Transcultural
Mental Health Centre

NSW GOVERNMENT
Western Sydney
Local Health District

Culturally Responsive Emotional Wellbeing Clinical Services for People with Refugee or Asylum Seeker Experiences

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Background & Context

Refugee Health Flexible Fund

The NSW Health Refugee Health Flexible Fund (RHFF) sponsored projects from NSW Health organisations and related services to address the goals and priorities identified in the NSW Refugee Health Plan 2022-2027. The RHFF aligns with NSW Health priorities and principles, outlined in the Future Health: Guiding the Next Decade of Health Care in NSW 2022-2032 and the NSW Plan for Healthy Culturally and Linguistically Diverse Communities: 2019-2023.

The RHFF supports healthcare for people from refugee backgrounds across NSW. The "projects share a common purpose, that is, to ensure access to timely, culturally responsive and trauma-informed healthcare services for people from refugee and asylum seeker backgrounds" (NSW Ministry of Health, 2023). Enhancing collaboration across NSW Health, its partners and communities are a key feature of the RHFF. Through targeted strategies, the projects aim to address local and statewide needs, to enhance services like cancer screening, women's health, paediatrics and child health as well as service access for oral health and mental health.

The Transcultural Mental Health Centre (TMHC), a NSW Health statewide service hosted in Western Sydney Local Health District (WSLHD) was funded by the RHFF to undertake a project over two years 2021-22 and 2022-23. The project worked with Non-Government Organisations (NGOs) and related services to provide emotional wellbeing services for people from Afghanistan and Sri Lanka (Tamil-speaking) who reside in Western Sydney. The project sought to identify and ameliorate signs and symptoms of psychological distress and prevent mental status deterioration and the need for hospitalisation. The TMHC aimed to work with, support and supervise clinicians from specific communities to use their cultural and language concordance and professional skills to meet the project goals.

Transcultural Mental Health Centre

The TMHC contributes to a comprehensive NSW Health response including public health planning and service provision in which the primary goal is to improve the mental health and wellbeing of populations. The TMHC's focus is to work in partnership with health and related professionals and a range of organisations to protect and enhance the mental health and wellbeing of culturally and linguistically diverse (CALD) communities across the lifespan and migration experience.

The TMHC enhances access and equity for CALD communities by working from a system through to an operational level by building the capacity of clinical and community services and through multilingual resource development to support the delivery of culturally responsive and safe services and programs.

A range of services and programs are provided by TMHC including:

- Service development, planning and evaluation
- Research support and academic partnerships
- Education, professional development and clinical supervision
- Mental health promotion, prevention and early intervention
- Specialist clinical services
- Resources, information and communications.

TMHC's Capacity Building Mental Health Program for New and Emerging Refugee Populations

People with refugee and asylum seeker experiences are reluctant to access mental health services due to cultural stigma and the prioritisation of basic survival needs. The TMHC has a capacity building mental health program for new and emerging refugee populations that works collaboratively with service providers to strengthen and support the wellbeing of refugee populations. The program has two components that work in tandem: building capacity within mental health services and building community capacity.

The clinical component of this program aims to support and strengthen the skills of public mental health and other health services in providing responsive mental health services to newly arrived refugees. The aim of the community capacity building component of the program is to improve mental health and wellbeing among newly arrived refugee communities, with a focus on prevention and staying well.

Refugee and Asylum Seeker Communities

By the end of 2022, the United Nations High Commissioner for Refugees (UNHCR, 2023a), reported that there were 108.4 million people forcibly displaced worldwide. People have fled their home countries as a result of conflict, persecution, violence or human rights violations (UNHCR, 2023a). Across the world, there are approximately 35.3 million people who are refugees as defined by the UNHCR (2023a). A refugee is defined as "a person who is outside their own country and is unable or unwilling to return due to a well-founded fear of being persecuted because of their: race, religion, nationality, membership of a particular social group or political opinion" (Australian Human Rights Commission (AHRC), 2019). In addition, there are 4.6 million asylum seekers, who are defined as those who have fled their country and applied for protection as a refugee (AHRC,2019). Many seek refuge and settlement in other countries such as Canada, the United States or Australia.

There is significant demand from people seeking refuge in Australia. Between July 2020 and June 2021, the Australian Government's Humanitarian Program received over 50,000 applications for a total of 13,750 places (Department of Home Affairs (DHA), 2022b). The Australian Government has committed to an additional 16,500 places over four years for refugees from Afghanistan (DHA, 2022a).

Over the last ten years, there were 53,408 Humanitarian entrants to New South Wales. The top five countries of birth were Iraq, Syrian Arab Republic, Afghanistan, Iran and Pakistan and the top five languages spoken were Arabic, Assyrian, Dari, Farsi (Persian) and Chaldean Neo-Aramaic (DHA, 2023a). Humanitarian entrants had a diverse range of ethnic backgrounds, with the top five ethnicities being Iraqi, Assyrian, Chaldean (Iraq), Syrian and Arab (DHA, 2023a). These communities have had significant history of conflict, violence and persecution due to war in their countries of origin.

WSLHD is one of the most diverse districts in NSW making it an appropriate and logical focus area of the project. Between January 2017 and April 2021, there were 2,735 humanitarian entrants settled in the WSLHD. The top five languages spoken by the humanitarian entrants were Arabic, Dari, Farsi (Persian), Hazaraghi and Swahili (DHA, 2021).

Temporary humanitarian visas are issued to people who arrive in Australia seeking asylum (DHA, 2023b). There are 10,828 individuals on temporary humanitarian visas (i.e. Bridging Visa E) in Australia with 3,932 in NSW (Refugee Council of Australia, 2023). Often these visas have conditions that limit access to government supports and services. Although, NSW Health has a policy in place to provide specific public health services including mental health services for Medicare ineligible asylum seekers, their ability to advocate for this may be limited (NSW Ministry of Health, 2020). As outlined below, English language barriers and unfamiliarity of Australian health services are likely to impact their advocacy for services, despite their need for mental health support. Recent Australian research by Nickerson and colleagues (2023), draws attention to the likely significant mental health and social burden of longstanding uncertainty of security of settlement when granted temporary visas.

Afghan Population

Since 2011 approximately 6,000 people arrived in NSW from Afghanistan and at the time of the recent census, 72.5% of those living in NSW who were born in Afghanistan reside in WSLHD (ABS, 2022c). Of those individuals, 40% speak Dari, 32% speak Harazarghi and 12% speak Persian (excluding Dari) (ABS, 2021a). A large number (80%) of Afghan people are aged between 20 and 35 years while 57% identify as male (ABS, 2022a). Afghanistan is a multiethnic nation with the majority identifying as Muslim. The culture is largely collectivistic with strong community and family ties. Afghanistan has had a history of political turmoil over the past four decades. Particular Afghan populations have been persecuted due to their ethnicity, resulting in significant trauma for many. The rise of the Taliban has also meant extensive constraints for Afghan women impacting many aspects of their life through systematic discrimination like exclusion from public space (Ramos, 2023). Afghan women are impacted both by war-related violence as well as gender-based violence (Alemi et al., 2023). As a result of this conflict and persecution many have sought asylum in Australia. The impacts of significant trauma are notable for many Afghan people living in Australia. Studies among Afghan refugees have shown a high incidence of depression (Rintoul, 2010), post-traumatic stress disorder (PTSD) and anxiety (Ahmad, Othman, & Lou, 2020; Hamrah et al., 2021). Further, Afghan women who have resettled in other countries often present with high incidences of both physical and mental health issues like hypertension, depression and anxiety (Ramos, 2023).

Afghans arriving in Australia are likely to require substantial support to meet their mental health needs. Silove and Ventevogel (2022) suggest that 10% of populations exposed to such violence will need mental health treatment immediately and another 20% will require psychosocial support.

In August 2021, heavily armed Taliban fighters took control of the Afghan capital Kabul effectively bringing down the government of the day. The Taliban takeover saw increasing violations of human rights and an escalating humanitarian crisis across Afghanistan (Transcultural Mental Health Centre (TMHC), 2023). This Project was proposed in response to the immense distress and anxiety these events caused for Afghan communities in Australia and throughout the world. Therefore, this unfolding crisis also informed and directed the focus of the new clinic with Afghan communities living in Western Sydney to help better meet their mental health needs. Given the events in their home country and the significant number of Afghan individuals living in Western Sydney a clinic focused on early identification of mental ill health was aimed at supporting individuals into health care in a timely and proactive manner.

Sri Lankan (Tamil-speaking) Population

According to the 2021 Census, since 2011 over 3,100 people arrived in NSW from Sri Lanka (Tamil-speaking) with a majority (73%) of Sri Lankan Tamils in NSW living in the WSLHD, at the time of the last census (Australian Bureau of Statistics (ABS), 2022c). Of the 14,233 people born in Sri Lanka living in WSLHD, 62% speak Tamil at home. Of those born in Sri Lanka living in WSLHD, who speak Tamil, 69% are aged between 20 and 59 years of age with 53% identifying as male (ABS,2022a). In NSW, 32% of individuals on temporary humanitarian visas (Bridging Visa E) are from Sri Lanka with 60% living in the WSLHD (Refugee Council of Australia, 2023).

In Sri Lanka, there has been significant human rights violations against Tamils in the context of organised violence (NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), 2015). War, natural disasters, and terrorism has influenced migration journeys, where many first came to Australia seeking better socioeconomic opportunities and others have sought asylum because of the conflict in Sri Lanka (TMHC, 2022).

Sri Lanka has a strong collective culture, sense of community and shared experience that is an important source of strength and resilience in the Sri Lankan Tamil diaspora in Australia (TMHC, 2022). Members of the Sri Lankan (Tamil-speaking) population have sought protection in Australia due to the fear of persecution in Sri Lanka from possible connections with the Liberation of Tigers of Tamil Eelam, commonly known as Tamil Tigers (TMHC, 2022). The Tamil Tigers are a separatist group seeking independence within Sri Lanka (Kandasamy, 2021) who have been identified as a militant group (Department of Foreign Affairs and Trade, 2021).

It is understood that the Sri Lankan (Tamil-speaking) population seeking asylum face one of the lowest acceptance rates due to the information used by the government to grant permanent protection (Kandasamy, 2021). The identified risk level to return to Sri Lanka is reported to be low in relation to official and societal discrimination as well as torture (Department of Foreign Affairs and Trade, 2021). This likely exacerbates how these individuals may then engage with mainstream and government organisations when seeking mental health support. Given their limited access to free health services by virtue of their visa status and the significant number living within the WSLHD catchment area, the clinic aimed to work with Sri Lankan (Tamil-speaking) communities to better support the specific mental health needs of this group.

Literature Review

This literature review was undertaken to inform the establishment of a culturally responsive and trauma informed emotional wellbeing clinic for the specific communities. It identifies the needs and appropriate services to build resilience and support good mental health for adult Afghan and Sri Lankan (Tamil-speaking) communities in Western Sydney. These communities in Western Sydney have specific and unique mental health needs that impact access and use of mainstream mental health services. The literature review considered the intersection of culture, mental health and the forced migration experience with contemporary issues like the COVID-19 pandemic. It reviewed the mental health needs and help seeking behaviours of refugees and asylum seekers, identifying barriers and enablers in accessing mental health services, while discussing current services and models of care for refugee mental health care. It informs how best to establish a time-limited emotional wellbeing clinic for adult Afghan and Sri Lankan (Tamil-speaking) new communities in Western Sydney.

Culture and Mental Health

In more recent times, culture is described as dynamic and constantly evolving:

> 'Contemporary views of culture understand it as an abstraction based on social processes of identity construction, negotiation of relationships, and participation in institutions. The identities that result are fluid, multiple, and hybrid' (Kirmayer, 2013, p. 4).

The World Health Organisation (WHO) defines mental health as

> "a state of wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (2018).

Across cultures, social settings and families, what is seen as problematic and pathological can differ with varied thresholds of correlated behaviour and symptoms (American Psychological Association (APA), 2013, 2022). Importantly, cultural meaning, habits and traditions can contribute to the stigma of mental health or enhance resilience by providing coping strategies. It can also have implications on engagement with services through treatment adherence, course of illness and recovery as well as acceptance of diagnosis (APA, 2013). Culture contextualises a person's suffering and assists health professionals better engage with a person and understand their life (APA, 2019).

It is important to recognise that high prevalence estimates of mental illness for particular CALD communities need to be treated with caution, ensuring they do not conflate mental disorders with psychosocial distress (Alemi et al., 2023). Therefore, in clinical contexts there are various elements of culture and mental health, including cultural difference and diversity, that practitioners need to consider.

Spirituality and religion may also shape an individual's attribution and coping with mental health issues which can then impact on their use of services and their beliefs around mental health (Gopalkrishnan, 2018).

The Forced Migration Experience and Social Determinants of Mental Health

Rousseau and Frounfelker (2019) identified that some migrant populations had substantial mental illness burden as a result of their migration experience. Exposure to stressors during migration impacts on mental health and ongoing stressors during the settlement period can exacerbate mental illness, with research generally finding that this is higher for those from refugee backgrounds (Rousseau & Frounfelker, 2019). Therefore, the impact of culture on mental health is within the context of the migration experience, which is not a single event but an ongoing process that impacts the integration and settlement of migrants and more significantly the integration and settlement of refugees and asylum seekers. Their forced migration experience contextualises some significant mental health needs.

There has been a notable shift towards more structural explanations of why certain populations groups, have worse health and mental health outcomes, such as socio-economic status, social inclusion and exclusion, and migration status (Australian Institute of Health and Welfare, 2022).

With this a greater appreciation of the context from where people are coming from and the context into which they are migrating to, including understanding of health and mental health advantage and disadvantage in migrant populations (World Health Organization & Calouste Gulbenkian Foundation, 2014).

The social determinants of health shed light on the conditions of the social world that influence the health and wellbeing of individuals and groups. These conditions are shaped by the distribution of money, power and resources at personal, local, national and global levels. Health status is not merely the result of personal or individual factors, but rather a complex interrelationship of social and economic factors which can positively or negatively influence health and mental health. The determinants for health and mental health include education level, employment status, gender, ethnicity and socio-economic status (Australian Institute of Health and Welfare, 2022).

Much of what is presented in the literature is based on pre covid understandings of culture and mental health. Therefore, the below section adds to understandings of culture, mental health and the COVID-19 pandemic.

COVID-19 Pandemic

The COVID-19 pandemic affected the world with travel restrictions such as international border closures, restrictions on internal travel, and stay at home orders in an effort to reduce the spread of the coronavirus (Mcauliffe & Traindafllidou, 2021). Migration globally was restricted but it did not change the need of protection for refugees and asylum seekers and exacerbated the health inequalities impacting mental health outcomes for socially disadvantaged groups (El Arab, Somerville, Abuadas, Rubinat-Arnaldo, & Sagbakken, 2023; Gibson, Schneider, Talamonti, & Forshaw, 2021; Khatri & Assefa, 2022). A systematic review of 117 studies and over 300,000 participants found that several inequality factors predicted worse mental health outcomes during the COVID-19 pandemic. This included financial insecurity, lack of access to clear messaging/information about the pandemic, having existing health conditions as well as being in an ethnic or sexual marginalised group (Gibson et al., 2021). Access to healthcare during the pandemic was prioritised for COVID-19 patients and those with chronic conditions were discouraged to present to emergency or

feared attending healthcare due to infection by attending health services (Mauro, Lorenzo, Paolo, & Sergio, 2020). The mental health impacts of the COVID-19 pandemic was felt across the globe and in Australia where the financial instability and disrupted social world, negatively affected mental health. (Bower et al., 2022). However, the COVID-19 pandemic also provided opportunities for innovation in easier provision and access to mental health care throughout the globe, which may help benefit those most in need (Collins, 2020). This includes integrating technology, peers and lay health workers (Collins, 2020).

Mental Health Needs of Refugee and Asylum Seeker Populations

For people who migrate the prevalence of specific types of mental health conditions is influenced by the nature of the migration experience, in terms of adversity experienced before, during and after resettlement (Kirmayer et al., 2011). International and local research has demonstrated that refugees are at substantially higher risk than the general population for a variety of specific psychiatric disorders, with up to ten times the rate of PTSD as well as elevated rates of depression, anxiety disorders, chronic pain and other somatic complaints. Exposure to torture is the strongest predictor of symptoms of PTSD among refugees (Henley & Robinson, 2011; Kirmayer et al., 2011; Murray, Davidson, & Schweitzer, 2008). Depression, panic attacks, sleeping difficulties, and anxiety are well-recognised issues in refugee communities (Harris & Zwar, 2005; Silove, 2004; M. Smith, 2003; Steel & Silove, 2001; Sultan & O'Sullivan, 2001).

The large number of refugees fleeing conflict zones with significant mental health needs place significant demands on mental health services in receiving countries (Shawyer, Enticott, Block, Cheng, & Meadows, 2017).

A recent systematic review by Blackmore and colleagues (2020) that included 26 studies with over 5000 adult refugees and asylum seekers across 15 countries that included Australia, found global prevalence rates of PTSD and depression were higher and more persistent in refugee populations than the general population of those countries. While, anxiety and psychosis prevalence rates for refugee populations were more comparable to the general population (Blackmore et al., 2020).

A refugee health clinic in Melbourne estimated the prevalence of psychiatric disorders in a sample of 135 refugee and asylum seekers. Similar to the global refugee prevalence rates, they found rates of PTSD significantly higher in their refugee and asylum seeker population in comparison to the general Australian population (Shawyer et al., 2017).

An Australian longitudinal study of over 2000 refugees reviewed the various pre and post migration stressors that can impact an individual overtime (Wu et al., 2021). These stressors included economic stressors, English language barriers, family conflicts, loneliness, discrimination and problems generally with adjusting to life in Australia. The researchers reviewed the prevalence of PTSD, risk levels and burden of severe mental illness and identified that the high risk for severe mental illness decreased over time. Further, they found socioeconomic stressors, loneliness and adjustment to life in Australia prominent across time and associated with mental illness.

These studies highlight the significant mental health impact resulting from refugee and asylum seeker experiences. The post migration stressors that refugees experience can perpetuate and exacerbate mental health issues like PTSD (Specker et al., 2023). Although, there are a significant number of risk factors that lead to psychopathology for refugees prior

to their settlement, postmigration factors can also impact trajectories of mental health (O'Donnell, Paolini, & Stuart, 2022). This can include stressors like discrimination, reduced community supports as well as cultural bereavement (Wu et al., 2021). Difficulties with regulating emotions also acts as a mechanism in maintaining experiences of PTSD post settlement (Specker et al., 2023).

Asylum seekers who are held in immigration detention are consistently reported to have significant rates of mental distress (Forrest & Steel, 2023). A systematic review on the mental health of asylum seekers and refugees who were placed in immigration detention found high levels of mental health problems with PTSD, anxiety and depression commonly reported both during and following detention (von Werthern et al., 2018).

A model of refugee mental health has been proposed that identifies variations based on levels of environmental stress and adaptive psychological factors of the individual (Kashyap, Keegan, Liddell, Thomson, & Nickerson, 2021). Despite the universal exposure of these individuals to pre-migration and post-migration stressors, the development of psychological disorders is likely to be mediated by mechanisms related to their ability to cope and adapt to the stress exposure. This provides a framework that highlights strengths and resilience of a person, while also allowing the enhancement of an individual's capacity to manage environmental stress.

These studies highlight difficulties faced and the significant needs that refugee and asylum seekers have in relation to their mental health and wellbeing. Research suggests more integrated and tailored services for specific characteristics of ethnic groups including how promotional material and mental health interventions may be delivered (Tomasi, Slewa-Younan, Narchal, & Rioseco, 2022). For the Afghan community, research has identified partnership between communities and health services can help improve the delivery of primary health care in Australia (Cheng, Wahidi, Vasi, & Samuel, 2015). Culturally tailored mental health programs have also been recommended for the Afghan community (Slewa-Younan, Rioseco, Guajardo, & Mond, 2019). This is not dissimilar to the Sri Lankan Tamil-speaking population who also benefit from engagement with communities to negotiate care through social networks (Antoniades, Mazza, & Brijnath, 2018). Research in Canada also highlights the importance of close community connections, and suggests service providers to be present focused rather than focusing on traumatic events of the past (Kanagaratnam, Rummens, & TonerVa, 2020).

The project was informed by evaluation reports that incorporated community engagement and consultation (e.g. STARTTS, 2022). Local consultations conducted by organisations like WSLHD Multicultural Health identified the need for support of emotional distress and advice on wellbeing for these two communities. Collectively, the literature identified the importance of empowering community members through the clinic and enhancing mental health services though the addition of the clinic.

Understanding Help Seeking

Despite significant psychological distress experienced by refugee and asylum seeker populations, professional help seeking rates are low. The help seeking behaviour of these populations can be attributed to multiple factors including poor mental health literacy, cultural interpretation of mental health symptoms as well as mental health stigma (Australian Institute of Family Studies, 2022).

A longitudinal study of Afghan refugees in Australia found those more likely to seek help are older adults with higher psychological distress (Tomasi et al., 2022). While those who lived in regional Australia, not requiring an interpreter and knew how to seek government service information were less likely to seek help (Tomasi et al., 2022). A recent systematic review also revealed that help-seeking behaviour was influenced by limited finances, housing instability and specific issues related to the refugee experience (Byrow, Pajak, Specker, & Nickerson, 2020).

A study initiated by a Tamil community in Canada identified causes for scepticism of mental health services that included a fear of discrimination, and cultural beliefs about mental health attributing mental illnesses to supernatural, biological, or astrological reasons (Beiser, Simich, & Pandalangat, 2003). Therefore, it is important to understand the factors that impact help-seeking behaviours in order to develop appropriate policies and services to increase engagement by particular population groups.

Importantly, culture impacts the way the wider health system is designed and furthermore the way health professionals respond and provide services (Gopalkrishnan, 2018). This means that services and health professionals need to be continually attuned to reaching out to populations whose help-seeking behaviours vary from that of mainstream population groups (Manchikanti, Cheng, Advocat, & Russell, 2017).

Existing Mental Health Services and Treatment for Refugees and Asylum Seekers

The UNHCR strives to integrate mental health and psychosocial support in health services for refugees and advocates that mental health systems include refugees (UNHCR, 2023b). Unfortunately, scarcity of resources can be a challenge in meeting the demands for services (Silove, 2021). This can then mean constraints on what mental health services and supports can be provided. The UNHCR has identified that when there are supports available, only a small portion of the population is reached, however refugee community outreach volunteers can assist in guiding access to services (UNHCR, 2023b). Furthermore, visa status may limit access to services in some high income countries (Silove, 2021). This in turn can impact the practitioner in providing optimal mental health care for refugees and asylum seekers.

McKinney and colleagues (2007) examined the development of a culturally sensitive psychosocial model of care for survivors of torture and trauma in western countries of resettlement. Their findings were based on a clinic in north-eastern United States where they developed their treatment model, seeing individuals from various countries including Sri Lanka. They identified themes that impacted the running of the clinic, including ongoing power imbalance within the hierarchy of mental health professionals involved in the clinic, issues managing the culturalisation of care and the impact of working with populations experiencing trauma.

Internationally, there has been adaptation of services and treatment models in relation to meeting the mental health needs of individuals with refugee and asylum seeker experiences. Canadian researchers focused on the recently arrived Sri Lankan Tamil population for their study and found the holistic view of health was not taken into account by service providers but did culturally adapt their services based on their knowledge of the community (Pandalangat, 2012).

Some studies suggest that the needs of refugees and asylum seekers may not necessarily be met through the delivery of existing models of psychotherapy (Murray, Davidson, & Schweitzer, 2010). Kananian and colleagues (2020) culturally adapted cognitive behaviour therapy to support Afghan refugees in Germany. Their pilot study showed promising results with improvements in general psychopathological distress and quality of life for these individuals.

An American study identified practical supports, provider rapport and continuity of care for improved access to health care for recent refugees from Afghanistan (Reihani et al., 2021). This included the provision of interpreting to enhance the interpersonal relationship and quality of care with clinicians demonstrating empathy and compassion.

In Australia, refugees and asylum seekers have higher burden of mental health disorders like PTSD, anxiety, depression and somatisation due to difficult migration experiences and conflict in their country of origin (Khatri & Assefa, 2022). Despite the high level of need within refugee and asylum seeker communities, access to health services is poor suggesting a need for targeted program interventions (Khatri & Assefa, 2022). A clinic in Melbourne for refugees and asylum seekers found approaches including friendly staff and connecting to those with similar social and ethnic backgrounds was effective for clinical assessment of Afghan refugees (Khatri & Assefa, 2022).

A scoping review (Lester, Ryakhovskaya, & Olorunnisola, 2023) on approaches to building resilience amongst refugees in Australia highlighted the interplay of trauma, distress, help-seeking behaviour and mental health literacy. The review identifies the importance of a trauma informed approach, community engagement and culturally appropriate services that need to be specified in government policies and guidelines to improve the quality of mental health services for this population (Lester et al., 2023).

The evaluation findings for the recent Armidale Refugee Health Program (White, 2022) identified the importance of early access to allied health including mental health support. It also identified a gap in accessing specialist trauma mental health services.

Specific planning of mental health service provision was highlighted in Australian research where it was suggested that the service be co-located within health services that were specialised in refugee health given their skills at providing culturally responsive health care (Shawyer et al., 2017). Whilst other research found multicultural centres were successful in supporting young Adult Hazaras (Copolov & Knowles, 2021).

Social prescribing is a non-clinical model of health service delivery that can help address the social, emotional and practical needs of individuals, where existing health services cannot (Kellezi, Wakefield, Bowe, Bridger, & Teague, 2021). It can be used to complement clinical treatment and help address challenges that arise from socio-political stressors like loneliness and discrimination by providing social connections and empowerment. Consistent with holistic and culturally responsive approaches in addressing mental health needs, it may be a useful approach in supporting the emotional wellbeing of refugees and asylum seekers. A review of the evidence in the United Kingdom for social prescribing found frequently reported outcomes were improved self-esteem, confidence empowerment and social connectivity for their migrant communities (Zhang et al., 2021).

Understanding the evidence and existing mental health services of refugees and asylum seekers helped identify important aspects to inform the basis of the project including

culturally responsive care, trauma informed practice, interpreter service utility and adaptation of treatment based on the context and experiences of the individual.

Barriers to Accessing Australian Mental Health Services

There are substantial structural and cultural barriers experienced by CALD communities, when seeking support and accessing mental health services (Byrow, Pajak, McMahon, Rajouria, & Nickerson, 2019; Mudunna, Antoniades, Tran, & Fisher, 2022; Saberi, Wachtler, & Lau, 2021). These include poor language proficiency, stigma, mistrust, lack of transport and lack of knowledge of the health system in Australia.

Inability to communicate as a result of poor English language proficiency impacts many aspects of service provision from accessing and using to knowing a service is available (Kaplan, Stow, & Szwarc, 2016; Kheradyar & Couch, 2019). For example, the inability to communicate with reception (Cheng, Vasi, Wahidi, & Russell, 2015) and lack of access to interpreters (L. A. Smith et al., 2019) act as barriers that may further impact the wellbeing of individuals seeking support.

Many would be unfamiliar with the Australian health system which is likely to be different to the health system in their country of origin (Au, Anandakumar, Preston, Ray, & Davis, 2019). There may be distrust of Western medicine and its methods (Cheng, Wahidi, et al., 2015) while lack of interpreters, can further impact the trust individuals have in services and also cause disempowerment and loss of autonomy for the individual (Au et al., 2019). This can compound the mental health impacts of migration experiences for those who have already endured significant adverse events with negative impacts on their autonomy and control (Au et al., 2019).

Trauma is often experienced collectively, by families and communities rather than by an individual alone in refugee source countries (Kanagaratnam et al., 2020). This has implications on how receptive a person may be to mental health services, given the western mental health system is individualistic in nature.

Psychosocial stressors such as temporary housing, lack of transport, and visa status uncertainty may also act as barriers to accessing services. As mental health literacy may be low or non-existent in some communities (Daluwatta, Peiris, Fletcher, Ludlow, & Murray, 2022), prioritising services for basic needs to meet psychosocial stressors may often take priority.

Furthermore, those who may have understanding of mental health as a result of prior mental health issues, may not want to attend a service due to stigma and possible shame to their family and community (Mudunna et al., 2022). Negative health service experiences related to language and cultural differences can also impact service access (Kheradyar & Couch, 2019). Knowledge from community members on addressing mental health issues maybe preferred for support while social problems conceptualised as the aetiology of mental health issues may mean that using mental health services is not a priority over those services that can address the social issues (Antoniades & Brijnath, 2016). Additional barriers may also include the lack of suitable health professionals who may be matched to culture and language of client, long wait times for services or the cost of care in seeking and accessing mental health support (Cheng, Vasi, et al., 2015).

Barriers to accessing mental health services are likely to apply to both the Sri Lankan (Tamil-speaking) and Afghan communities. However, better understanding by health professionals of the unique impact of particular barriers on each community as well as subgroups within communities like ethnically identified Hazara community is necessary. Research that interviewed a group of refugees identified the importance of tailoring the delivery of health care to the evolving needs of both the newly arrived and established refugees (Manchikanti et al., 2017).

For example, being unaware of services, language barriers, and cultural expectations to remain at home with children as well as not being likely to access mental health support was identified in a Sydney-based study of Tamil refugee women from Sri Lanka. These challenges clearly impact their physical, social and emotional domains both in their private and public lives, including accessing mental health services (Cousens, 2003).

Enablers to Accessing Australian Mental Health Services

In contrast, factors that enable access to mental health services include availability of interpreters, cultural sensitivity and understanding cultural practises. Being understood is important in enabling refugee and asylum seeker communities to access services and seek support for mental health issues. This includes linguistic as well as cultural understanding (Slewa-Younan, Blignault, Renzaho, & Doherty, 2018). Health professionals who understand cultural practise (Rintoul, 2010), are culturally competent (Au et al., 2019) and engage interpreters (Cousens, 2003; L. A. Smith et al., 2019) in their clinical work enables access to mental health services for these communities. Cultural sensitivity including knowing what are acceptable ways of dealing with distress in different cultures (Rintoul, 2010) and an awareness of the differences in mental health services from their country of origin to Australia (Cheng, Wahidi, et al., 2015), can assist in understanding an individuals' expectations of the mental health service. Being culturally responsive is more than cultural awareness, it is about a culturally safe approach to care, where health professionals are also cognisant of the power differences and the impact this may have on health care and the engagement and interaction of the individual in front of them (Curtis et al., 2019; Indigenous Allied Health Australia).

In a study related to primary health care for refugees in a Melbourne clinic, researchers identified that the needs of refugees evolved as individuals become more established with integrated services and "refugee friendly" staff as enablers for acceptable for individuals (Manchikanti et al., 2017). Those individuals who have been longer in Australia are also more likely to attend mental health services (Mudunna et al., 2022). What is also clear in the literature is that community engagement is a meaningful and non-tokenistic factor in enabling help seeking and access to mental health services (Peterson, Ali, Kenneh, & Wakefield, 2019).

Australian research (Copolov & Knowles, 2021) with the Hazara community suggests that developing culturally sensitive interventions, like incorporating self-help strategies including religious based practices, can be effective for engagement with this group. Further, the research found a preference among these refugees for thinking and planning for the future rather than focusing on their previous trauma experiences (Copolov & Knowles, 2021). A holistic approach in alleviating distress through being culturally responsive, trauma informed and considering support in domains that include education, financial, social as well as psychological is also important (Copolov & Knowles, 2021).

A study of Afghan communities in NSW identified strategies to improve access to mental health services (Omeri, Lennings, & Raymond, 2003). These included enhancing mental health services through promoting culturally acceptable coping strategies like meditation as well as understanding that there is cultural diversity within the Afghan community and that there are different needs across the life span (Omeri, Lennings, & Raymond, 2006). Other important factors include the provision of culturally congruent and competent care, education to improve transcultural understanding of health professionals and a commitment from mainstream service providers to health as a right not a privilege for all communities (Omeri et al., 2003).

A study of Sri Lankan migrants identified that a bottom up approach was important in the engagement of this group with mental health services (Antoniades et al., 2018). Those perceived to understand mental illness in their community described as ‘compatriots’ in the article were seen as part of the social network of people supporting participants and normalising their experiences (Antoniades et al., 2018).

Models of Care and Frameworks for Refugee Mental Health Care

The foundation of models of care and frameworks for refugee mental health care requires health professionals to have empathy, provide emotional support as well as advocacy to reduce social adversity (Kronick, 2018).

One model uses a pyramidal structure to assist addressing the different level of psychosocial needs in the treatment of war affected adults and children (Kronick, 2018). Initially, basic social needs of larger populations are targeted supporting immediate safety and basic physical needs. This is followed by increasing community and family support through connection with ethnic cultural or religious communities, providing protection from isolation and discrimination. The model also highlights the importance of understanding individualised identities and affiliations as not all will feel connected to nationality or religious based communities. The next level is focused but nonspecialised support with the final level looking at a smaller proportion of persons who require specialised mental health services (Kronick, 2018). Fundamental to recovery as identified by the model was support related to immigration status, housing, employment, family reunification and reestablishment of meaningful roles.

The ADAPT model identifies five core psychosocial pillars: safety/security, bond/networks, justice, roles and identities, and existential meaning (Silove, 2013). Important in recovery, this model identifies the need for a sense of security, the impact of grief, explicit recognition of injustices, evolving roles and identities as well as the impact of existential issues (Silove, 2013).

The Multitiered Refugee Mental Health Care Model proposed by Im and colleagues (2021) is consistent with the previous models and identifies the need to fill the gap between mainstream mental health services and refugee resettlement programs. In this model multilayered supports are matched to distress levels, where trauma informed and culturally informed approaches are used within all layers. Support can range from meeting basic needs, community-based wellbeing promotion to more specialised trauma focused treatment.

An independent evaluation was conducted of the Program of Assistance for Survivors of Torture and Trauma (PASTT) to examine implementation, outcomes and economic

considerations (Abell, Carter, Davidson, Rodwell, & Tyack, 2022) of the program. Administered by state and territory based not for profit agencies, the program provides specialist services to refugees who settle in Australia. The evaluation found culturally appropriate approaches and needs-based support were as important in improving the client's wellbeing as therapeutic approaches. It also found mainstream care was not perceived to be appropriate in reading the complex needs of these populations, however there was a need to build the skills and capacity of mainstream services to respond to and care for refugees. It also found that a specialised culturally responsive and trauma informed service model, connection to community and flexibility in approach relating to how, when and which services are accessed and delivered; were defining features in the appropriateness of the PASTT service.

Targeted services during settlement is also important with five categories of psychosocial programmes with positive effects on refugee mental health and wellbeing including: trauma informed psychotherapy programs delivered with a group component, community based psychoeducation and/or health programs, physical activity and sports based programs, peer support and/or mentoring programmes as well as targeted school based programs (Australian Institute of Family Studies, 2022).

Transcultural Mental Health Centre's Emotional Wellbeing Clinic

Clinic Objectives

The Emotional Wellbeing Clinic (EWC) provided culturally responsive; trauma informed holistic care that was person centred in its approach to Afghan and Sri Lankan (Tamil-speaking) communities.

The primary objective was for individuals from the selected refugee communities in WSLHD to receive clinical and psychosocial assessment from a skilled clinician, resulting in early mental health support and timely referral to mental health services where needed. Non-Government Organisations (NGOs) funded to work with specific communities would be better able to serve their clients and have strengthened relationships with their respective NSW Health Local Health District (LHD) partners.

Clinic Governance and Relationships

The EWC objectives align with the strategic goals of the NSW Refugee Health Plan (NSW Ministry of Health, 2022). The clinic also aligns with the 2022-2025 WSLHD Multicultural Health plan's strategic priorities (2023).

The Clinic adhered to relevant and established WSLHD (2023) and NSW Health (2021). policies and procedures. The EWC was able to be platformed from the well-established TMHC services and programs, along with the skills and experience that exist within TMHC. It was supported by existing TMHC management and the WSLHD governance structure that TMHC reports through. TMHC's model of care and service wide policies, procedures and templates were also utilised with specific clinical procedures developed for operation of the clinic.

In TMHC's work with CALD communities, established links within the wider community as well as its clinical networks were utilised to engage individuals and service providers supporting refugees and asylum seekers. As shame and stigma related to mental health can prevent people from seeking mental health support and services, connection to the EWC via these services assisted linkage to these two communities.

Referrals to the EWC were possible from various agencies including NSW Refugee Health Service (RHS), NGOs in the Settlement Services International (SSI) NSW Settlement Partnership, and the Primary Health Network (PHN), the public health sector, mental health clinicians and through internal TMHC services including the Transcultural Mental Health Line (TMHL). Individuals from the specific refugee communities were also able to self-refer, ideally linked to a general practitioner or a settlement services case manager ensuring continuity of care.

Aftercare and on-referral were provided via a handover process to ensure effective linkage to the relevant private and public sector health providers including welfare or NGO support services such as the NSW Health Mental Health Community Living Supports for Refugees (MH-CLSR) program.

Assumptions and Dependencies of the Clinic

From the outset of the EWC set up there was the assumption that the selected groups will have been exposed to a range of life changing and traumatic experiences that significantly affect people's mental and physical health. Loss and grief were also seen as central issues for this group. These experiences included the loss of loved ones, separation from home, family and community, witnessing or being subject to violence and torture, gender-based violence and disruption to education.

The need for mental health and emotional wellbeing services becomes apparent after basic human needs are addressed, following settlement and when life has returned to some routine allowing mental health issues to present. Therefore, creating culturally safe environments within LHD settings is essential for people from refugee and asylum seeker backgrounds to construct meaning from suffering and finding adaptive strategies to cope with an individual's situation.

It was also recognised that while the project would initially commence in WSLHD, geographical flexibility was required as settlement locations may change over time.

Guiding tenets to enhance healthcare service for people of refugee background included:

- Clients and families from refugee communities engage more productively with a culture, language, and gender-matched clinician.
- The western constructs of psychological functioning and emotional wellbeing are not understood in some migrant and refugee communities, restricting participation in comprehensive assessment by general services.
- Diverse perceptions of the nexus of mental and physical health highlight the need for a culturally accurate approach.
- The triage process assisting persons who require public mental health care to access these services in a timelier manner.
- Clinical interventions addressing a significant gap in preventative care and pre-acute intervention for refugees and asylum seekers.
- Psychosocial intervention aiming to optimise role functioning to promote more self-sustaining lives for refugees and asylum seekers.

Emotional Wellbeing Clinic Implementation

Scope of the Clinic

The clinic was operated by the TMHC and provided free brief emotional health and wellbeing services for people with refugee and asylum seeker experiences from the Afghan and Sri Lankan (Tamil-speaking) communities who live in the WSLHD. The groups and anticipated outcome are outlined in Table 1.

In scope group	Anticipated outcome
Persons aged 18 – 65 years from Afghan community including Dari, Hazaraghi & Pashto-speaking & Sri Lankan community (Tamil-speaking) with humanitarian entrant/asylum seeker status and who have arrived in Australia in approximately the last	Improved mental health status and eliminated/diminished need for public sector mental health services in the foreseeable future.

5 years at risk of decompensation leading to need for public sector mental health intervention, but not meeting the threshold for public mental health care.	
Persons aged 18 – 65 years from Afghan community including Dari, Hazaraghi & Pashto-speaking & Sri Lankan community (Tamil-speaking) with humanitarian entrant/asylum seeker status and who have arrived in Australia in approximately the last 5 years experiencing role dysfunction due to emotional health problems who are likely to remain dysfunctional without professional intervention.	Return to constructive role functioning including gainful employment and/or family duties.

Table 1. Groups and anticipated outcomes

Table 2 outlines the exclusion criteria and anticipated outcome. These individuals were connected to more appropriate mental health services such as the TMHC's Clinical Consultation Service.

Exclusions	Anticipated outcome
Persons aged 18 – 65 years from all other language groups. Persons from Afghan community including Dari, Hazaraghi & Pashto-speaking & Sri Lankan community (Tamil-speaking) with humanitarian entrant/asylum seeker status and who have arrived in Australia in approximately the last 5 years who are receiving services from NSW Health mental health services (inpatient and community mental health).	Ensuring all individuals are linked to the appropriate source of care, including culturally responsive clinical consultation services.

Table 2. Exclusion criteria and anticipated outcome

Individuals from the in-scope groups were provided with support for their emotional distress through brief clinical intervention. This included stress management, problem-solving skills or adaptive coping strategies if the person felt distress, unable to concentrate or sleep, or too worried to work or care for their families. Advice on where to find health and psychosocial support such as community services was also offered to assist in holistic provision of care. The clinic did not assist with food, housing, visa or other legal problems but provided connection and resources to other services that would be able to assist.

Individuals identified at risk of mental ill health or had been identified in crisis or requiring longer term therapy were referred to relevant mental health services. Individuals when appropriate remained with the EWC whilst waiting to commence treatment with other service to support mental health and wellbeing in the interim and to ensure continuity of care.

The EWC was available during normal business hours from 9:00 am to 4:30 pm Monday to Friday. It attempted to fill a gap, where individuals did not meet the threshold for public mental health services (hospital or community mental health services). It served to complement existing services and worked collaboratively with the individual and their existing service providers to prevent further deterioration of wellbeing.

Services were flexibly delivered to ensure safe and suitable options based on the needs of the individual clients as well as the clinician. Initially, due to COVID restrictions, services were provided via phone or video conferencing only. With the relaxing of these restrictions within NSW Health, the clinic was available for in person sessions, utilising TMHC's clinic rooms on WSLHD's Cumberland Hospital East Campus (North Parramatta).

Initial individual sessions involved a semi-structured interview and administration of psychometric measures, the Kessler Psychological Distress Scale 10 (K10) (2003) and WHOQOL-BREF (2023) to assist in assessing the outcomes for clients. The K10 is made up of ten items and is a measure of distress focusing on symptoms related to anxiety and depression (Kessler et al., 2003). Individuals rate the items on a scale from 1 to 5, where 1 is "none of the time" and 5 is "all of the time", where higher scores indicate higher levels of distress. The WHOQOL-BREF is a measure that assesses quality of life and was developed by the World Health Organisation (2023). It is a self-reported 26-item scale requiring individuals to endorse ratings across different domains including physical health and social relationships. Higher scores identify higher perceived quality of life in the different domains. Both measures were available in translated versions. In combination, the measures aimed to provide a more holistic assessment of the outcomes for the EWC clients.

Bilingual/bicultural clinicians were available to provide in-language and culturally congruent services to individuals. However, if this was not available, professional interpreters of preferred language were available to ensure individuals were well supported to express and explain their emotional wellbeing and distress in their preferred language.

The EWC provided approximately ten sessions of clinical intervention. This was guided by the Medicare Better Access initiative that aims to support mental health care, where the number of sessions in a calendar year were limited to ten (Department of Health, 2023).

Establishing and Promoting the Clinic

In response to the literature review, the clinic was aptly named Emotional Wellbeing Clinic, underscoring holistic care and reducing potential shame around accessing mental health services, given the stigma associated with the words, "mental health". The clinic's presence was established within TMHC with a separate office space for clinic staff and a dedicated clinic telephone line and email address. TMHC's internal procedures were utilised and adapted for use in the clinic to ensure adherence to confidentiality and privacy policies. This included adaptation of TMHC's database to record the EWC as one of the services and collect transcultural mental health information. Internal referral pathways were also created to ensure appropriate services were linked into individuals contacting the EWC.

A webpage was created on the TMHC website for promotion of the EWC for greater reach and easier dissemination of information (See Figure 1). The website outlined the scope of the clinic in English but also provided downloadable translated flyers about the clinic in Dari, Pashto and Tamil (See Appendix).

Figure 1. Emotional Wellbeing Clinic website

The webpage also created an opportunity to increase mental health literacy to the specified groups with translated psychoeducation resources in Dari, Pashto, Tamil and English. These resources included practical guides about sleep hygiene, stress and stress management, which were newly developed in these languages to help support the EWC and to address the findings of the project's literature review.

In addition, guidelines in using videoconferencing software PEXIP, used internally for clinical interactions in NSW Health were translated into Dari, Pashto and Tamil. The clinic documentation and activity was captured via NSW Health's electronic medical records in accordance with ambulatory care for community mental health. Additional transcultural mental health information was captured on the TMHC database.

Through TMHC's existing connections and networks, EWC was promoted to various government, non-government and private services within the WSLHD area. This included WentWest (Western Sydney PHN), Cumberland Council, Anglicare, and SydWest Multicultural Services.

It was identified there were limited options for parents on temporary visas for psychological supports. Therefore, education institutions like TAFE, universities as well as Intensive English Centres that serviced the WSLHD were provided with information on the EWC to encourage students from the specific communities to use the service and/or to share the information with family members and others in the specific communities.

Private practices and medical centres were also focused services for promotion to provide an alternative treatment pathway for their clients who may be unable to afford private services or were on mental health waitlists. In addition, the EWC had ongoing connections with providers like the NSW RHS and SSI to ensure clinicians and case managers had opportunities to refer to the EWC where appropriate.

Given that settlement locations can change over time, EWC also worked with other LHDs in the greater Western Sydney area including the Nepean Blue Mountains LHD and South Western Sydney LHD. PHNs, relevant ethnospecific community groups and networks in these areas were also provided information on the EWC.

The promotion of the EWC was conducted via in person and videoconferencing meetings, telephone conversations and via email. It also provided an additional referral pathway for service providers to assist and support the emotional wellbeing of the two refugee communities.

Other TMHC services also shared information of the EWC as a referral pathway to enhance existing services. This included promotion by TMHC at various training and education sessions to public mental health services and NGOs, increased interest, enquiries and referrals of individuals for the EWC.

Supervision of Clinic Staff

The clinic was overseen by a clinical lead and the TMHC Manager. It was envisaged that the EWC would be staffed with a part-time bilingual social worker and a part-time bilingual psychologist based at the TMHC offices. The positions were extensively advertised on the NSW Health jobs, Seek and the Australian Psychological Society's job advertisement website, PsychXchange. In addition, the advertisements were circulated through clinical networks including universities. Student placements were also considered for postgraduate students who were bilingual. This provided opportunities to upskill aspiring clinicians within the communities and strengthen their skills and provide connection to the community. There were challenges with recruitment due to limited applications from a narrow pool of trained clinicians within the specific language and cultural groups. Therefore, several rounds of advertising for both positions ensued in late onboarding of clinicians.

In response to challenges with recruitment the clinic engaged cultural and language specific clinicians from the existing TMHC sessional clinical workforce. The TMHC sessional clinical workforce is comprised of bilingual and cultural concordant, mental health trained, qualified, registered clinicians. The sessional clinicians hold qualifications in either psychology, social work, mental health nursing and counselling backgrounds. Professional NAATI accredited interpreters from Health Care Interpreter Services (HCIS) were utilised by clinicians at times in which in-language clinicians were not available.

All clinical staff involved in the clinic were provided support and supervision by senior TMHC staff to ensure confidence in providing culturally responsive care reflecting the unique needs of the in scope groups and the particular needs of each individual. Staff new to TMHC were supported in their development with daily clinic meetings to review issues as they arose and address the unique circumstances new clinical staff may not have come across before in their clinical work. Further, opportunities for professional development were also provided to expand the clinical skills and knowledge of clinic staff.

Emotional Wellbeing Clinic Outcomes

Referrals

Referrals came from services such as the NSW RHS, SSI, Refugee Trauma and Recovery Program (RTRP) run by the University of New South Wales, and internally through other

TMHC services. Referrals were triaged confirming client consent and reviewed for risk and appropriateness for the clinic.

The reason for referrals varied with largely service providers requiring short term, or alternative mental health services for their clients, where long wait lists deemed them unavailable or had prohibitive service costs. Some were also referred due to other services being inappropriate for their clients' needs. There was also a reluctance for engagement with mental health services, having declined offer of other mental health services. The EWC provided interim support and short-term services for some individuals who were waiting for longer term psychological intervention. The EWC was also utilised to support individuals who were to be discharged from other services, but requiring ongoing short term support, maintaining treatment gains and connection to services related to aspects of daily life where no case manager was available.

Presenting issues were not necessarily described in psychological terms, often somatic symptoms like headaches, insomnia and physical pain symptoms were used to describe their difficulties with a trauma background. There were also issues related to social isolation, loneliness as well as reports of low mood, restlessness, nightmares and feeling overwhelmed. Similar to the general population, clients of the EWC presented issues related to various psychosocial concerns like family conflict, domestic violence, grief, caring and parenting issues. Stressors related to the forced migration experience was expected and reported such as housing, separation from family, and navigating the Australian health system.

Referrals were largely of individuals born in Afghanistan with a majority identifying as female, largely arriving in the last two years. Most were married, stating their religion was Islam and although all were of working age, no individuals were employed. Many were looking for work or keen to return to study at the time of referral. About half of the individuals were tertiary educated and almost all had permanent visas. A majority had a physical condition or illness that was impacting their wellbeing.

Individuals who were referred and did not meet criteria for the EWC such as speaking a different language were provided with alternative services to approach including the TMHL and STARTTS Witness to War Multilingual Telephone Helpline. In addition, those linked in with their local LHD services and our TMHC clinical consultation service would be more suitable and appropriate to meet their health needs and engagement with mainstream health services.

Enquiries by service providers was not limited to referring individuals to the clinic with requests related to accessing a psychiatrist and mental health information for other refugee communities. The awareness of the EWC created an avenue to seek information with requests also for other health services like speech therapy. These enquiries were appropriately redirected or responded to, to assist service providers in their work with communities.

Emotional Wellbeing Clinic – Clinical Services Provided

Treatment was delivered flexibly to EWC clients adapting to the needs of the individuals with most sessions run virtually via video conferencing or telephone. These sessions were provided in Dari, Hazaraghi, Pashto and Persian as well as English via bilingual clinicians or supported via interpreters. HCIS provided interpreters of the individual's preferred language

and where possible the same interpreter for the same client over a number of clinical sessions which enabled consistency of clinical care and familiarity with the EWC. Reminder phone calls in language were also conducted by HCIS on behalf of the EWC. Translated text and email messages were used via the Multicultural Health Communication Services' appointment reminder translation tool for literate clients (Multicultural Health Communication Service). These strategies assisted with all clients attending most appointments.

Most clients were seen in the last three months of the clinic and each client having on average seven sessions of approximately 60 minutes in length. The initial session was to include the administration of psychometric measures, K10 and WHOQL-BREF. However, to assist in establishing rapport and building trust with clients, the delivery of measures did not necessarily occur at the first session or subsequent sessions. Some individuals aware of the requirements in attending health services were amenable to completing the shorter scale, K10. For clients who were illiterate, translated versions of the measures were administered with the assistance of an interpreter . The WHOQOL-BREF was not administered to all clients as it was more time consuming due to the length of the measure and because clients had more immediate psychosocial issues to resolve.

The results of the K10 were mixed across the group with some showing ongoing distress with no deterioration on discharge and others showing reduction in distress. Not captured in the K10 were reports of reduced tension, nervousness and restlessness as well as improved concentration and identified usefulness in implemented wellbeing strategies.

Generally, clients had increased mental health literacy through resources provided and sessions conducted. Tools and strategies to support their emotional wellbeing were also provided and practiced in session. Most clients seen by the clinic were provided with translated copies of written mental health resources related to sleep hygiene and stress management to support psychoeducation provided in session. In addition, clients were also provided audio visual links to videos related to strategies like progressive muscle relaxation in language as an alternative to those who were not literate or preferred this mode of information learning. Social prescribing was an important aspect of treatment to help reduce isolation and improve social connection through encouragement of meeting friends in the local park as well as suggesting contact with ethnospecific and religious groups in their local area.

Contact with their general practitioners, identified support of individuals in engaging in life goals and requesting EWC clinicians to encourage their clients to return to their general practitioners for ongoing support.

Discharge from the Clinic

In addition to short term psychological intervention clients were also referred to community service providers to assist them in other aspects of their lives such as the Muslim Women Australia, Refugee Advice and Casework Service, Perinatal Anxiety and Depression Australia and St Vincent de Paul Society.

Due to the level of psychological distress presented by some clients, individuals were linked to STARTTS or public mental health services. Clients who were still with the clinic at the time of closure were also referred to the local MH-CLSR program to ensure ongoing support with their settlement.

Following support via the EWC some clients indicated that they did not require follow on trauma focussed mental health services. Some also indicated that they did not want to dwell on the past.

Emotional Wellbeing Clinic Reflections

The EWC was an opportunity to learn about how best to provide mental health services to individuals who have refugee and asylum seeker experiences. The unique position of TMHC having readily available experienced clinical staff who were bicultural and bilingual as well as the capacity to develop translated material to promote and support the EWC. Having an experienced team that was culturally responsive, trauma informed and person centred is only the foundation of what was necessary to run the EWC. The EWC also required staff to take an ecological approach and be holistic; understanding that emotional wellbeing is more than clinical intervention. Combined with psychological strategies, social prescribing as well as connection to community services and social networks was fundamental in the overall wellbeing of the clients.

Flexibly Delivered Culturally Responsive Clinical Services

The EWC provided both culturally congruent and cross-cultural services to individuals. The clinic employed clinicians and worked together with experienced bilingual sessional clinicians to support the service.

The use of professional interpreters requires additional coordination of the interpreter service, client and clinician. Despite this, professional interpreters provided culturally rich information that informed communication and clinical discussions, reduced clinical risks, minimised miscommunication and supported overall clinical care.

The literature also identified patient satisfaction (Kwan, Jeemi, Norman, & Dantas, 2023) and quality of service (Crossman, Wiener, Roosevelt, Bajaj, & Hampers, 2010) was no different when they were provided by a clinician who utilise a professional interpreter versus a bilingual clinician. The EWC demonstrated that services could be provided inter and intra culturally to newly arrived individuals from refugee and asylum seeker backgrounds when communication is appropriately supported with professional interpreters.

Establishing electronic medical records for new clients required identification paperwork which was not always readily available due to various reasons including virtual sessions via telephone. Requests for identification paperwork may re-traumatise individuals who have had adverse events with authorities in the past, impacting engagement with the service. The lack of trust may negatively impact engagement with services (Au et al., 2019). Providing longer sessions was therefore necessary to allow establishment of rapport, explanation of services to empower and provide autonomy, allowing control in choice of options to clients. This included informed consent in referral to other services and sharing of their information.

Initial contact and sessions were spent establishing rapport and trust through time spent explaining the purpose of the EWC, the roles of clinic staff and reasons for their referral to the clinic. Further, to build trust and rapport, there was a need to run sessions flexibly based on individuals' priorities balanced against protocols and procedures in conducting a mental health assessment and intervention.

Utilising psychometric measures were difficult at times, particularly when sessions were conducted virtually and/or through interpreters and when literacy levels were low. There are known limitations in the use of such measures which can bring about false positives in populations like refugees, where trauma related disorders can differ from other populations with PTSD and where suffering is viewed from a medical lens (Kronick, 2018). Although, clients appeared amenable to following procedures in line with clinical requirements, such as completing consent forms and psychometric measures. Therefore, psychometric measures were completed once the therapeutic relationship was established, and time available to complete them at their pace. Results from the measures often provided supportive evidence to information discussed via interview.

Completing alternative psychometric measures or using a qualitative measure to identify outcomes for wellbeing success may be more useful. Although the measures used were appropriate for the needs and all clients attended more than one session, given the clinic was short term in nature, a brief in-session tool related to treatment outcomes and experiences may have worked more effectively. Tracking a client's wellbeing and the quality of the therapeutic alliance of each session may provide prompt feedback on the fit of the clinician and treatment of the individual. This alternative option may be more helpful given the importance of the therapeutic alliance with refugees and asylum seekers (Mahon, 2020).

The clinic highlighted the importance of having an alternative flexible mental health service to support short term mental health needs whilst individuals navigate settlement. It underscored the value of connecting and reinforcing the different services including clinical mainstream health services, long term mental health services and community based psychosocial work as discussed in the literature for Afghan communities (Alemi et al., 2023).

Research acknowledges that the number of refugees and asylum seekers are likely to rise with increasing conflict in a number of countries causing forced displacement, resulting in increased mental health issues and pressures of providing more mental health services across the world (Alemi et al., 2023). Addressing somatic symptoms, acknowledging the social context of the distress rather than medicalising the suffering was important in the EWC and consistent with the literature regarding working with Afghan communities and supporting mental health needs (Alemi et al., 2023). Focusing on strengthening individual's capacity to manage stress and support themselves and their family help build autonomy and control over their emotional wellbeing.

The proposed multitiered model of care (Im et al., 2021) for individuals with refugee and asylum seeker experiences, appeared consistent with the EWC which attempted to fill the gap between mainstream mental health services and refugee resettlement programs. The clinic was able to complement and supplement existing services. By providing short term individual therapy, it supported those waiting for services for longer term and specialist therapy as well as those who were requesting engagement with social or wellbeing groups.

Holistic Emotional Wellbeing Care

Clients engaged with the clinic who were well linked into community services and social networks allowed sessions to focus on more traditional and structured approach to counselling and therapy. Given the complex presentations with trauma backgrounds, emotional regulation strategies were also necessary to support the individuals. However, from the outset, it was clear that a flexible and semi-structured approach to working with refugee and asylum seekers was more appropriate and promoted trust and storytelling.

In addition to physical and psychological needs, most clients presented with a range of situational and contextual needs like housing, financial, and legal (e.g. visa issues, sponsorship of family overseas, fines). Addressing immediate and tangible needs was often required before addressing psychological health needs. This assistance with immediate and tangible needs may alleviate the psychological issues. The short-term nature of the clinic impacted the completion of service for some clients but others were referred to appropriate services for ongoing psychosocial care.

Newly arrived refugees and asylum seekers also have competing demands in settlement, related to housing, finances and adjustment to many aspects of life. Engaging flexibly with clients through delivering sessions and communicating with them around these competing demands and constraints was helpful to meeting their needs and their attendance at sessions. Further, active follow up of clients helped manage non-attendance and lack of response from clients, maintaining established therapeutic relationships. Often clinic staff persevered with communication, trying several avenues to contact individuals allowing space and time to explain. Discussions ensued with open communication around how best to meet their needs and priorities.

Flexible delivery was not limited to mode and duration of sessions but also timing where sessions would occur every one to four weeks to work around the clients' other commitments like English classes. It also included individuals bringing children to sessions where care was not available or allowing sessions to run in different spaces like walking outdoors or in cars for privacy, always ensuring consent and understanding from the individual about the limits of privacy. Clients were aware of the impact of their children in session and contingencies were employed to have them leave the room or alter discussions based on the presence of the children.

It was also identified that some clients were not keen to engage with ethnospecific cultural groups and declined connection to those community networks. Some were hesitant to provide consent on some services and this was respected. Further, engagement with clinicians provided opportunities for some clients to improve their English skills with the support of the interpreters present.

Service Connection

At times, it can be expected that the settlement sector would be aware of all services available to refugees and asylum seekers. However, through the EWC, it became clear that across the settlement sector, not all service providers were aware of the diversity of services that could be offered to individuals. To ensure all aspects of care were covered for clients, service providers were supported through linkage with other services and/or provided information about accessing services for their clients. This identifies the importance of the TMHC's Capacity Building Mental Health Program for New and Emerging refugee populations, where a link can be maintained with community and direct mental health services such as the TMHL.

Working collaboratively with settlement case managers to ensure psychosocial needs were met, whilst working with mainstream health services to meet the health needs of individuals was essential to reduce the negative impact on the individual's overall emotional wellbeing. The unique space that TMHC provided the EWC meant gaps in communication and clinical care could be closed to assist individuals in their overall health care. Relinking individuals and services due to barriers of language, misunderstanding of the purpose of services as

well as ensuring connection to local health services in collaboration with NSW RHS was also a key role of the EWC.

Clinician Experiences

Working collaboratively with clients and learning about their forced migration experience meant clinicians were listening to unique stories that could be highly distressing. Clinicians required skills to regulate their own emotions, know their triggers, their vulnerabilities and have the tools to support themselves. Being able to have space to reflect and clinically discuss how best to support clients holistically as a team was particularly important in providing care within the EWC.

Furthermore, clinicians remained aware of the power differences between themselves and the individuals seen and were acutely aware of possible tendencies of clients to agree to requests despite not necessarily agreeing. However, a trauma informed approach with culturally responsive care provided individuals opportunities to be empowered and were supported to have agency through explanation of service and action conducted within sessions. The use of mental health peer workers or community members with experience in mental health from within communities, in conjunction with skilled clinicians should also be explored in future work as such partnerships will likely be effective in engaging communities. This harnesses the community based and social aspect of mental health advocated in providing effective and sustainable mental health care (Alemi et al., 2023).

Future Directions

Although, the clinic was time limited and has closed, the clinic has provided connection for the specific groups to TMHC and its services and programs. Through accessing the EWC individuals became aware of TMHC services like the TMHL and web-based information in their language. Mental health literacy can be particularly low among newly arrived refugee communities, while stigma around mental illness can be high. Sleep and stress are issues that affect the mental health and wellbeing of newly arrived communities, but which hold less stigma than mental illness. By introducing mental health issues through resources about sleep and stress the EWC also increased mental health literacy in a practical and acceptable manner for the intended audience. Sustainability of the EWC work can be seen through the newly translated mental health resources for these communities, increased awareness of the TMHL as an option for culturally responsive mental health service for CALD communities including migrant and refugees.

The importance of the TMHC's Capacity Building Mental Health Program for New and Emerging refugee populations has been highlighted and will be continued in both its community and clinical components. Community engagement focusing on the Afghan and Sri Lankan (Tamil-speaking) communities through mental health literacy presentations of services. Clinical capacity building of clinicians on providing culturally responsive mental health care as well as clinical supervision given the risk of vicarious trauma and burnout in working with individuals who have trauma experiences.

Lessons Learned

The project limitations include 2-year funding which coincided with the COVID-19 pandemic period. This meant the clinic was restricted at the start in its ability to promote and conduct

the clinic's services in person which in turn restricted the ability to hire appropriate staff and then engage and connect with the specific communities.

The project was also constrained by the challenges of identifying and appointing employees with relevant bilingual and transcultural mental health clinical and community skills further challenged during COVID-19 period. To respond to this the TMHC was fortunate to be able to utilise available sessional clinicians to support the running of the clinic. The project highlighted the benefits of having an available transcultural mental health sessional clinical pool that can be used as required.

The clinic had also been developed for Sri Lankan (Tamil-speaking) community members who may be unable to access free mental health services due to the conditions of their temporary visas. This community did not engage with the EWC. Time may have been needed to build trust in a new and unknown service within the community further exacerbated by covid restrictions. Engagement may have been influenced by the existence of pre-existing familiar services, albeit servicing different needs. (Samuel, Advocat, & Russell, 2018). The pre-migration experiences including adverse events with authorities as well as immigration related fears like deportation may have created fear of government-based organisations like the EWC, when permanency of residency in Australia is unknown (Munro, Jarvis, Munoz, D'Souza, & Graves, 2013). The building of trust over short term would be difficult with the likely multilayered and complex issues for this community in accessing the service. More research into engaging asylum seekers is warranted to learn more about how best to engage this population in accessing mental health services.

Research from Melbourne identified the acceptability of services through bilingual workers using culturally grounded interventions (Samuel et al., 2018). Further, Antoniades and colleagues found social networks within cultural and ethnic communities as influential in help seeking for mental health amongst Sri Lankan migrants. Therefore, unsuccessful attempts to employ a bilingual worker from the Sri Lankan (Tamil-speaking) community within the clinic may have added to the impact of poor engagement of the EWC with this community. Interestingly, the Tamil translated clinic flyer was downloaded from the website almost as many times as the other flyers. This possibly indicates interest in the clinic but the stigma of mental health discussed may have hindered accessing services.

Alternatively, the level of English proficiency may have impacted access of the EWC where the clinic promoted the bilingual/bicultural nature of the clinic. About 80% of Sri Lankan (Tamil-speaking) individuals living in WSLHD who arrived in approximately the last ten years speak English very well or well compared to about 63% of those born in Afghanistan (ABS, 2021b). Therefore, individuals may have considered other options for treatment given language may not have been a barrier for services.

The EWC's location at TMHC on WSLHD's Cumberland Hospital East Campus (North Parramatta) proved difficult for some clients attending in person and having to use public transport. Maps with directions and photos of the building were provided prior to the appointments but some difficulties still arose. Further, navigating the campus even with a car can be difficult. However, the option to attend in person for some clients was helpful in providing an opportunity to leave home on a regular basis and engage in some physical activity as attested to by one client and others could opt for sessions to be conducted virtually to overcome this.

The clinic was initially set up to only service WSLHD and overtime it also served some clients residing on the outskirts of WSLHD, i.e., South Western Sydney, so services should consider expanding boundaries to meet the needs of these specific communities if required.

Conclusions

Services that provide holistic care and consider the unique needs of the person and their family are likely to best service individuals with refugee and asylum seeker backgrounds. The flexible delivery of clinical services has allowed better engagement and outcomes for clients who attended the clinic. It improved mental health literacy and familiarity with Australian mental health services for these individuals. The short-term nature of the clinic has meant limited ability to provide longer term mental health care however it has identified the importance of meeting the situational and contextual needs of the client to support improvement in their emotional wellbeing. The clinic attempted to fill a gap, providing an alternative service for individuals who were future focused or declined trauma related mental health services. It also was successful in connecting people to trauma related mental health services when this was required. Reach may be improved by embedding a future TMHC EWC into existing and established services like NSW RHS and working with ethnospecific cultural groups to provide outreach mental health services within the community. Providing integrated care for communities within mainstream health services as well as community-based organisations continues to be the most helpful way to help settle our newest Australians.

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Appendix

TMHC Emotional Wellbeing Clinic Flyers

1) English – Long version
2) Dari – English
3) Pashto – English
4) Tamil - English

Transcultural
Mental Health Centre

Appendix 1

Transcultural Mental Health Emotional Wellbeing Clinic for

Refugees and Asylum Seekers from Afghan and Sri Lankan Tamil Communities

Free brief emotional health and wellbeing services are available for people with refugee experience and asylum seekers from the Afghan and Sri Lankan Tamil communities who live in the Western Sydney Local Health District.

The Clinic is operated by the Transcultural Mental Health Centre to support people who:

- Have refugee-like experiences from Afghanistan or Sri Lanka
- Are seeking asylum within Australia
- Are within the 18 – 65 age group
- Live in the Blacktown, Cumberland, Hills Shire or Parramatta Local Government Areas.

Clinicians are available from 9:00 am to 4:30 pm Monday-to-Friday to provide in-language help for emotional distress and provide advice on where to find health and psychosocial support, such as a General Practitioner and community services.

Callers will be offered brief clinical intervention such as stress management, problem-solving skills, or positive coping strategies if they feel distressed, are unable to concentrate or sleep, or are too worried to work or care for their family. Clinical services and information about where to get help for the practical concerns of life will primarily be provided online via secure video link.

The Clinic *cannot* assist with food, housing or visa and other legal problems. The Clinic can give advice on where to find resources and connect people with others from their community and supportive organisations.

To contact the Clinic, telephone 9840 4020 from 9:00 am to 4:30 pm Monday to Friday

The clinic is NOT a crisis service

Emergencies and urgent referrals should contact 000 or the Mental Health Line 1800 011 511

The emotional wellbeing of people with refugee and asylum-seeker experience may be overlooked when prioritising the basic needs of life. Early intervention by clinicians who speak a relevant language can assist recovery and help ensure that emotional difficulties do not escalate. The Clinic will offer strategies to build the ability to cope as well as help to decrease stressors such as isolation and poor mental health literacy. It will use evidence-based intervention to assist individuals to function better in their everyday lives and allow them to fulfill work and family obligations.

The Clinic works collaboratively with other agencies, such as the NSW Refugee Health Service, Settlement Services International and non-government organisations.

Webpage: www.dhi.health.nsw.gov.au/TMHC/EmotionalWellbeingClinic

Transcultural
Mental Health Centre

Appendix 2

Dari

کلینیک سلامت عاطفی برای افراد از جوامع

افغان و تامیل

خدمات مختصر سلامت عاطفی و رفاه برای افراد از جوامع افغان و تامیل که تجربه پناهندگی و پناهجوی دارند و در مناطق دولت محلی بلک تاون (Blacktown)، کمبرلند (Cumberland)، هیلزشایر (Hills Shire)و پاراماتا (Parramatta) زندگی مینمایند، در دسترس است.

این کلینیک توسط مرکز صحت روانی بین فرهنگی اداره میشود و برای افراد زیر باز خواهد بود:

- افراد از افغانستان یا سریلانکا که تجربیات مشابه به تجربه افراد پناهنده دارند;
- افرادیکه در جستجوی پناهندگی در آسترالیا هستند;
- آنهای که بین ۱۸ الی ۶۵ سال عمر دارند;
- افرادیکه درمناطق دولت محلی بلک تاون (Blacktown)، کمبرلند (Cumberland)، هیلزشایر(Hills Shire) و پاراماتا (Parramatta) زندگی مینمایند

داکتران دوزبانه برای پریشانی عاطفی کمک نموده و برای پیدا نمودن خدمات حمایتی مناسب از قبیل داکتران عمومی یا خدمات اجتماعی معلومات ارائه مینمایند.

در صورت که تماس گیرینده ها احساس اضطراب داشته باشند، نتوانند تمرکز کنند، یا نتوانند بخوابند، خیلی پریشان باشند که نتوانند کار کنند یا از خانواده خود مراقبت کنند، یا ضرورت به مشاوره در باره اینکه از کجا برای نگرانی های عملی زندگی کمک بگیرند، خدمات مختصر برای شان ارائه خواهد شد.

این کلینیک در قسمت مشکلات مواد غذایی، خانه، ویزه یا مشکلات دیگر حقوقی نمیتواند کمک نماید. این کلینیک در قسمت پیدا کردن منابع میتواند مشوره بدهد ومیتواند افراد را در قسمت برقراری ارتباط شان با افراد دیگر از اجتماع شان و سازمان های کمک کننده همکاری نماید.

برای تماس به کلینیک، به شماره ۹۸۴۰ ۴۰۲۰ زنگ بزنید.

ساعات کاری کلینیک از ساعت ۹ صبح الی ۴:۳۰ بعد از ظهر، در روزهای دوشنبه الی جمعه میباشد.

Transcultural
Mental Health Centre

Emotional Wellbeing Clinic for People from the Afghan and Tamil Communities

Free brief emotional health and wellbeing services are available for people from the Afghan and Tamil communities who have refugee and asylum seeker experiences and live *in the Blacktown, Cumberland, Hills Shire or Parramatta Local Government Areas*.

The Clinic is operated by the Transcultural Mental Health Centre and will be open for people:

- From Afghanistan or Sri Lanka who have refugee-like experiences;
- Seeking asylum within Australia;
- Are 18 – 65 years of age;
- Live in the Blacktown, Cumberland, Hills Shire or Parramatta Local Government Areas.

Bilingual clinicians will provide help for emotional distress and provide advice on where to find appropriate support, such as a General Practitioner or community service.

Callers will be offered brief intervention if they feel distressed, are unable to concentrate or sleep, are too worried to work or care for their family or need advice about where to get help for the practical concerns of life.

The Clinic cannot assist with food, housing or visa and other legal problems. The Clinic can give advice on where to find resources and connect people with others from their community and supportive organisations.

To contact the Clinic, telephone 9840 4020.

Clinic hours are Monday to Friday from 9:00 am to 4:30 pm.

Transcultural
Mental Health Centre

Appendix 3

Pashto

د دري، پښتو او تامیل ټولنو خلکو لپاره د احساساتي روغتیا کلینیک

د دري، پښتو او تامل ټولنو د خلکو لپاره وړیا لنډ د احساساتي روغتیا او هوساینې خدمتونه شتون لري څوک چې د کډوالۍ او پناه غوښتونکي تجربې لري او په ، بلیک ټاون (Blacktown)، کمبرلند (Cumberland)، هیلز شایر (Hills Shire)، او پارامتا (Parramatta) سیمه ایزو حکومتي سیمو کې ژوند کوي.

دا کلینیک د څو کلتوري رواني روغتیا مرکز لخوا پرمخ وړل کیږي او د خلکو لپاره به پرانیستی وي:

- له افغانستان یا سریلانکا څخه چې د کډوالۍ په څیر تجربې لري
- په استرالیا کې د پناه غوښتنې په لټه کې وي؛
- له 18 څخه تر 65 کالو پورې عمر ولري.
- په بلیک ټاون (Blacktown)، کمبرلند (Cumberland)، هیلز شایر (Hills Shire) او پارامتا (Parramatta) سیمه ایزو حکومتي سیمو کې ژوند کوي.

دوه ژبیز ډاکټران د احساساتي اضطراب په کمولو کې مرسته کوي او مشوره ورکوي چې چیرې مناسب مالاتړ وموميي، لکه یومتخصص یا ټولنیز خدمتونه.

زنګ وهوونکو ته به د لنډ وساطت وړاندیز وشي که دوی د خپګان یا نارامۍ احساس وکړي، د تمرکز کولو یا خوب کولو توان نلري، د کار کولو یا د خپلې کورنۍ پاملرنې لپاره ډیر اندیښمن وي، یا مشوري ته اړتیا لري چې د ژوند د عملي اندیښنو لپاره چیرته مرسته تر لاسه کړي.

کلینک نشي کولی د خوراک، کور یا ویزې او نورو قانوني ستونزو په اړوند مرسته وکړي.

کلینیک کولی شي مشوره ورکړي چې چیرې سرچینې وموميي او خلک د دوی د ټولنې او ملاتړ کوونکو سازمانونو سره وصل کړي.

کلینیک ته د اړیکې ټینګولو لپاره، دې شمیرې 4020 9840 ته زنګ ووهئ.

د کلینیک ساعتونه د دوشنبې څخه تر جمعې پورې د سهار له 9:00 بجو څخه تر مازدیګر 4:30 بجو پورې دي.

Transcultural
Mental Health Centre

Emotional Wellbeing Clinic for People from the Afghan and Tamil Communities

Free brief emotional health and wellbeing services are available for people from the Afghan and Tamil communities who have refugee and asylum seeker experiences and live *in the Blacktown, Cumberland, Hills Shire or Parramatta Local Government Areas*.

The Clinic is operated by the Transcultural Mental Health Centre and will be open for people:

- From Afghanistan or Sri Lanka who have refugee-like experiences;
- Seeking asylum within Australia;
- Are 18 – 65 years of age;
- Live in the Blacktown, Cumberland, Hills Shire or Parramatta Local Government Areas.

Bilingual clinicians will provide help for emotional distress and provide advice on where to find appropriate support, such as a General Practitioner or community service.

Callers will be offered brief intervention if they feel distressed, are unable to concentrate or sleep, are too worried to work or care for their family or need advice about where to get help for the practical concerns of life.

The Clinic cannot assist with food, housing or visa and other legal problems. The Clinic can give advice on where to find resources and connect people with others from their community and supportive organisations.

To contact the Clinic, telephone 9840 4020.

Clinic hours are Monday to Friday from 9:00 am to 4:30 pm.

Transcultural
Mental Health Centre

Appendix 4

டாரி, பாஷ்டோ மற்றும் தமிழ்ச் சமூகங்களைச் சேர்ந்த மக்களுக்கான

உணர்ச்சி ரீதியான நல்வாழ்வுச் சிகிச்சை நிலையங்கள்

அகதி மற்றும் புகலிடக் கோரிக்கையாளர் எனும் அனுபவங்களைக் கொண்ட, அத்துடன் *Blacktown, Cumberland, Hills Shire, மற்றும் Parramatta உள்ளூர் அரசாங்கப் பகுதிகளில்* வசிக்கும், டாரி, பாஷ்டோ மற்றும் தமிழ்ச் சமூகங்களைச் சேர்ந்த மக்களுக்கு, இலவசமான மற்றும் சுருக்கமான உணர்ச்சி ரீதியான ஆரோக்கிய மற்றும் நல்வாழ்வுச் சேவைகள் கிடைக்கின்றன.

இந்தச் சிகிச்சை நிலையமானது, Transcultural Mental Health Centre (கலப்புப் பண்பாடு மனநல மையம்)-ஆல் இயக்கப்படுகிறது மற்றும் பின்வரும் மக்களுக்காக இது திறந்திருக்கும்:

- அகதி போன்ற அனுபவங்களைக் கொண்ட, ஆப்கானிஸ்தான் அல்லது இலங்கையிலிருந்து வருவோர்;
- ஆஸ்திரேலியாவிற்குள் தஞ்சம் கோருவோர்;
- 18 - 65 வயதுடையோர்;
- Blacktown, Cumberland, Hills Shire, மற்றும் Parramatta உள்ளூர் அரசாங்கப் பகுதிகளில் வசிப்போர்.

இருமொழிகளைப் பேசக்கூடிய மருத்துவர்கள், உணர்ச்சி ரீதியான கஷ்டங்களுக்கு உதவி வழங்குவார்கள் மற்றும் பொது மருத்துவர் (ஜி.பி) அல்லது சமூக சேவை போன்ற பொருத்தமான ஆதரவுதவியை எங்கே பெறுவது என்பது குறித்த ஆலோசனைகளையும் வழங்குவார்கள்.

மன உளைச்சலுக்கு ஆளாதல், கவனம் செலுத்த முடியாமல் அல்லது தூங்க முடியாமல் இருத்தல், வேலை செய்ய அல்லது தங்கள் குடும்பத்தைக் கவனித்துக்கொள்ள இயலாத அளவிற்கு மிகவும் கவலைப்படுதல், அல்லது வாழ்க்கையின் நடைமுறைக் கவலைகளுக்கு எங்கு உதவி பெறுவது என்பது பற்றிய ஆலோசனை தேவைப்படுபவர்களாக இருத்தல், ஆகிய நிலையிலுள்ள தொலைபேசி அழைப்பாளர்களுக்கு சுருக்கமான தலையீட்டு உதவி வழங்கப்படும்.

உணவு, வீட்டுவசதி அல்லது விசா மற்றும் பிற சட்டச் சிக்கல்களுக்கு இந்த சிகிச்சை நிலையத்தால் உதவ முடியாது. மூலாதாரங்களை எங்கு தேடுவது என்பது பற்றிய ஆலோசனையையும், குறித்த நபர்களின் சமூகத்தைச் சேர்ந்த மற்றவர்களுடனும் ஆதரவுதவி வழங்கும் நிறுவனங்களுடனும் மக்களை இணைப்பது குறித்த ஆலோசனையையும் இந்த சிகிச்சை நிலையத்தால் வழங்க முடியும்.

சிகிச்சை நிலையத்துடன் தொடர்பு கொள்ள 9840 4020 என்ற எண்ணை அழைக்கவும். சிகிச்சை நிலைய நேரம், திங்கள் முதல் வெள்ளி வரை காலை 9:00 மணி முதல் மாலை 4:30 மணி வரை ஆகும்.

Transcultural
Mental Health Centre

Emotional Wellbeing Clinic for People from the Dari, Pashto and Tamil Communities

Free brief emotional health and wellbeing services are available for people from the Dari, Pashto and Tamil communities who have refugee and asylum seeker experiences and live *in the Blacktown, Cumberland, Hills Shire and Parramatta Local Government Areas*.

The Clinic is operated by the Transcultural Mental Health Centre and will be open for people:

- From Afghanistan or Sri Lanka who have refugee-like experiences
- Seeking asylum within Australia;
- Are 18 – 65 years of age;
- Live in the Blacktown, Cumberland, Hills Shire and Parramatta Local Government Areas.

Bilingual clinicians will provide help for emotional distress and provide advice on where to find appropriate support, such as a General Practitioner or community service.

Callers will be offered brief intervention if they feel distressed, are unable to concentrate or sleep, are too worried to work or care for their family, or need advice about where to get help for the practical concerns of life.

The Clinic cannot assist with food, housing or visa and other legal problems. The Clinic can give advice on where to find resources and connect people with others from their community and supportive organisations.

To contact the Clinic, telephone 9840 4020.

Clinic hours are Monday to Friday from 9:00 am to 4:30 pm.

www.dhi.health.nsw.gov.au/tmhc