSW Health, 2011).

Department of Communities and Justice

- Corrective Services NSW Inmate Census 2019

  This census provides data on all inmates in NSW for 30th June 2019 (Corrective Services NSW, 2019).

- Department of Justice Multicultural Plan 2015-2018

  This plan describes CSNSW "commitment to consultation and information sharing with multicultural communities. It includes strategies to improve our service delivery to multicultural communities and support our culturally, linguistically and religiously diverse workforce." (NSW Department of Justice, 2015, p.3)

Justice Health and Forensic Mental Health Network

- Strategic Plan 2018-2022

  The purpose of this plan is to provide a strategic framework that ensures "the continued delivery of quality, safe, patient-centred healthcare. Research evidence and patient experiences of care inform the delivery of best practice healthcare and support services for people in contact with the NSW forensic mental health and criminal justice systems." (JHFMHN, 2018a, p.1). The plan also emphasises the importance of working and collaborating with other organisations including NSW Ministry of Health and pillar organisations, Corrective Services NSW, local health districts and specialty health networks, Aboriginal Community Controlled Health Organisations, Department of Justice, universities, non-government organisations, community groups and advocacy groups" (p.3).

- JHFMHN NSW Healthy Prisons: Framework for Action 2019-2022

  This framework describes a pathway towards healthy and health promoting prisons which is underpinned by three guiding principles:

- The importance of policies, partnerships and programs between lead agencies that promote health and wellbeing
- Environments that actively support and improve health
- Targeted and relevant health promotion and health literacy interventions that are specific to the needs of patients in secure settings.

(JHFMHN, 2019)

6.2 Organisations that Support Migrants, Asylum Seekers, and Refugees

There are a many government and non-government organisations that provide a range of information and services to refugees and migrants. Many of these also provide education, information, guidelines, and referral information to non-specialist health services.

The following is not an exhaustive list of all services available, rather key organisations that are either relevant to or have links with health care for migrants and refugees are included.

6.2.1 Global Organisations that Support Migrants, and Refugees

World Health Organisation

The WHO has developed some useful documents related to the healthcare of migrants and refugees which have informed the research section of this paper.

- Refugee and Migrant Health: Global Standards for Health Workers
  This document "highlights the competencies and behaviours of the health workforce in providing quality care to refugee and migrant populations. Achieving universal health coverage for refugee and migrant populations requires strong health systems with competent health workers who are trained, supported and empowered to provide the care needed." (WHO, 2021, p.1)
- Health Literacy the Solid Facts
  There are many resources that discuss the importance of health literacy and its impact on health and wellbeing with varying definitions. This one, although nearly 10 years old, has a global view and as a result specifically mentions the impact of low health literacy on migrants and how this limits access to health services and health outcomes. For this reason, it is a relevant document for this review (WHO, 2013).

6.2.2 Australian Government and Non-Government Organisations that have a Broad Focus on RASM Welfare

There are many community and non-government organisations (NGO) that provide information, resources, support, advice and health care to migrants, asylum seekers and refugees. Some of these organisations also inform and influence government policy and provide education and information to their clients and to the broader community. They are listed here to provide context in terms of both the breadth and depth of what is available for people.

Australia

Australian Government

The Australian Government Immigration Assessment Authority provides a list of support services for migrants and asylum seekers in each state and territory around mental and general health and welfare. For NSW there are 19 organisations listed including the Translating and Interpreting Service (TIS). Six of these are government organisations including the Department of Human Services, Refugee Health Services, Transcultural Mental Health Services and Emergency Services (2019).
https://www.iaa.gov.au

Federation of Ethnic Communities Councils of Australia (FECCA)
FECCA is the peak, national body representing Australians from culturally and linguistically diverse backgrounds. FECCA's role is to advocate and promote issues on behalf of its constituency to government, business and the broader community.
https://fecca.org.au

Refugee Council of Australia (RCOA)
The RCOA is the national umbrella body for asylum seekers, refugees and people and organisations that support them. It does not have a health focus but does provide links to health services. It has over 200 organisational and 300 individual members.
https://www.refugeecouncil.org.au

NSW
The RCOA has an extensive list of 123 government and non-government organisations that provide services to refugees in NSW (too many to list here). The focus of services available include:

- Health
- Welfare
- Legal (visa and non-visa related)
- Housing
- Learning English
- Getting work
- Education and Training
- Families
- Young people

https://www.refugeecouncil.org.au

6.2.3 Australian Government and Non-Government Organisations that have a Focus on Migrant, Asylum Seeker and Refugee Health

Australia

Migration Council Australia (MCA)
MCA auspices the Migrant and Refugee Health Partnership that brings together the health care providers and the community to address systemic barriers to health access for migrant and refugee communities. The partnership provides a strong focus both on the health system capability to work effectively with migrants and refugees, and on strengthening health-promoting assets in migrant and refugee communities with a view to improving community health and wellbeing.
https://www.migrationcouncil.org.au

Refugee Health Network of Australia (RHeaNA)
The Refugee Health Network of Australia (RHeaNA) is a network of health and community professionals who share an interest and/or expertise in refugee health. The Network draws members from every Australian State and Territory.
https://www.refugeecouncil.org.au

The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT)
A network of Australia's eight specialist rehabilitation agencies that work with survivors of torture and trauma who have come to Australia from overseas.

1. Association for Services to Torture and Trauma Survivors (ASeTTS) (WA)
2. Companion House: Assisting Survivors of Torture and Trauma (ACT)
3. Foundation House: The Victorian Foundation for Survivors of Torture
4. Melaleuca Australia: Torture and Trauma Survivors Service of the Northern Territory
5. Phoenix Centre Support for Survivors of Torture and Trauma (Tasmania)

6. Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)
7. Service for the Treatment & Rehabilitation of Torture & Trauma Survivors (STARTTS) (NSW)
8. Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS) (SA)

https://www.fasstt.org.au

Australian Refugee Health Practice Guide

This is an online practical health practice handbook that has been developed and is maintained by NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS). It contains comprehensive information about refugee health assessment from a person centred and trauma informed perspective. It contains information on history taking, physical examination, management planning and referral (Australian Refugee Health Practice Guide, n.d.).

https://refugeehealthguide.org.au

NSW

NSW Health Multicultural and Refugee Health Services

This is an NSW Health specialist multicultural and refugee health service that provides:

> "Specialist state-wide multicultural and refugee health services (that) develop and implement initiatives across NSW to increase the capacity of the health system and provide targeted services. Depending on the service, they provide training for health staff, policy advice, as well as assessment and treatment for consumers from culturally and linguistically diverse backgrounds. Services are hosted by local health districts." These services include:

- Multicultural HIV and Hepatitis Services
- Multicultural Problem Gambling Services for NSW
- Health Care Interpreter services at 5 local health districts in over 120 languages
- NSW Education program on Female Genital Mutilation
- NSW Education Centre Against Violence
- NSW Refugee Health Service
- Transcultural Mental Health Centre

https://www.health.nsw.gov.au/multicultural/Pages/multicultural-statewide-services.aspx

(NSW Health, n.d., para.1)

Refugee Council of Australia (RCOA)

The RCOA provides direct links to refugee health, casework, legal and advocacy services in NSW as mentioned above

***Service for the Treatment & Rehabilitation of Torture & Trauma Survivors (*STARTTS)**

STARTTS provides a range of services including psychological support, treatment and support for individuals, communities and services, as well as engaging in training, advocacy and policy work. The mission of STARTTS is:

> "To develop and implement ways to facilitate the healing process of survivors of torture and refugee trauma in order to assist them to regain their ability to live fulfilling lives, and to support and resource organisations who work with them to provide appropriate, effective and culturally sensitive services, while actively supporting the global effort to prevent and eradicate torture." (n.d., para.3).

http://www.startts.org/

6.3 Evidence Relating to what is known about RASM Health and Health Care Needs in Australia and NSW

6.3.1 Experiences and Impacts of Migration for Refugees, Asylum Seekers, and Migrants

The Migration Journey to Australian for Refugees, Asylum Seekers and Migrants

Many RASM have experienced inhumane treatment along their journey to settlement in Australia including persecution, violence, torture and other human rights violations. They may have witnessed violence and been involved in conflict in their country of origin and along the way, experienced displacement, poverty, or famine. They may have been held in detention as AS along their journey or upon arrival. After settlement into the host community, issues refugees and migrants may face include racism, discrimination, language and cultural differences, difficulties finding accommodation, having qualifications recognised and gaining employment These experiences can occur over a long period of time and negatively impact both the physical and mental health of refugees and migrants, which in turn can affect things like, social relationships, employment and trust for individuals and even whole communities. This affects social connections, social determinants of health and individual and collective identities. (Kaplan, 2020; NSW Health, 2019; URBIS, 2019; Matlin, et.al., 2018; RANZCP, 2017; FASSTT, 2011; NSW Health 2011).

Refugees, Asylum Seekers and Migrants Experiences of Torture and Trauma

Torture

Torture, as defined in 1984 by the United Nations *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment* is a human rights violation that

> "means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him (sic) or a third person information or a confession, punishing him (sic) for an act he (sic) or a third person has committed or is suspected of having committed, or intimidating or coercing him (sic) or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions" (cited by the Australian Human Rights Commission, (n.d., para.1).

In terms of torture prevalence, much of the literature is related to the impact of torture and doesn't focus on prevalence. Among the literature that does look at prevalence, there are a range of findings. One review article that looked at more than 3400 research papers summarised this well, finding a wide range of torture prevalence among refugees of between one and seventy six percent with a median of 27%. Across the papers reviewed there were many differences in country of origin and length of time settled in the country (Kaplan, 2020; Abu et al., 2019; Sigvardsdotter et al., 2016). Kaplan (2020), states that torture is widely practiced across 75% of the world in 140 countries and anyone can be a victim. Perpetrators too can come from a range of backgrounds. They can be police or the military, people in health and legal professions and even other prisoners under duress.

It is important to note here, that RASM can experience other things which also result in mental or physical pain and suffering, but do not fit the definition of torture. These include being persecuted, psychologically or physically constrained, experiencing hunger or thirst, being smuggled or trafficked, experiencing conflict and witnessing the death of loved ones (de Silva et al., 2021; Kaplan, 2020; Wylie et al., 2018).

Trauma

There is inconsistency in how both trauma and PTSD are discussed and defined within the literature and there is some controversy across the counselling and therapy related literature about the trauma definition in the Diagnostic and Statistical Manual of Mental Disorders version 5 (DSM-5) (Pai et al., 2017; Briere and Scott, 2015). There are concerns that the definition has become too limited, leaving out events that can cause trauma, complex trauma and subsequently PTSD and complex PTSD (CPTSD) (Kaplan, 2020; Pai et al., 2017; Briere and Scott, 2015). For these reasons a range of definitions are included below to capture the breadth of current thinking in this area.

The DSM-5 defines trauma as:

> "Actual or threatened death, serious injury, or sexual violence" (cited in Pai et al., 2017).

Kaplan (2020) in the context of working with refugees describes traumatic events as those which:

> "Pose a serious and major threat to a person's life or self. This includes exposure to actual or threatened death, a serious injury, losses in violent circumstances and/or witnessing such events. Traumatic events include war, torture, rape, violent assault and serious accidents. The demarcation between traumatic events and other adversities is not clear cut…" (Kaplan, 2020, p.4).

A broader definition is Briere and Scott's view

> "That an event is traumatic if it is extremely upsetting, at least temporarily overwhelms the individuals' internal resources, and produces lasting psychological symptoms" (2015, p.9)

And the Blue Knot Foundation (n.d. para.1), Australia's *National Centre of Excellence for Complex Trauma* state that:

> "Trauma is a state of high arousal. It is an event or events in which a person is threatened or feels threatened. The experience of trauma overwhelms the person's capacity to cope. Trauma also describes the impacts of the event or events."

and

> "Different people experience different traumas differently. Certain experiences are traumatic for some people and not for others. The impacts of trauma depend on your age/s, your previous experience/s of trauma, how long the trauma lasts, how often it happens and how extreme it is. They also depend on your culture, background and the social context of your life." (para.3)

Trauma experiences and responses manifest across the continuum of trauma, childhood trauma and complex trauma (Kaplan, 2020; Kezelman and Stavropulos, 2019). Because of the experiences refugees and asylum seekers can face through their journeys towards settlement in a country, many are survivors of torture, trauma, and complex trauma (Kaplan, 2020).

It is important to note, that non-refugee migrants are also at risk of experiencing trauma and mental health issues as a direct result of moving to and settling in a new country (NSW Health, 2019; Lineth et al., 2018). Factors such as whether migration was voluntary or forced, the stress of moving to and settling somewhere that is culturally very different with a different language, experiencing racism and discrimination and difficulties with finding accommodation and employment all contribute to this risk (Jobst et al., 2020; NSW Health, 2019; Lineth et al., 2018). Trauma that has occurred because of, or following migration, however, has not been well studied in comparison to that which occurs as a result of being an asylum seeker or refugee (Sigvardsdotter, et al., 2016).

Complex Trauma
Complex trauma is well described by de Silva, (2021, p. 1) as:

> "Characteristically interpersonal in nature (i.e., perpetrated deliberately by other people) and involves repeated, prolonged and often multiple traumatic exposures between victim and perpetrator(s). The victim has typically been held in conditions from which they are unable to escape, because of physical, maturational, social family/environmental or psychological constraints."

Complex trauma is recognised as causing specific and mental health symptoms that are more severe and impactful than those related to PTSD. Literature identifies three disorders that can occur after complex trauma. These are complex PTSD, Enduring Personality Change after Catastrophic Events (EPCACE) and Disorder of Extreme Stress Not Otherwise Specified (DESNOS). Symptoms overlap and all are associated with more severe psychological impairment and comorbidities than PTSD and require a different and specialised approach to treatment (de Silva, et al., 2021; Mellor, et al., 2021; Kaplan, 2020). CPTSD, EPCACE and DESNOS can occur in various populations who have experienced complex trauma including asylum seekers and refugees, survivors of institutional abuse and survivors of childhood physical or sexual abuse (de Silva et.al, 2021).

Impact of Torture and Trauma on Survivors

There is an abundance of literature that describes the prevalence and broad health impacts of torture and trauma among survivors. In the main, findings across the literature are consistent and agree that a history of trauma and in particular torture is a significant factor in the development of mental ill health (Blackmore et. al., 2020; NSW Health, 2019; URBIS, 2019; RANZCP, 2017; Sigvardsdotter et. al., 2016; NSW Health, 2011). The resource that best describes the impact of torture and trauma among survivors as it affects symptoms and behaviours is from the organisation *Victorian Foundation for Survivors of Torture* (https://foundationhouse.org.au/). This resource, is a text book, *Rebuilding Shattered Lives* (Kaplan, 2020) and approaches the impact of torture and trauma in refugee survivors in the context of a recovery model. It presents both the impact of trauma and survivors' reactions to it and separates the social and psychological impact of trauma from a person's reaction to trauma.

Impacts and reactions include:

1. Ongoing fear, helplessness, and loss of agency over aspects of life, which creates worry and anxiety, avoiding behaviours and intense feelings around perceived threats.
2. Separation from connections with people including family and friends, community. This can lead to feelings of depression and grief and can impact attachments to loved ones and others.
3. Disruption to beliefs about self, other people, and the world, which can lead to existential questioning and a focus on injustice
4. Degradation and humiliation which causes guilt and shame.

(Kaplan, 2020)

Recovery from Trauma

Recovery from the impact of and reactions to trauma and complex trauma is possible with treatment by specialist mental health services, especially when survivors are assisted to strengthen protective factors such as social skills, self-efficacy, family connection and information, education and a welcoming community. Responsive trauma informed health systems and other services are also important (Kaplan, 2020).

The risk factors linked to a delay in recovery include poor health and barriers to health care access, stress around family, employment, and money and a lack of familiarity with the new culture and systems. Limited social support, racism and discrimination can also contribute, as can health and other services that are not trauma informed (Kaplan, 2020; Victorian Foundation for Survivors of Torture, 2016).

6.3.2 Health Issues that Impact Migrants and Refugees

The risks to health that impact migrants and refugees can occur across any stage of migration including prior to departure from their country of origin, because of events along their journey, upon arrival and after settlement in their destination. Migrants and especially refugees can arrive in the host country with both physical and mental health issues. Similarly, health issues can emerge and progress at different times (Kaplan, 2020; Abu, 2019; Matlin et al., 2018). Common health issues that impact migrants and refugees include:

Physical Health

- Physical health issues that are the result of torture, persecution, or conflict
- Communicable diseases, tropical and vaccine preventable diseases
- Under immunisation
- Chronic disease either poorly managed or undetected
- Poor dental health
- Disability

(Penney, 2020; URBIS, 2019; NSW Health, 2019; Lineth et al., 2018; NSW Health, 2011)

Mental Health

The literature shows that both refugees and non-refugee migrants experience mental and physical health challenges and mental ill health because of migration and settlement, but the prevalence of mental health issues for non-refugee migrants is difficult to discern because it is “underexplored” in the literature (Lineth, et al., 2018, p.223). Examples of this are the NSW Plan for Healthy Culturally and Linguistically Diverse Communities 2019-2023 (2019), which states there is some evidence to support mental health impacts, but no data is available. What is clear however, is that both refugees and migrants are at risk of experiencing mental health issues and that their health and recovery can be adversely affected by poor access to health care and health care that is not culturally responsive (Kaplan, 2020; Titze, 2021;NSW Health, 2019).

Mental health issues and illnesses that commonly impact migrants and refugees include depression, PTSD, CPTSD, Prolonged Grief Disorder (PGD) and anxiety. Interestingly a meta-analysis of the prevalence of other mental illness in refugees and asylum seekers globally found the prevalence of anxiety disorders and psychosis comparable to findings from general populations at 11% and 1.5% respectively (Blackmore, et al., 2020). The mental health issues commonly described in the literature are detailed below. (Blackmore, et al., 2020; Penney, 2020; URBIS, 2019; NSW Health, 2019; Lineth et al., 2018; Turrini et. al., 2017; NSW Health, 2011).

Depression and Anxiety

Anxiety disorders can manifest as excessive worry or fear and impact behaviours. Depression is defined by a low mood and can result in a loss of interest and pleasure in activities that used to be enjoyed. It is possible for a person to experience both at the same time (Uphoff et al., 2020). The literature, although inconsistent around definition, prevalence, and causation, is consistent in the assertion that depression and anxiety are likely to be prevalent among and problematic for RASM (WHO, 2021; Uphoff, 2020; Suhaiban, 2019; NSW Health, 2019; URBIS, 2019; Lineth, 2018; NSW Health, 2016).

Post-Traumatic Stress Disorder (PTSD)
PTSD is a complex mental health disorder that can develop after a traumatic event or a series of events. PTSD is characterised by several symptoms that include reexperiencing events, avoiding things like people, places or emotions, insomnia, negative thoughts, and hyperarousal (Uphoff et al., 2020). The data related to PTSD and depression from a review article that examined around 12,500 articles, revealed heterogeneity between the studies finding a PTSD prevalence of 31% and a prevalence of 31.5% for depression among refugees compared to the general population prevalence of 3.0% and 12% respectively (Blackmore et. al., 2020; Bustamante, 2017). Lineth et al. (2018) identified a PTSD prevalence rate of 47% among migrants generally, which may indicate that non refugee migrants are also likely to experience PTSD. There is little information however about of non-refugee migrants' prevalence of PTSD specifically.

Complex PTSD
There are different types of trauma and people have trauma responses along a spectrum with variations in both symptomology and severity. As discussed above, the terms in the literature that describe some of these severe symptoms are EPCACE, DESNOS and CPTSD. Recent literature however (in the last 5 years), tends to favour the term CPTSD, with the other two terms rarely seen. Neither the literature, or the two recognised diagnostic tools the DSM-5 and the International Classification of Diseases-11 (ICD-11) however, agree on the classification of, or terminology between PTSD and CPTSD (Kaplan, 2020; Ford, 2019). Recent literature shows that complex and repeated trauma and trauma that occurred at a young age can be characterised by symptoms that are more severe and varied that PTSD. These can include personality change, change in beliefs, withdrawal from society and relationships, mistrust, somatisation, disassociation, and feelings of hopelessness (de Silva et al., 2021; Kaplan, 2020; Ford, 2019; Liddell et al., 2019). Some of these presentations are similar to borderline personality disorder (BPD), (Ford, 2019).

In recent years, CPTSD has been included in the ICD-11 and despite its lack of inclusion in the DSM-5, it has a growing evidence base in relation to trauma that both occurred in childhood and cumulative trauma that has occurred in adulthood, such as that experienced by refugees (Ford, 2019). While there is a paucity of prevalence studies looking at CPTSD among RASM, one systematic review of fifteen studies identified a CPTSD prevalence of 16% to 38% among refugees and asylum seekers (de Silva et al., 2021). Little is known about CPTSD among non-refugee migrants.

Comorbidity with CPTSD and other common mental health disorders such as depression is also prevalent in people who have experienced trauma and complex trauma (Coventry et al., 2020). One study in the UK looking at PTSD and CPTSD among male prisoners identified additional comorbidities of psychosis, anxiety, substance misuse and attention deficit hyperactivity disorder (ADHD). Also, the broadly diagnosis and management of CPTSD may be complicated by a similarity to BPD symptoms (Facer-Irwin, 2021; Ford, 2019; Nickerson, et al., 2017).

Prolonged Grief
The presence of bereavement among RASM is high with 38.1 percent of people reporting in one Australian longitudinal refugee cohort study, that someone close to them had died (Bryant et al., 2020). Of these 15.8% (6% of the entire cohort) reported symptoms of probable prolonged grief disorder (PGD). In the general population, the level of PGD is under 4%. The impact of PGD on mental health and wellbeing is significant with comorbidities reported being associated with PTSD, anxiety, and depression. It also affects employment and the ability to trust other people (Bryan et. Al., 2020). Again, little is known about non-refugee migrants experiences of PGD.

6.3.3 Social, Cultural and Environmental Determinants of Health for Migrants and Refugees

Once refugees and migrants are settled in a host country, a range of external factors can negatively impact their physical and mental health and wellbeing. These include:

- The stress of migration including finding work, accommodation and learning a new language
- Poverty and poor nutrition
- Legal issues related to migration
- Loss of family, social networks, and other familiar support
- Social exclusion
- Isolation
- Racism and discrimination
- Barriers to accessing health care
- Health care that is not trauma informed
- Acculturation (see next section)

(WHO, 2021; NSW Health, 2019; Matlin et.al., 2018)

6.3.4 Culture, Refugees, Migrants and Health Care

First, it is important to note that in Australia, migrants come from a range of cultural backgrounds as do health care staff, which means that cross cultural care encounters are likely to be common and possibly complex (Kaplan, 2020). Secondly it is important to discuss culture from a common understanding about what it is and what it means. This is difficult because there are a range of definitions. Given that this paper is exploring the experiences of refugees and migrants from a range of perspectives and with a focus on torture and trauma, the context for discussing culture here has been taken from Kaplans book *Rebuilding Shattered Lives, Integrated Trauma Recovery for people from refugee backgrounds* (2020). Culture in this context, encompasses empathy and understanding of the "human experience" including values, beliefs, meanings, behaviours, goals activities and settings and includes both the individual and the community (p.118).

6.3.5 NSW Health Principles for Health Care Delivery to Culturally and Linguistically Diverse Communities

The following are the principles that underpin the NSW Plan for Healthy Culturally and Linguistically Diverse Communities: 2019-2023 (2019). These provide an overarching policy framework through which findings in the literature about culture and cultural responsiveness in health care delivery can be applied.

Principles

- People from culturally and linguistically diverse backgrounds will have access to quality health services that recognise and respect their linguistic and cultural needs.
- People from culturally and linguistically diverse backgrounds will have access to appropriate health information.
- Health policies, programs and services will be responsive to the health needs of people from culturally and linguistically diverse backgrounds.
- People from culturally and linguistically diverse backgrounds will be included in decisions about health services that affect them.
- Multicultural health programs and services will be evidence-based and/or support best practice in the provision of health services in a culturally and linguistically diverse society.

(NSW Health, 2019, p.4)

6.3.6 Culture and Effective and Responsive Health Care Delivery

Acculturation and Health

Acculturation, described by Berry in 1990 (Sam and Berry, 2010), is a strategy that migrants adopt over time as they begin to live in the new culture. Berry states that there are four potential acculturation outcomes that migrants experience:

- Assimilation: compete adaption to the new culture and loss of original values
- Integration: a combination of both adopting the norms of the new culture and keeping those of the culture of origin
- Separation: maintenance of all aspects of the culture of origin and separation from the new culture
- Marginalisation: isolation from both the new culture and culture of origin.

Outcomes are dependent upon a range of factors including a welcoming or discriminatory experience in the host community (Sam and Berry, 2010). In terms of physical and mental health and psychological well-being, some studies show that integration has the best outcome for people. However, there are inconsistencies on the literature (George et al., 2021).

The concept of acculturation is relevant to the NSW Health principles above in relation to evidence and responsiveness because it is likely to be an important factor in refugees and migrants' health care experiences, including in custodial and forensic settings. This is because health settings are themselves communities with norms, values and expected behaviours and as such acculturation is likely to happen here too (George et. al., 2021 Titze et al.2021; Sam and Berry, 2010).

Cultural Safety

Cultural safety is a concept that, in Australia is commonly discussed in the context of providing care for Aboriginal and Torres Strait Islander peoples. It has a focus on inequities in determinants of health and the systemic bias and barriers to care inherent in the health system that affect people who have a different world view and communication requirements to the prevailing culture (Curtis, 2019). In terms of responding to this, Cutis et al. (2019, p.1), in line with the NSW Health multicultural principles above, states that health services:

> "…must be prepared to critique the 'taken for granted' power structures and be prepared to challenge their own culture and cultural systems rather than prioritise becoming 'competent' in the cultures of others."

Cultural Competence in Health Care

A commonly cited definition of cultural competence is by Cross et al. (1989 p.13).

> …a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations. The word "culture" is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group.

The consensus in the literature is that cultural competence is the key to providing "culturally sensitive and effective care" to refugees and migrants (WHO, 2021, p. 2). To develop competence, it is necessary for health workers to understand standards of competency in this area and undergo ongoing training that includes the development and attitudes skills and knowledge and their application to practice (WHO, 2021; Jongen, et al., 2018). The concept of cultural competence is relevant to the NSW Health multicultural principles and to the context of culture in this paper (2019).

Culturally Competent Models of Care

There are several models of care that can be useful for health services to draw on during the development of a culturally competent workforce. One is example is Purnell's Model of Competence. This model takes a whole of life approach identifies 12 aspects of life and health including things like health care, workforce death rituals and pregnancy in the context of the person, their family, and the community. This model describes developing and maintaining cultural competence as a continuous and changing process of adapting, learning, and applying learnings to the context of the patient. Such models could be adapted to operationalise the development of cultural competence education and its application to health service delivery with refugees and migrants to best meet their needs in specific contexts (Ulutasdemir, 2021; Sindayigaya, 2016).

A Transcultural Approach to Health Care

A transcultural approach is the provision if care that incorporates knowledge and understanding of differences between cultures in the way members hold and express their values and beliefs and how these impact their view of health, illness, and care. Transcultural care requires health workers to apply their knowledge of cultural differences in the context of respectful and sensitive care giving, when working with people from different cultures and ethnicities and can lead to more effective and culturally appropriate care (Ulutasdemir, 2021; Wylie et al., 2018).

Cultural Responsiveness in Health Care

To enact the NSW Health multicultural health principles (2019), health staff are required to be culturally responsive and competent. Being responsive means being self-aware enough to notice differences in all aspects of culture and explore what these mean to people (Kaplan, 2020). The following definition of Cultural responsiveness in relation to health care delivery has been taken from the Agency for Clinical Innovation Enablement Guide (n.d., para. 4).

> "Cultural responsiveness is a new way of thinking about culture. It means being open to new ideas that may conflict with the ideas, beliefs and values of your own culture, and being able to see these differences as equal. For example, in many cultures spiritual beliefs are an important part of overall wellbeing.
>
> It means being respectful of everyone's backgrounds, beliefs, values, customs, knowledge, lifestyle and social behaviours. It helps you provide culturally appropriate care and support, so people are empowered to manage their own health.
>
> Cultural responsiveness is important for all social and cultural groups, including:
>
> - Aboriginal and Torres Strait Islander peoples
> - people from culturally and linguistically diverse backgrounds
> - refugees or displaced migrants
> - people at all life stages, including end of life
> - people with different abilities, including intellectual and cognitive disabilities
> - LGBTIQ (sic) people
> - people from priority populations and sub-cultures, such as the deaf and vision-impaired community.
>
> Cultural responsiveness involves continuous learning, self-exploration and reflection. It draws on a number of concepts, including cultural awareness, cultural sensitivity, cultural safety and cultural competence."

In relation to the provision of culturally responsive care for both refugees and migrants there are factors that need to be considered across health care environments and there are factors that are specific to secure settings (Titze, 2021; Kaplan, 2020).

6.3.6 Trauma Informed Care

Research shows that people from different cultures can experience, respond to, and be impacted by trauma differently (Kaplan, 2020; Wylie et al., 2018). To provide effective care to people who have experienced trauma in the context of the NSW Health multicultural principles (2019), it is necessary for health workers to be informed about the impact of trauma as it applies to cultural differences and how and respond to trauma reactions accordingly (Kaplan 2020; Wylie et al., 2018). To do this, care must be both trauma informed and culturally responsive.
There are many definitions of TIC and for the purpose of this paper, due to its connection with torture and trauma, a definition from the NSW Health Agency for Clinical Innovation in the context of Mental Health has been chosen (2019, p.1).

> "Trauma-informed care is an approach to service delivery based on an understanding of the ways trauma affects people's lives, their service needs and service usage. It incorporates principles of safety, choice, collaboration, trust and empowerment".

Similarly, to cultural competence, to develop competence in TIC when working with both refugees and CALD migrants, training is required (Im and Swan, 2020).

6.3.7 Refugees, Migrants and the Custodial Health and Forensic Mental Health Context

Refugees and Migrants in the Custodial Context

As mentioned previously in this paper, 20% of prisoners in Australia were born overseas (ABS, 2021). This data is replicated in JHFMHN through a CALD mapping exercise showing that 18% of patients identified as CALD (JHFMHN, 2019a). It is known that more than two thirds of people in custody in NSW self-report having experienced trauma and reported experiencing mental health issues (JHFMHN, 2017). This finding is repeated across several studies that report higher rates of mental illness, including PTSD among prisoners than the general community. These prisoners, like refugees and migrants may present with a range of behavioral reactions to trauma (Kaplan, 2020). In addition, they may have difficulty engaging with society upon release and may be more likely to reoffend (Rose, 2019). There is, however, a paucity of literature that addresses RASM in secure settings, outside of the immigration detention context. Of the articles sourced, migrants were the focus, with no mention of asylum seekers or refugees (Rose et al., 2019; Watt et al., 2018). It is known, that nearly one in five people who enter custody in NSW are CALD (JHFMHN, 2019). It is possible that some of these have a refugee background.

Refugees and Migrants in the Forensic Mental Health Context

In Germany and Canada, it is known is that migrants are overrepresented in forensic mental health facilities compared to the general population. Little is known however about the relationship between migration, mental illness and admission to a forensic facility (Titze et a., 2021; Penney et al., 2020). Across Australia there is little published in the white or grey literature about the numbers of refugees and migrants in the forensic mental health setting. There is also a paucity of data relating to the experiences of refugees and migrants in these settings. The JHFMHN *2016 Forensic Mental Health Patient Report*. (2018) does however provide some information. In relation to representation of refugees and migrants, nearly a third of respondents report speaking a language other than English as their primary language.

This report also contains self-reported patient data on mental illness diagnosis and history of trauma. In relation to self-reported mental health issues, although this data is not linked to ethnicity, it is interesting to note that there is a high prevalence of both trauma and the mental health issues that commonly impact refugees and migrants. Seventy-two-point five percent of respondents self-reported experiencing trauma, with 43.7% reporting anxiety and 63.4%

depression. Seventy-two point five self-reported a history of trauma. Of these, 2.9% of self-reported traumas were torture or terrorist related, 15.9% related to being threatened or kidnapped, and 21.7% were because of feeling physically or psychologically unsafe. Also of note is that 26.1% of respondents have experienced three or more traumatic events and 14.5% have experienced two (JHFMHN, 2018).

Mental Health and Criminogenic Tendencies

The potential link between mental illness and criminogenic behaviour, given the overrepresentation of mental illness among people in secure setting seems likely. There are few studies available that have investigated this subject and a causal link has not been well researched. For example, one study showed that the risk varies according to conditions and symptoms and another stated that the relationship is poorly understood (Van Deinse et al., 2021; Morgan et al., 2019). Other studies found an indirect link between mental health and criminogenic behaviours and treatment needs, but related to social and economic factors as well as health behaviours such as substance use, rather than a direct causal link (Bonfine et al., 2019 Skeem, et al., 2013). It is clear therefore, that while this area of criminology intersects with heath care, the development of health models that prevent incarceration or reincarceration for people who have mental illness is in its infancy.

Health Care in the NSW Custodial and Forensic Mental Health Environments

Custodial Settings
The Justice Health and Forensic Mental Health Network (the Network) in NSW is a NSW Health funded Statutory Health Corporation established under the Health Services Act (New South Wales) 1997. The services provided by the Network in each custodial facility, are well described in the Patients' Experiences and Perceptions Study (2019, p. 13):

> "Healthcare services for patients in correctional centres is provided by the Network as they no longer have access to the community Medicare system. Healthcare services provided by the Network include mental health, drug and alcohol, including addictions medicine, dental care, midwifery, optometry, allied health services, pharmacy services, radiology, orthopaedics, ophthalmology, dialysis, podiatry and population health services including hepatology, sexual health and harm minimisation services."

Forensic Mental Health
These services are described in the Network Strategic Plan (JHFMHN, 2018a, p.15):

> "The Network is the principal service provider and coordinating agency for forensic mental health services in NSW. The partnership and collaboration of services in the statewide Forensic Mental Health Network (FMHN) aims to improve patient flow through the forensic system while providing high quality assessment, care, treatment, and other services to people with mental illness who are, or have been, in contact with the criminal justice system."

The services include four inpatient units with a total of 209 beds, the biggest of which is the Forensic Hospital at Malabar with 135 beds. Services are also provided in community settings.

6.3.7 Refugee and Migrants Experiences of Health Care in Australia

Refugee and Migrants Experiences of Health Care in the Community

How refugees and migrants experience health care has been well studied and a range of issues have been identified that are common across health contexts. These identified issues create barriers to health seeking behaviours, health information sharing and understanding diagnosis and treatment for these groups. They include:

- The health system can be an unfamiliar environment and lack of knowledge about how it works, and previous negative experiences can affect if, how and when people access services.
- Concerns related to privacy, trust, fear, and disempowerment
- Services can be poorly available, inaccessible, and difficult to engage with
- Lack of diversity among health care workers
- Language and health literacy can be significant barriers to access, understanding, information sharing and compliance:
  - Translated health information can be inappropriate or poorly translated
  - Interpreters do not always understand the context or health information
- Poor information sharing resulting in loss of autonomy over health care and subsequent disempowerment
- There are different perceptions, expressions and expectations around mental health, mental illness, and trauma between cultures and this is not well understood by health staff
- A history of trauma, social isolation and few support networks can also negatively impact access for refugees and migrants, if the service is not trauma informed.

(Gaya-Sancho, et. al., 2021; Parajuli and Horey, 2020; NSW Health, 2019; Au et. al., 2019, Wylie et. al., 2018)

Refugee and Migrants Experiences of Health Care in Secure Settings

The is a paucity of data about refugees and migrants' experiences of health care in secure settings that are not immigration detention, both in Australia and globally. There is however one small qualitative study that has been conducted in NSW that provides some insight. This study looked at the health care experiences of CALD women in three NSW prisons, with a focus on language (Watt, et al., 2018). In relation to the issue of language as a barrier to health care access, it showed similar findings to other studies. The context however highlighted different implications.

The findings from this study identified that the use of informal interpreters in prison (friends and peers) informally impacts both information quality due to lack of training, and confidentiality. This is consistent with findings across the broader community (Au et. al., 2019; Watt et al., 2018). However, prison culture adds another layer of complexity. It can increase barriers to care due to complex hierarchical relationships among prisoners impacting upon confidentiality and willingness to speak freely. It can also conversely reduce barriers, due to relationships and pre-existing support between prisoners and an understanding of personal history and context. Being an informal peer interpreter in a prison setting can, however, have negative implications for the interpreter. This is because they can be coerced to assist which can affect how they are perceived by other prisoners (Watt et al., 2018).

6.4 Knowledge Gaps

Having reviewed the available grey and white literature, there are knowledge gaps across many aspects of migrants and refugees experiences in mainstream health and in the NSW custodial and forensic health settings. Identified gaps are evident in:

- Demographic information
- Information about non refugee and migrants' experiences in relation to trauma

- Prevalence of mental and physical health issues pertaining to traumatic migration experiences
- Health protective factors and risk factors for patients who have experienced trauma in the custodial and forensic mental health settings in relation to both TIC broadly and the treatment of trauma and complex trauma
- Health seeking behaviours and barriers
- Health literacy and barriers
- Refugee and migrants' experiences of health care in secure environments
- Prevalence of PTSD and CPTSD in forensic and custodial mental health settings
- Co morbidity of PTSD and CPTSD with other mental illnesses in forensic and custodial mental health settings
- How best to apply cultural responsiveness and TIC principles to health care delivery with refugee and migrant trauma survivors in secure custodial settings across mental health, primary care, "drug and alcohol, dental care, midwifery, optometry, allied health services, pharmacy services, radiology, orthopaedics, ophthalmology, dialysis, podiatry and population health services including hepatology, sexual health and harm minimisation services." (JHFMHN, 2019, p.13).
- How best to apply cultural responsiveness and TIC principles to health care delivery with refugee and migrant trauma survivors in Forensic Mental Health settings
- Health staff capability to respond to refugees and migrant trauma survivors in a TIC and culturally responsive way
- The level of competence of health staff in both trauma informed care and cultural responsiveness in health contexts in NSW is unknown

(Kaplan, 2020; Justice Health and Forensic Mental Health Network, 2019; Justice Health and Forensic Mental Health Network, 2018; Justice Health and Forensic Mental Health Network, 2017; Minas et al., 2013)

These are consistent with the "If We Don't Count it… **It Doesn't Count"** report by FECCA (2020) that highlights many gaps in knowledge across contexts for people from "cultural, ethnic and linguistic diversity" (2020, p.5). This lack of information is important because it impacts people's representation in research studies. This means that benefits of research-based health care services, and health care delivery approaches may not reach, or be relevant for these vulnerable groups. FECCA recommends that more comprehensive data be collected and that measures be appropriate and consistent (2020).

7 Discussion

The purpose of this review was to gather and analyse available information in the literature about refugees and migrants' experiences in the custodial and forensic mental health settings, who have been psychologically impacted by traumatic events and torture. It became clear during early searches that this is a complex area of health and social care and that there is a paucity of evidence in the literature that pertains both to these settings and to heath care more broadly. This resulted in a wide net being cast, from which a large amount of relevant information was discovered.

The learnings from this information can be distilled into the following points:

- Data collection about refugees, migrants and their social and health care needs across and within various settings both globally and in Australia is poor
- The percentage of prisoners who are refugees in custodial and forensic settings is unknown
- The prevalence of previous torture among people in custodial and forensic settings is unknown
- Despite data gaps, there are migrants in both the custodial and forensic settings in NSW in which studies show, self-reported trauma is high. Also of note is that a history of torture has been reported by a small number of patients in the Forensic Hospital (JHFMHN, 2018; JHFMHN, 2017).
- The development of a culturally responsive health workforce that is guided by the NSW Health multicultural health principles is a complex undertaking and one in which the health setting is likely to be important
- There are a range of opinions and approaches to cultural responsiveness
- Trauma informed care is well described, but not specifically in the context of secure settings
- There is a difference between trauma (PTSD and CPTSD) treatment and trauma informed care
- The availability of a workforce that is both culturally responsive and trauma informed is important across health care settings and is critical in some. Custodial and forensic settings may be an example of these. More information is needed.
- The trauma histories and subsequent health needs of prisoners, refugees and migrants might be similar, and more information is needed
- The level of competence of health staff in both trauma informed care and cultural responsiveness in NSW is unknown and more information is needed.

Overall, this literature review has shown that both globally and in NSW, refugee and migrant health and social care is complex and multifaceted. In NSW, the health and social care needs of refugees and migrants are met predominantly by both government and non-government organisations. This means that planning and developing care models and a competent workforce is also a complex issue that will require time, resources and the development of partnerships.

In relation to the notion of JHFMHN developing a trauma informed and culturally responsive model of care in the NSW and custodial settings, more information is needed about the:

- Numbers of patients who are refugees and migrants
- Prevalence of torture and trauma among refugee and migrant patients
- Existing knowledge, skills, attitudes, confidence and competence for both trauma informed care and cultural responsiveness among Network health staff.
- Existing knowledge, skills, confidence and competence in trauma treatment among mental health staff.

8 Limitations

There are several limitations within this review. Firstly, exploring refugee and migrant health in secure settings (excluding immigration detention), necessitated a broad search of a range of aspects of that pertain to this issue. These included migration, refugee health, migrant health, custodial and forensic mental health delivery, physical and mental health of refugees and migrants, cultural responsiveness, trauma, trauma informed care, social determinants of health and health literacy. As a result, this was not a systematic review and an assessment of the quality of studies was not performed. To counter this however, where possible, review papers were used to inform the content. A second limitation is the paucity of data that relates to migrant health generally as well as refugee and non-refugee migrants' experiences across the broad health system (excluding specialist services and including secure settings). Finally, there may be aspects of this subject that have been unintentionally omitted. This is because the initial search returned narrow repetitive results and as a result, learnings from the literature were used to inform further searches. It is not possible to say if all relevant aspects of this subject have been uncovered.

9 Recommendations

The data gaps identified through this review highlight the need for more information that pertains to the NSW custodial and forensic settings and focuses on health care delivery to refugees and migrants in the context of torture and trauma. A consultation is recommended followed by the development of a position paper. Recommendations for the consultation are below:

1. Conduct JHFMHN staff interviews using a set of questions to guide the conversation. Staff to include leaders and clinicians from both mental health and forensic mental health settings. This is because there is a higher prevalence of mental health issues among refugees and migrants than the general population.

   The following questions are suggested

   - How many CALD patients has the org/your Hosp/your unit cared for in the last month?
     - How many have been refugees?
     - How do you know this?
     - How do the care needs differ between CALD patients and non-CALD patients?
     - How do the care needs differ between CALD patients and patients from a refugee background?
     - What are the data and knowledge gaps?

   - What percentage of CALD patients has the org/your hosp/your unit cared for over the last month do you think have experienced trauma in their lives? How many have experienced complex trauma?

     - How do you know this?
     - How many have been refugees?
     - How do you know this?
     - What are the data and knowledge gaps?

   - How does the organisation hospital or unit address cultural differences?

   - How does the organisation hospital or unit approach working with patients from different cultures?

   - What is your understanding of culturally responsive care?

   - What barriers does the organisation hospital or unit experience providing culturally responsive care?

     - What would help?

   - What is your understanding of Trauma Informed Care?

     - How does the organisation hospital or unit apply it?
     - What barriers does the organisation hospital or unit experience providing TIC?
     - What would help?

2. Seek a meeting with the CSNSW Co-ordinator Cultural & Linguistic Diversity, Corrections Strategy & Policy, Department of Communities & Justice, CSNSW about:

- Perspective on cultural responsiveness
- Current knowledge of and response to CALD inmates who may have experienced trauma.
- Knowledge about refugee numbers in NSW prisons

3. Identify stakeholders at STARTTS with a view to building a relationship between the two organisations for the purpose of information sharing, collaboration and improving care for refugees and migrants in custodial and forensic mental health settings.

10 References

1. Abu Suhaiban, H., Grasser, L. R., & Javanbakht, A. (2019). Mental Health of Refugees and Torture Survivors: A Critical Review of Prevalence, Predictors, and Integrated Care. *International Journal of Environmental Research and Public Health, 16*(13). https://doi.org/10.3390/ijerph16132309

2. Agency for Clinical Innovation (2019). *Trauma Informed Care and Mental Health in NSW*. https://aci.health.nsw.gov.au/networks/mental-health/about/trauma-informed-care

3. Agency for Clinical Innovation, (n.d.). Consumer Enablement Guide. https://aci.health.nsw.gov.au/resources/primary-health/consumer-enablement/guide/how-to-support-enablement/culturally-responsive-practice

4. Au, M., Anandakumar, A. D., Preston, R., Ray, R. A., & Davis, M. (2019). A model explaining refugee experiences of the Australian healthcare system: a systematic review of refugee perceptions. *BMC International Health and Human Rights*, *19*(1), 22. https://doi.org/10.1186/s12914-019-0206-6

5. Australian Government Department of Home Affairs (n.d.). Australia's Humanitarian Program 2021-22. https://www.homeaffairs.gov.au/reports-and-publications/submissions-and-discussion-papers/australia-humanitarian-program-2021-22

6. Australian Government (2021). *Settlement data reports financial year 2020-2021.* https://www.data.gov.au/dataset/ds-dga-8d1b90a9-a4d7-4b10-ad6a-8273722c8628/distribution/dist-dga-b7e95faf-4b74-4bbd-bc3d-b067544ce942/details?q

7. Australian Government Department of Health (2019). *National Men's Health Strategy 2020-2030.* https://www.health.gov.au/sites/default/files/documents/2021/05/national-men-s-health-strategy-2020-2030.pdf

8. Australian Government Department of Health (2018). *National Women's Health Strategy 2020-2030.* https://www.health.gov.au/sites/default/files/documents/2021/05/national-women-s-health-strategy-2020-2030.pdf

9. Australian Government Department of Home Affairs (2022). *Australia's Humanitarian Program 2021-22*. https://www.homeaffairs.gov.au/reports-and-publications/submissions-and-discussion-papers/australia-humanitarian-program-2021-22

10. Australian Government Immigration Assessment Authority (2019). *Support Services (NSW & ACT).* https://www.iaa.gov.au/external-services/support-services

11. Australian Human Rights Commission, (n.d.). *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment - Human rights at your fingertips - Human rights at your fingertips*. https://humanrights.gov.au/our-work/commission-general/convention-against-torture-and-other-cruel-inhuman-or-degrading

12. Australian Institute of Health and Welfare, (2020). *What is health*. https://www.aihw.gov.au/reports/australias-health/what-is-health

13. Australian Institute of Health and Welfare, (2020a). *Health Literacy*. https://www.aihw.gov.au/reports/australias-health/health-literacy

14. Australian Refugee Health Practice Guide, (n.d.) https://refugeehealthguide.org.au

15. Berry, J., W. & Hou, F. (2017). Acculturation, discrimination and wellbeing among second generation of immigrants in Canada, *International Journal of Intercultural Relations*, 61, 29-39

16. Blackmore, R., Boyle, J. A., Fazel, M., Ranasinha, S., Gray, K. M., Fitzgerald, G., Misso, M., & Gibson-Helm, M. (2020). The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. *PLoS Medicine*, *17*(9), 1-24. https://doi.org/10.1371/journal.pmed.1003337

17. Blue Knot Foundation (n.d.). *What is Trauma?* https://blueknot.org.au/resources/understanding-trauma-and-abuse/

18. Bonfine, N., Wilson, A. B., Muntez & M. R. (2019). Meeting the Needs of Justice-Involved People with Serious Mental Illness Within Community Behavioral Health Systems. *Psychiatry Online*, https://doi.org/10.1176/appi.ps.201900453.

19. Briere, J., N. & Scott, C. (2015). *Principles of Trauma Therapy: A Guide to Symptoms, Evaluation and Treatment*. California, USA: Sage Publications.

20. Bryant, R. A., B. Edwards, M., Creamer, O'Donnell, M., Forbes, D., Felmingham, K. L., Silove, D., Steel Z., McFarlane, A. C., van Hooff, M., Nickerson, A. & Hadzi-Pavlovic, D. (2020). A Population Study of Prolonged Grief. *Epidemiology Psychiatric Sciences*, 29: e44.

21. Bustamante, L. H. U., Cerqueira, R. O., Leclerc, E., & Brietzke, E. (2017). Stress, trauma, and posttraumatic stress disorder in migrants: a comprehensive review. Revista Brasileira de Psiquiatria (Sao Paulo, Brazil,ÄØ: 1999), 40(2), 220-225. https://doi.org/10.1590/1516-4446-2017-2290

22. Clinical Excellence Commission, (2019). *NSW Health Literacy Framework. 2019-2024, Sydney:* Clinical Excellence Commission. https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0008/487169/NSW-Health-Literacy-Framework-2019-2024.pdf

23. Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). Towards a culturally competent system of care (Vol. 1). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

24. Curtis, E., Jones, R., Tipene-Leach, D. Walker, C., Loring, B., Paine, S-J. and Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *Int J Equity Health* 18, 174 https://doi.org/10.1186/s12939-019-1082-3

25. de Silva U., Glover N. & Katona C. (2021). Prevalence of complex post-traumatic stress disorder in refugees and asylum seekers: systematic review. *BJPsych open*, *7*(6): e194. doi:10.1192/bjo.2021.1013

26. Facer-Irwin, E., Karatzias, T., Bird, A., Blackwood, N., & MacManus, D. (2021). PTSD and complex PTSD in sentenced male prisoners in the UK: prevalence, trauma antecedents, and psychiatric comorbidities. Psychological Medicine, 1–11. https://doi.org/10.1017/S0033291720004936

27. FASSTT (2011). *From Darkness to Light*. https://fasstt.org.au/wordpress/wp-content/uploads/2014/02/3590_Darkness-to-light_web_s.pdf

28. Federation Of Ethnic Communities Councils of Australia (FECCA) (2020). *If We don't Count it… it Doesn't Count*. https://fecca.org.au/if-we-dont-count-it-it-doesnt-count/

29. Ford, J. D. (2019). Commentary on the Special Section on Complex PTSD: Still Going Strong After All These Years. Journal of Traumatic Stress, 32(6), 877–880. https://doi.org/10.1002/jts.22474

30. Gaya-Sancho, B., Vanceulebroeck, V., Kömürcü, N., Kalkan, I., Casa-Nova, A., Tambo-Lizalde, E., Coelho, M., Present, E., Değirmenci Öz, S., Coelho, T., Vermeiren, S., Kavala, A., Jerue, B. A., Sáez-Gutiérrez, B. & Antón-Solanas, I. (2021). Perception and Experience of Transcultural Care of Stakeholders and Health Service Users with a Migrant Background: A Qualitative Study. *International Journal of Environmental Research and Public Health*, 18(19), 10503. https://doi.org/10.3390/ijerph181910503

31. George, S. J., Tripp, H. L., & Ardia, D. (2021). Pilot Study Examining the Impact of Acculturation on Refugees' Healthcare Satisfaction. *International Social Science Review*, 97(2), NA. https://link.gale.com/apps/doc/A668019182/AONE?u=slnsw_public&sid=bookmark-AONE&xid=a0e41842

32. Groves, M. (2004). Immigration detention vs imprisonment: Differences explored. *Alternative Law Journal 69; 29*(5). http://classic.austlii.edu.au/au/journals/AltLawJl/2004/69.html

33. Jobst, S., Windeisen, M., Wuensch, A., Meng, M., & Kugler, C. (2020). Supporting migrants and refugees with posttraumatic stress disorder: development, pilot implementation, and pilot evaluation of a continuing interprofessional education for healthcare providers. *BMC Medical Education, 20*(1), 311. https://doi.org/10.1186/s12909-020-02220-

34. Im, H., & Swan, L. (2020). Capacity Building for Refugee Mental Health in Resettlement: Implementation and Evaluation of Cross-Cultural Trauma-Informed Care Training. *Journal of immigrant and minority health*, *22*(5), 923–934. https://doi.org/10.1007/s10903-020-00992-w

35. Jongen, C, McCalman, J. & Bainbridge, R. (2018). Health workforce cultural competency interventions: a systematic review. *BMC Health Services Research,18*:232

36. Justice Health and Forensic Mental Health Network (2019). *NSW Healthy Prisons: Framework for Action 2019-2022*. Unpub.

37. Justice Health and Forensic Mental Health Network (2019a). *Culturally and Linguistically Diverse Mapping Project Report*. Unpub

38. Justice Health and Forensic Mental Health Network (2018). *2016 Forensic Mental Health Patient Report*. https://www.justicehealth.nsw.gov.au/publications/2016-forensic-mental-health-patient-report-final-1.pdf

39. Justice Health and Forensic Mental Health Network (2018a). Strategic Plan 2018-2022 https://www.justicehealth.nsw.gov.au/publications/BookletStrategicPlan20182022.pdf

40. Justice Health and Forensic Mental Health Network (2017). *2015 Network Patient Health Survey Report.* http://intranetjh/SiteAssets/Pages/CHRCJ-Publications/2015_NHPS_FINAL%20REPORT.pdf

41. Kaplan, I. (2020). Rebuilding Shattered Lives (2nd ed.). Foundation House.

42. Kezelman, C. and Stavropulos, P. (2019). *Practice Guidelines for Clinical Treatment of Complex Trauma.* Blue Knot Foundation.

43. Liddell, B. J., Nickerson, A., Felmingham, K. L., Malhi, G. S., Cheung, J., Den, M., Askovic, M., Coello, M., Aroche, J., & Bryant, R. A. (2019). Complex Posttraumatic Stress Disorder Symptom Profiles in Traumatized Refugees. *Journal of Traumatic Stress*, *32*(6), 822–832. https://doi.org/10.1002/jts.22453

44. Lineth, H.U., Bustamante, L. H. U., Cerqueira, R. O., Leclerc, E., & Brietzke, E. (2017). Stress, trauma, and posttraumatic stress disorder in migrants: a comprehensive review. *Revista Brasileira de Psiquiatria (Sao Paulo, Brazil,ÄØ: 1999), 40*(2), 220-225. https://doi.org/10.1590/1516-4446-2017-2290

45. Matlin, S.A., Depoux, A., Schutte, S. Antoine Flahault, A. & Luciano Saso, S. (2018). Migrants' and refugees' health: towards an agenda of solutions. *Public Health Rev 39*, 27. https://doi.org/10.1186/s40985-018-0104-9

46. Mellor, R., Werner, A., Moussa, B., Mohsin, M., Jayasuriya, R., & Tay, A. K. (2021). Prevalence, predictors and associations of complex post-traumatic stress disorder with common mental disorders in refugees and forcibly displaced populations: a systematic review. European Journal of Psychotraumatology, 12(1), 1863579

47. Mental Health Commission of NSW (2014). *Views of the NSW Refugee Health Improvement Network.* https://www.nswmentalhealthcommission.com.au/sites/default/files/old/assets/File/RHIN%20mental%20health%20cover%20page.pdf

48. Minas, H., Kakuma, R., Too, L.S, Hamza Vayani, H., Orapeleng, S., Prasad-Ildes, R., Turner, G., Procter, N. & Oehm, D. (2013). Mental health research and evaluation in multicultural Australia: developing a culture of inclusion. *Int J Ment Health Syst* 7**,** 23 https://doi.org/10.1186/1752-4458-7-23

49. Morgan, R., Scanlon, F., & Van Horn, S. (2020). Criminogenic risk and mental health: A complicated relationship. *CNS Spectrums, 25*(2), 237-244. doi:10.1017/S109285291900141X

50. Nickerson, A., Matthis, S., Schnyder, U., Bryant, R. A. & Morina, N. (2017). Comorbidity of Postraumatic Stress Disorder and Depression in Tortured, Treatment-Seeking Refugees. Journal of Traumitic Stress, 30, 409-415.

51. NSW Corrective Services (2019). *NSW Inmate Census summary of characteristics.* https://correctiveservices.dcj.nsw.gov.au/csnsw-home/resources/research-and-reports/corrections-research-evaluation-and-statistics/nsw-offender-census.html

52. NSW Department of Communities and Justice NSW (2015). *Department of Justice Multicultural Plan 2015-2018.* https://www.justice.nsw.gov.au/diversityservices/Documents/dj-multicultural-plan-2015-2018.pdf

53. NSW Health (n.d). *Specialist multicultural and refugee health services.* https://www.health.nsw.gov.au/multicultural/Pages/multicultural-statewide-services.aspx

54. NSW Ministry of Health (2022). *Future Health, Guiding the next decade of care in NSW 2022-2032.* NSW Ministry of Health.

55. NSW Ministry of Health (2020). *20-Year Health Infrastructure Strategy.* https://www.health.nsw.gov.au/priorities/Pages/his-overview.aspx

56. NSW Ministry of Health (2019). *NSW Plan for Healthy Culturally and Linguistically Diverse Communities: 2019-2023.* https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2019_018.pdf

57. NSW Ministry of Health (2019). *NSW Women's Health Framework.* https://www.health.nsw.gov.au/women/Pages/womens-health-framework-2019.aspx

58. NSW Ministry of Health (2018). *NSW Men's Health Framework.* https://www.health.nsw.gov.au/men/Pages/mens-health-framework.aspx

59. NSW Health (2011). *Refugee Health Plan, 2011-2016.* https://www1.health.nsw.gov.au/pds/pages/doc.aspx?dn=PD2011_014

60. Pai, A., Suris, A. M., & North, C. S. (2017). Posttraumatic Stress Disorder in the DSM-5: Controversy, Change, and Conceptual Considerations. *Behavioral sciences (Basel, Switzerland)*, *7*(1), 7. https://doi.org/10.3390/bs7010007

61. Parajuli, J., & Horey, D. (2020). Barriers to and facilitators of health services utilisation by refugees in resettlement countries: an overview of systematic reviews. Australian Health Review, 44(1), 132–142. https://doi.org/10.1071/AH18108

62. Parliament of Australia (2011). *Seeking asylum: Australia's humanitarian program.* https://www.aph.gov.au/binaries/library/pubs/bn/sp/seekingasylum.pdf

63. Penney, S. R., Prosser, A., Grimbos, T., Egag, E. & Simpson, A. I. F. (2020). Voluntary and Forced Migrants in Forensic Mental Health Care. *International Journal of Forensic Mental Health.* 19, 1-12. 10.1080/14999013.2020.1812772.

64. Pham,T.T.L., Berecki-Gisolf, J., Clapperton, A., O'Brien, K.S., Liu, S., Gibson, K. (2021). Definitions of Culturally and Linguistically Diverse (CALD): A Literature Review of Epidemiological Research. *Australia. Int. J. Environ. Res. Public Health*, 18, 737. https://doi.org/10.3390/ijerph 18020737

65. RANZCP (2017). *The provision of mental Health Services for asylum seekers and refugees Position Statement*. https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/mental-health-services-for-asylum-seekers-refugees

66. Rose, A., Trounson, J., Skues, J., Daffern, M., Shepherd, S. M., Pfeifer, J. E., & Ogloff, J. (2019). Psychological wellbeing, distress and coping in Australian Indigenous and multicultural prisoners: a mixed methods analysis. *Psychiatry, psychology, and law: an interdisciplinary journal of the Australian and New Zealand Association of Psychiatry, Psychology and Law*, *26*(6), 886–903. https://doi.org/10.1080/13218719.2019.1642259

67. Sam, D. L., & Berry, J. W. (2010). Acculturation: When Individuals and Groups of Different Cultural Backgrounds Meet. *Perspectives on Psychological Science*, *5*(4), 472–481. http://www.jstor.org/stable/41613454

68. Service for the Treatment & Rehabilitation of Torture & Trauma Survivors (n.d.). *Mission Statement*. https://www.startts.org.au/about-us/

69. Skeem, J. L., Winter, E., Kennealy, P. J., Eno Louden, J., & Tatar, J. R., (2013). Offenders With Mental Illness Have Criminogenic Needs, too: Toward Recidivism Reduction. *Law and Human Behavior*. Advance online publication. doi: 10.1037/lhb0000054

70. Shepherd, S. (2015): Criminal Engagement and Australian Culturally and Linguistically Diverse Populations: Challenges and Implications for Forensic Risk Assessment, *Psychiatry, Psychology and Law*, DOI:10.1080/13218719.2015.1053164

71. Sigvardsdotter, E., Vaez, M., Rydholm Hedman, A.-M., & Saboonchi, F. (2016). Prevalence of torture and other warrelated traumatic events in forced migrants: A systematic review. *Torture: Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture, 26*(2), 41–73

72. Sindayigaya, F. (2017) How do nurses feel about their cultural competence? : A Literature Review. [Bachelors Thesis, JAMK University of Applied Sciences. https://core.ac.uk/download/pdf/84793128.pdf

73. Titze, L., Gros, J., Büsselmann, M., Lutz, M., Streb, J., & Dudeck, M. (2021). Immigrant Patients Adapt to the Culture of Admission and Experience Less Safety in Forensic Psychiatric Care. *Frontiers in psychology*, *12*, 701544. https://doi.org/10.3389/fpsyg.2021.701544

74. Turrini, G., Purgato, M., Ballette, F., Nosè, M., Ostuzzi, G., & Barbui, C. (2017). Common mental disorders in asylum seekers and refugees: umbrella review of prevalence and intervention studies. International Journal of Mental Health Systems, 11, 51. https://doi.org/10.1186/s13033-017-0156-0

75. Ulutasdemir, N. Ed. (2021, August 3). *Transcultural Nursing Care Models*. Gümüşhane University. https://med.libretexts.org/@go/page/49275

76. United Nations (n.d.), *Refugees and Migrants. Definitions*. https://refugeesmigrants.un.org/definitions

77. UNHCR, (2001). *Frequently asked questions about the 1951 Refugee Convention* https://www.unhcr.org/en-au/news/stories/2001/6/3b4c06578/frequently-asked-questions-1951-refugee-convention.html#_Toc519482138

78. UNHCR, (2016). *Refugees and Migrant Frequently Asked Questions.* https://www.unhcr.org/en-au/news/latest/2016/3/56e95c676/refugees-migrants-frequently-asked-questions-faqs.html

79. UNHCR, (2022). *Asylum-Seekers*. https://www.unhcr.org/en-au/asylum-seekers.html.

80. Uphoff, E., Robertson, L., Cabieses, B., Villalun, F. J., Purgato, M., Churchill, R., & Barbui, C. (2020). An overview of systematic reviews on mental health promotion, prevention, and treatment of common mental disorders for refugees, asylum seekers, and internally displaced persons. *The Cochrane Database of Systematic Reviews*, 9, CD013458. https://doi.org/10.1002/14651858.CD013458.pub2

81. URBIS (2019). *URBIS EVIDENCE REVIEW_100519.* https://www.health.nsw.gov.au/multicultural/Documents/evidence-review.pdf

82. Victorian Foundation for Survivors of Torture, (2016). *Integrated Trauma Recovery Service Model.* https://www.foundationhouse.org.au/wp-

content/uploads/2018/08/INTEGRATED-TRAUMA-SERVICE-RECOVERY-MODEL_cr.pdf

83. Van Deinse, T. B., Cuddeback, G. S., Wilson, A. B., Edwards, D., Jr, & Lambert, M. (2021). Variation in Criminogenic Risks by Mental Health Symptom Severity: Implications for Mental Health Services and Research. *The Psychiatric quarterly*, 92(1), 73–84. https://doi.org/10.1007/s11126-020-09782-x

84. Vogl and Methven, 2020. Life in the Shadow Carceral State: Surveillance and Control of Refugees in Australia. *International Journal for Crime, Justice and Social Democracy*, *9*(4), 61-75.

85. Watt, K., Hu, W., Magin, P. and Abbott, P. (2018). “Imagine if I’m not here, what they’re going to do?” – Health care access and cultural and linguistically diverse women in prison. *Health Expectations,* 21, 1159–1170.

86. WHO, (2021). *Refugee and migrant health: Global Competency Standards for health* workers. https://migrationcouncil.org.au/our-work/health/

87. WHO, (2018). *Mental health: strengthening our response*. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

88. WHO, (2013). *Health Literacy the Solid Facts.* https://apps.who.int/iris/bitstream/handle/10665/326432/9789289000154-eng.pdf?sequence=1&isAllowed=y

89. WHO (n.d.) Constitution. https://www.who.int/about/governance/constitution.

90. WHO, (n.d.a). Health Promotion. https://www.who.int/teams/health-promotion/enhanced-wellbeing/seventh-global-conference/health-literacy