



Submission from the

Forum of Australian Services for Survivors of Torture and Trauma

to the

Productivity Commission Inquiry into the Social and Economic Benefits to Improving Mental Health

The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) welcomes the opportunity to contribute to the Productivity Commission's Inquiry into the Social and Economic Benefits to Improving Mental Health.

This submission has two parts.

Part 1 – describes the FASSTT networks and its member services

Part 2 – responds to those questions raised by the Inquiry which sit within FASSTT's remit.

PART 1

FASSTT SERVICE "USER" CHARACTERISTICS

What is FASSTT

FASSTT is the national representative body of Australia's eight, not-for-profit, torture and trauma rehabilitation and support agencies (one in each state and territory). FASSTT agencies respond to the needs of survivors of torture and trauma who have come to Australia as refugee or humanitarian entrants. FASSTT agencies are listed in APPENDIX 1.

FASSTT agencies assist survivors to recover and rebuild their lives after having been tortured and traumatised in their countries of origin, while in flight, or during their stay in refugee camps. This is achieved by:

- providing high level specialist trauma counselling and casework services and facilitating referrals into mainstream health and educational services (for example, early intervention programs with children and adolescents to minimise longer term mental health problems and the trans- generational effects of torture and trauma);
- increasing the capacity of mainstream health, community and educational sectors to be more responsive to the needs of refugees and survivors of torture and trauma;
- training and consulting with other service providers (e.g. doctors, allied health professionals, community workers, teachers);
- producing resources for health, community and educational services about working with refugees and survivors of torture and trauma (for example, resource guides for general practitioners and primary health care workers, guides for group work with primary and secondary age children and young people);
- developing innovative programs for assisting clients and the community (for example, establishing mental and physical health clinics, undertaking group work with clients, conducting research, working in schools);

- building the capacity of newly arrived communities to integrate more effectively into Australian society.

Many clients have spent lengthy periods in refugee camps or in otherwise displaced circumstances. Most have lost family members in violent circumstances and some have been subjected to torture including rape, beatings, electric shock, sleep deprivation and mock executions. Our clients' experiences have impacted on them in a range of ways. These can include difficulties in concentrating, sleeplessness, nightmares, fear and anxiety, flashbacks and intrusive memories, and somatic responses such as severe headaches and musculoskeletal pain.

In the 12-month period 2017 – 2018, FASSTT member agencies provided psychological support to more than 18,000 individuals who have arrived in Australia under from refugee backgrounds. They came from more than 100 countries. More than 70% of people using FASSTT services require the support of an interpreter.

FASSTT agencies have been delivering services to survivors of torture and trauma and to other services for more than 30 years. They are regarded as expert specialists both nationally and internationally. FASSTT agencies are all not-for-profit organisations and receive funding from State and Federal Governments, philanthropic trusts and private donations. FASSTT agencies are also the principal contractors to the Department of Health (DoH) to provide services under the Program of Assistance for Survivors of Torture and Trauma (PASTT). This program provides services to torture and trauma survivors at any time after their arrival in Australia and allows for medium–long term psychosocial interventions.

PASTT funding is also used to build the capacity of other service providers to respond to the needs of survivors of torture. As such FASSTT is committed not only to the provision of services to refugee survivors of torture and trauma but also to building their capacity to access relevant services and enhancing social capital of refugee families and communities through community capacity building interventions.

The unique context of FASSTT

Torture ¹ has a specific definition and methods of torture are well documented². A recent estimate by the Centre for Victims of Torture (2015) based on a literature review and a subsequent meta-analysis suggests that close to 45% of refugees in the US have survived torture³. Many refugees have experienced other traumatic events in countries of origin, during flight and in transit countries. Research suggests survivors of torture are a particularly vulnerable group for health disorders of different kinds⁴. FASSTT member agencies provide a specialist service response to refugee survivors of torture and trauma. The rationale for a specialist service is not only the prevalence of mental health concerns associated with the legacy of the refugee experience but also their vulnerability in the course of settlement at an individual family and community level.

The majority of FASSTT clients have physical and mental health problems related directly to torture experiences or trauma associated with their refugee experience. For example, the most recent report to the Department of Health from FASSTT indicated that 70% of clients assessed by FASSTT services in the past 12 months (with PASTT funding) exhibited psychological sequelae of trauma to a significant degree. International clinical studies support the finding that refugees have high prevalence rates of mental health problems, significantly greater than the rates among the general population.^{5 6} In other words, FASSTT member agencies provide bio-psychosocial support to refugees and asylum seekers who are profoundly traumatised and whose recovery must develop essentially in a place of exile where systems, language, culture and identity all need to be renegotiated.

Client profiles and characteristics

Refugees and asylum seekers, particularly survivors of torture and trauma, have specific needs to which mental health service systems should have regard. These needs arise from the fact that their circumstances are commonly characterised by the following:

¹ Torture is the intentional infliction of severe mental or physical pain or suffering by or with the consent of the state authorities for a specific purpose. It is often used to punish, to obtain information or a confession, to take revenge on a person or persons or create terror and fear within a population. Some of the most common methods of physical torture include beating, electric shocks, stretching, submersion, suffocation, burns, rape and sexual assault. Psychological forms of torture and ill-treatment, which very often have the most long-lasting consequences for victims, commonly include: isolation, threats, humiliation, mock executions, mock amputations, and witnessing the torture of others.

² IRCT <http://www.irct.org/what-is-torture/defining-torture.aspx>

³ C. Higson-Smith, 'Updating the Estimate Of Refugees Resettled In The United States Who Have Suffered Torture ', The Center for Victims of Torture, https://www.cvt.org/sites/default/files/SurvivorNumberMetaAnalysis_Sept2015_0.pdf

⁴ UNHCR, *Refugee resettlement: an international handbook to guide reception and integration*, UNHCR and VFST, Melbourne, 2002, p233.

⁵ K Allden, Paper presented to the International Conference for the Reception and Integration of Resettled Refugees, Sweden, 2001.

⁶ C Gorst-Unsworth and E Goldenberg, 'Psychological sequelae of torture and organised violence suffered by refugees from Iraq: trauma related factors compared with social factors in exile', *British Journal of Psychiatry*, vol. 172, 1998, pp90-94; MA Simpson, 'Traumatic stress and the bruising of the soul' in J P Wilson and B Raphael (eds), *International Handbook of Traumatic Stress Syndromes*, Plenum Press, New York, 1993, pp667-684.

- extreme adverse life circumstances such as experience of war, persecution, torture, displacement and prolonged periods in refugee camps or countries of asylum prior to arrival
- limited or disrupted schooling
- family dislocation
- limited health care before arrival in Australia
- stressful nature of settlement demands
- limited employment opportunities for new arrivals
- limited social support and networks because of the small size of refugee communities and fragmentation within those communities
- cultural and language barriers to accessing mainstream health services and lack of culturally responsive service provision in the mainstream services
- for asylum seekers and people on temporary and bridging visas, uncertainty about their future status and ability to remain in Australia.

The Building a New Life in Australia (BNLA): The Longitudinal Study of Humanitarian Migrants⁷ study focuses on settlement it touches on various social determinants on health and risk and protective factors relevant to mental health of refugees settling in Australia (English language, employment, health, housing, social connections, self-esteem, self-efficacy, education, income and financial stress). BNLA respondents were found much more likely to be at risk of serious mental health problems compared to general Australian populations and women being at significantly higher risk. A high proportion of BNLA respondents had experienced PTSD symptoms (over 30%) and that proportion is significantly higher for women. Women also reported significantly higher levels of social isolation and lack of friends.

The well-being of children and young people can be particularly affected because of disruptions to attachment and family integrity which are major risk factors for poor health.

The profile of the refugee and humanitarian population is constantly changing and will continue to change because the make-up of this group reflects conflict situations around the world and decisions by government about regions from which refugees will be selected for resettlement.

What makes FASSTT unique

⁷ Building a New Life in Australia: The Longitudinal Study of Humanitarian Migrants. <https://www.dss.gov.au/settlement-services-publications/building-a-new-life-in-australia-bnla-the-longitudinal-study-of-humanitarian-migrants>.

FASSTT member agencies have been delivering services for between 20 and 30 years. Throughout this period FASSTT members have remained focussed on their agreed mission – that is – to provide psycho-social support to refugee survivors of torture and trauma. The scope of support has broadened during this time to include – counselling and clinical support, advocacy, community development, training and support to mainstream mental and primary health services, research and service innovation. The emphasis is on early intervention (i.e. soon after arrival) but support is also offered across the lifespan.

FASSTT member agencies share a strong commitment to working in collaborative partnerships and to developing clear protocols and “mission” for these partnerships. Partnerships are formed in order to provide wrap around support services for vulnerable people. Thus, partnerships have been developed with children, family and youth, housing, education, health, settlement and community services.

The PASTT funding models allows for flexibility in how each FASSTT agency can use its allocation to meet its particular State/Territory circumstances. For example, it not only provides high need clients with access to counselling and case advocacy, it can also be used to support resource development and infrastructure costs. PASTT supports a national infrastructure, through FASSTT, that provides a forum for sharing resources and expertise to maintain and increase service standards and minimise duplication.

During past 30 years, FASSTT has developed a unique international reputation for cooperation, collaboration, clinical expertise, quality assurance, and resource sharing and skill development. It is represented on a number of UN and international bodies addressing the issues for refugee related torture and trauma.

Innovative responses to meeting the needs of the client cohort

FASSTT member agencies have built an innovative model of service delivery that is based on a profound appreciation of the social and clinical impacts of trauma; latest advances in neuroscience and evidence based practice in relevant fields; how this applies to the refugee experience; a capacity to work cross culturally; and a focus on building capacity (at an individual community and systems level) to maximize an individual’s full participation in their new society.

The FASSTT model of service recognizes the fundamental importance of the social determinants of health and the importance of linkages to other supports. Links to innovative employment support options, community development, family relationship support, and work with health and education systems are key to the recovery model within which we work. FASSTT member agencies have implemented a number of programs that address linkages to a broad range of partner services.

PART 2

FASSTT services have addressed specific questions raised by the Inquiry. Evidence to the FASSTT comments is provided where possible.

QUESTIONS ON ASSESSMENT APPROACH	
What suggestions, if any, do you have on the Commission's proposed assessment approach for the inquiry? Please provide any data or other evidence that could be used to inform the assessment.	<p>FASSTT member agencies support the approach of the Commission to improve population mental health so as to realise benefits from increased social and economic participation and contribution to the wider community. The four assessment components provide a comprehensive model that encompasses relevant aspects required to inform policy development in mental health service provision – from the impact of mental ill-health to treatment effectiveness and potential for innovation in the field based on an increasing evidence base.</p> <p>FASSTT further supports the approach to make recommendations to improve the mental health and wellbeing of particular groups. The Commission cites measures that could improve the integration and continuity of support for particular groups, such as people with severe, persistent and complex mental illness, and which could better take into account the episodic nature of some mental illnesses.”⁸ We welcome the Commission's desire to obtain direct comment from vulnerable groups including culturally and linguistically diverse communities. However, it is unclear what methodology the Commission will pursue to engage such groups taking into account cultural and linguistic barriers, and with refugee populations – mistrust and fear of engagement with Government processes stemming from their previous experience. It is essential that consumer engagement and consultation processes are designed with the focus on the needs and specific circumstances of the participants.</p> <p>While particular vulnerable groups are mentioned throughout the document, Australians who are gender and sexuality diverse (LGBTIQ+) have not been mentioned. NSW STARTTS has recently commenced work with refugees and asylum seekers of diverse sexualities, genders and bodies, and has found that the issues all refugees and torture and trauma survivors face are compounded by well-documented mental health challenges faced by LGBTIQ+ communities.⁹ The discrimination faced by LGBTIQ+ people is well documented ¹⁰, and they are also more likely to self-report a mental health condition.</p>

⁸ Issues paper p 6

⁹ O. Noto, W. Leonard and A. Mitchell, 'Nothing for Them Understanding the support needs of Lesbian, Gay, Bisexual and Transgender (LGBT) young people from refugee and newly arrived backgrounds', Australian Research Centre In Sex, Health And Society, La Trobe University, 2014

¹⁰ Australian Bureau of Statistics, 'General Social Survey: Summary Results, Australia, 2014', released in 2015, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4159.0>

Further, FASSTT notes that the integration of people from refugee backgrounds are particularly at risk due to experiences of racism, cultural alienation and social exclusion. The mental health impacts of “not belonging” are well documented.¹¹ Those affected by mental ill-health struggle with social inclusion and stigma. The findings from the most recent Scanlon Foundation Survey (2018)¹² indicate profound and widespread experiences of racism for people of refugee backgrounds this is particularly so for people from Muslim backgrounds. Scanlon report further suggests that two factors have been commonly found to influence negative opinion of immigration – labour market conditions and the political prominence of immigration issues. Discrimination faced by FASSTT clients is a complex interplay of various factors including their mental health status, religion, ethnicity, gender and sexuality with clients experiencing numerous layers of exclusion, discrimination and stigma contributing to a severe impact on their mental health. It behoves therefore that when considering the mental health impacts of racism and discrimination it is important to note that the broad cumulative impact of racism and how it intersects with all aspects of a person’s life.

FASSTT notes that the Productivity Commission indicates its intention to ‘give greatest consideration to where there are the largest potential improvements in population mental health, participation and contribution over the long term’ including people with mild or moderate mental illness, young people, and disadvantaged groups. However, it is important for the Commission to also have regard to the fact that some of the most disadvantaged groups are relatively small in numbers. It is essential that the needs of small, yet highly affected individuals and communities, are recognised. FASSTT therefore recommends that the commission take into account factors which promote social inclusion – including early intervention and prevention activities which promote community level healing. The benefits of addressing social inclusion at community level are well documented including by Mitchell and Correa- Velez, who have identified the importance of supporting communities to “enhance a community’s capacity to support the emotional health and well-being of its members”.¹³ It is essential that the Commission takes into account social exclusion based on varied factors compounding the exclusion based on mental ill-health.

“Although we are accustomed to thinking of coping in individual terms, it may be helpful to broaden that view to include the capacity of communities to respond effectively to the mental health and psychosocial needs of community members. For example, a critical displacement-related challenge involves facilitating the development of social

¹¹ Ferdinand A, Kelaher M & Paradies Y 2013. Mental health impacts of racial discrimination in Victorian culturally and linguistically diverse communities: Full report. Victorian Health Promotion Foundation. Melbourne, Australia

¹² A. Markus, ‘Mapping Social Cohesion: The Scanlon Foundation Surveys 2018’, Scanlon Foundation, Australian Multicultural Foundation and Monash University, published in 2018.

¹³ Mitchell J & Correa-Velez I. 2009 Community development with survivors of torture and trauma: an evaluation framework, Community Development Journal, 45,1, pp90-110. .

	<p>networks that can provide much needed social support and a sharing of resources. Because political violence so often divides communities by generating suspicion and hostility among community members, the task of creating supportive social networks may entail an initial process of healing damaged relations within communities so that basic conditions of trust and openness are present.”¹⁴</p> <p>FASSTT recommends that the Commission consider the concept of Social Capital when exploring what may contribute to mental health and productivity. Social capital builds relationships and interconnectedness. NSW STARTTS and UNSW have undertaken a study¹⁵ on the impact of refugee experience on social capital and have developed a model of social capital in resettlement context. Social Capital was considered as an important concept for refugee mental health and social inclusion due to the two factors below:</p> <ol style="list-style-type: none"> 1. The majority of refugee communities arrived to Australia after exposure to organised violence aimed at severing connections and trust between individuals, families and groups. The overall impact is community fragmentation, social isolation and suspicion. This dynamic is present in settlement context and has potential to further impinge on individual mental health issues resulting from exposure to torture and trauma. 2. There is evidence that high levels of social capital have potential to foster mental health and wellbeing and prevent poor mental health outcomes.^{16 17} <p>It is important to consider cost effectiveness of interventions and FASSTT welcomes the Commission’s nuanced and holistic approach to defining and exploring cost effectiveness that looks at not only dollar per client but also considers long term benefits to both social and economic participation. An important element of cost effectiveness is also an ability of service providers to match the interventions to client needs and the highest likelihood of improvement via a specific intervention.</p>
QUESTIONS OF SPECIFIC HEALTH CONCERNS	
Should there be any changes to mental illness	Changes in the last few years have seen a move from community based early intervention mental health services to a polarisation of services between acute medical services and primary health along with NDIS. Most of these services are

¹⁴ In Miller, K & Rasco, L.M (Ed) *The Mental Health of Refugees: Ecological Approaches to Healing and Adaptation*, Mahway, NJ. 2004.p27

¹⁵ G. Doney, E. Pittaway, L. Bartolomei and K. Ward, ‘The Glue that Binds’; Social Capital in Refugee Communities Settling in Australia’, STARTTS, UNSW and Centre for Refugee Research, 2013

¹⁶ K. E. McPherson, S. Kerr, E. McGee, A. Morgan, F. M. Cheater, J. McLean, and J. Egan, ‘The association between social capital and mental health and behavioural problems in children and adolescents: an integrative systematic review’, BMC Psychol. 2014; 2: 7. Published online 2014 Mar 26. doi: 10.1186/2050-7283-2-7

¹⁷ J.A. Welsh and H. L. Berry, ‘Social capital and mental health and well-being’, National Centre for Epidemiology and Population Health, The Australian National University Paper presented at the Biennial HILDA Survey Research Conference 16-17 July 2009

<p>prevention and early intervention by healthcare providers?</p>	<p>diagnosis based and this has meant that there is now a lack of community based mental health services that people can go to for assistance/support without a referral or diagnosis. This potentially will mean that people need to become acute prior to receiving support. On the other hand, NSW Health have recently tendered for provision of Community Living Supports Program for Refugees (CLSR). While the program focuses on people with severe mental illness, formal diagnosis is not required to access the service. The Program will focus on provision of practical and social support and development of living skills with the aim of reducing engagement with acute mental health settings. CLSR is yet to be commenced and program evaluation tender has recently closed.</p> <p>However, the experience of FASSTT services is that in many states, there is limited focus on the area of early intervention and prevention. Mental health service funding is focused on primary health care, and services are limited, single faceted and sessional. FASSTT services have all engaged in prevention and early intervention initiatives and details of some of these projects are outlined in responses below. A number of projects have focused on increasing mental health literacy and community resilience.</p> <p>Some of the principles of increasing mental health literacy and engaging in mental health conversations with refugee communities include:</p> <ul style="list-style-type: none"> • Service providers must embrace a genuine partnership with structures of refugee communities; • In-depth exploration and understanding of: cultural idioms of distress¹⁸; cultural and faith-based causality frameworks surrounding mental health and illness; help-seeking patterns and community reactions to those with mental illness; socio political context of trauma and the impact of trauma on the affected population; • Knowledge of community structures, influencers and information dissemination patterns (eg. church, social media, ethnic media, peer leaders, community businesses, sporting and cultural events); • Consideration of literacy levels – in English and first language; • Use of health promotion mediums relevant and appropriate to culture, education and literacy including: small group conversations using experiential as opposed to didactic approaches to learning; ethnic media; audio-visual resources; use of visual and performing arts (eg. music and theatre). <p>Research cited in this submission provides evidence about the value of giving adequate resourcing to early intervention and prevention measures which promote social inclusion including working with communities as a whole.</p>
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¹⁸ B.A. Kohrt B.A., D.J. Hruschka , ‘ Nepali Concepts of Psychological Trauma: The Role of Idioms of Distress, Ethnopsychology and Ethnophysiology in Alleviating Suffering and Preventing Stigma’. in Culture Medicine and Psychiatry (2010) 34: 322-352. DOI 10.1007/s11013-010-9170-2, Springer Science+Business Media, LLC 2010. Published online: 23 March 2010

<p>Which forms of mental health promotion are effective in improving population mental health in either the short or longer term? What evidence supports this?</p>	<p>According to WHO recent report on ‘Mental health promotion and mental health care in refugees and migrants’ (2018)¹⁹, interventions to promote mental health and to provide good mental health care to these groups have focused on the following four areas:</p> <ul style="list-style-type: none"> • Promoting social integration • Overcoming barriers to access for mental health care • Facilitating engagement with care • Treating refugees and migrants with manifest mental disorders <p>The WHO report highlights the lack of quality evaluation for some of these interventions (see p.9). However, based on available evidence, the report recommends the following interventions</p> <ul style="list-style-type: none"> • Promoting social integration: guaranteeing basic needs (e.g. food security, accommodation, etc); education (e.g. classes to learn the language of host country, recognition of previous qualifications, vocational training, etc); activities to reduce social isolation (e.g. community forums, peer/mentoring programs, social activity programs involving volunteers from host community, sport events, cultural and recreational activities); • Overcoming barriers to access mental health care: provision of information on entitlements should be provided to both users and providers of health care; refugee/migrant-specific outreach services can provide a bridge into mainstream services; an integrated approach with proper coordination between mental and physical health care and social services; • Facilitating engagement with services: high quality interpreting services that support effective patient-clinician interaction; employing cultural mediators (e.g. bicultural support workers, health/community navigators); use of information technology (e.g. telephone/online interpretation, increasing use of software for interpreting services); cultural competence training for clinicians and other health professionals; • Treating refugees and migrants with manifest mental disorders: there is some evidence for Narrative Exposure Therapy (NET) and trauma-focused cognitive behavioural therapy for the treatment of PTSD in refugee populations.²⁰
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¹⁹WHO. Mental Health Promotion and Mental Health Care in Refugees and Migrants. Copenhagen: WHO Regional Office for Europe; 2018 (Technical guidance on refugee and migrant health) http://www.euro.who.int/_data/assets/pdf_file/0004/386563/mental-health-eng.pdf?ua=1

²⁰ See recent reviews: Nosè M, Ballette F, Bighelli I, Turrini G, Purgato M, Tol W et al. Psychosocial interventions for post-traumatic stress disorder in refugees and asylum seekers resettled in high-income countries: systematic review and meta-analysis. PLOS One. 2017;12:e0171030; Turrini G, Purgato M, Ballette F, Nosè M, Ostuzzi G, Barbui C. Common mental disorders in asylum seekers and refugees: umbrella review of prevalence and intervention studies. Int J Ment Health Syst. 2017;11:51

	<p>As above, FASSTT agencies have all implemented projects designed to improve population mental health. Further, the services have consulted with refugee communities to ascertain their mental health literacy and identify culturally appropriate mental health promotion strategies. For example, in 2018, NSW STARTTS was commissioned by the NSW Mental Health Commission to conduct mental health consultations with Hazara community (small ethnic community largely from Afghanistan with high number of asylum seekers experiencing acute distress resulting in complex mental health presentations and suicidal ideations and attempts). The consultations indicated:</p> <ul style="list-style-type: none"> • An importance of a long-term engagement with community and careful trust building process. • Negative impact of various social and political factors on mental health of Hazara community (immigration status, the impact of prolonged detention in immigration detention, family, reunion, unemployment and financial difficulties). • Community willingness to engage in mental health focused conversations • Importance of training peer leaders who can both promote mental health messages and act as points of referral to services • Need to develop mental health promotion resources that are culturally and linguistically appropriate and suitable for people with low literacy levels in first language as well as English and low computer literacy. The ideal resources the community identified would be audio-visual accompanied by small group discussions about the concepts presented in the resources. <p>Diet^{21 22 23 24} and physical exercise have been found to make significant contribution towards improvements in mental health and can be used to enhance the recovery process as an adjunct to other mental health interventions.^{25 26 27 28} NSW STARTTS</p>
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²¹ J. Firth et al, 'The effects of dietary improvements on symptoms of depression and anxiety: a meta-analysis of randomized control trials', Psychosomatic Medicine (in press), American Psychosomatic Society, 2018

²² P. Holford, 'Depression: the nutrition connection', Primary care mental health (2003) 1: 9-16, Radcliffe Medical Press

²³ Y. Li et al (2017), 'Dietary patterns and depression risk: A meta-analysis', Psychiatry research 253 (2017), 373-382

²⁴ N. Parletta et al, 'A Mediterranean-style dietary intervention supplemented with fish oil improves diet quality and mental health in people with depression: a randomized controlled trial', Nutritional Neuroscience, 2018, Taylor and Francis Group

²⁵ C. Lay, M.R. Barrio, A. Koch, "In the Sport I Am Here": Therapeutic Processes and Health Effects of Sport and Exercise on PTSD', Qualitative Health Research 2018, Vol. (28)3, pp. 491-507, Sage Publications.

²⁶ M. Haith-Cooper, C. Waskett, J. Montague & M. Horne, 'Exercise and Physical Activity in Asylum Seekers in Northern England; using the theoretical domains framework to identify barriers and facilitators', BMC Public health (2018) 18:762, University of Bradford, Bradford, UK

²⁷ H.N. Trinh et al, 'Physical Activity Education for Adults with Refugee background in the United States', Diversity and Equality in Health and Care (2018) 15(4): 158-163, Insight Medical Publishing Group,

²⁸ S. Edmunds et al, 'Let's Get Physical: The Impact of Physical Activity on Wellbeing', Mental Health Foundation, 2013, London, UK

	<p>has trialled and evaluated Behaviour Modification/Lifestyle Programs. The current program is based on the latest Australian guidelines for exercise and physical activity and aims to work in conjunction with counselling. The Program was able to:</p> <ul style="list-style-type: none"> • Provide information about the benefits of physical activity and create body-mind awareness; • Motivate and support the clients to establish goals that can contribute to their wellbeing; • Design exercise programs tailored to the specific needs of the client; • Adapt the program to the client and create a safe and comfortable learning environment; • Improve the client’s knowledge of technology and how use it to support and sustain their positive changes; and • Create a soft entry into counselling.
<p>What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation and productivity?</p>	<p>Although people from refugee backgrounds are known to be at higher risk of suicide than the general population²⁹, there is a dearth of research on suicide and self-harm about the refugee background population. A study conducted by QPASTT³⁰ in 2010–2011 with a non-random sample of 120 young people from refugee backgrounds who were originally from Africa, Middle East and South East Asia (51% females and 49% males) found the following</p> <ul style="list-style-type: none"> • A life-time history of self-harm was reported by 8.3% of respondents (3.4% among males; 13.1% among females); • Self-harm in the previous 12 months was reported by 5.8% (1.7% among males; 9.8% among females); • Suicidal ideation in the past year was reported by 8.3% (1.7% males; 14.8% females); • A life-time history of suicidal attempts was reported by 7.5% of respondents; • 3.3% reported having attempted suicide over the past year (all females; 6.6%); • A greater number of post-migration experiences (than pre-migration experiences) were found to be significantly associated with deliberate self-harm; • Three pre-migration experiences were found to be significantly associated with self-harm among females: witnessing murder of strangers; childhood physical abuse; and destruction of personal or family property/belongings; • Female respondents who reported poor family support were 6.5 times more likely to self-harm than those with good family support; • Other post-migration factors/experiences significantly associated with self-harm among females were: serious problems with family; violence in the family; living with a mentally ill family member; suicide/death of a close friend or loved one; loneliness and boredom; isolation; and academic failure;

²⁹ Vijayakumar L, Jotheeswaran A T. (2010). Suicide in refugees and asylum seekers. In D Bhugra, T Craigand and K Bhui (Eds.), Mental health of refugees and asylum seekers (pp. 195-210). New York: Oxford University Press

³⁰ Correa-Velez I. Self-harm among young people from refugee backgrounds: An investigation of pre- and post-migration risk and protective factors. Brisbane: Queensland Program of Assistance to Survivors of Torture and Trauma – QPASTT, 2011

	<ul style="list-style-type: none"> • Only a few of those female respondents who self-harmed in the previous year sought help either before (17%) or after (33%) the episode of self-harm, and one third required medical care; • Those who sought help were more likely to consult their friends, family or community leaders than medical or mental health services. <p>Although this study is cross-sectional, the findings suggest the need for programs that assist the settlement and integration of young people from refugee backgrounds, women in particular. Programs should not only assist young women to deal with past traumatic experiences such as childhood physical abuse and war-related trauma, but most importantly should address those issues that are likely to impact on young women’s wellbeing during resettlement: social isolation, academic difficulties, family conflict and violence, living with relatives who have a mental illness, and coping with the death or suicide of friends and loved ones.</p> <p>Additionally, more needs to be done to address the barriers that prevent young refugees from accessing mental health services, including understanding young people’s cultural concepts of mental health, illness, and treatment; improving service accessibility by creating youth-friendly environments such as drop-in and outreach services; fostering trust; working with interpreters; and engaging families and communities³¹.</p> <p>NSW STARTTS received funding from Western Sydney PHN (WentWest) to implement a Mental Health Literacy and Suicide Prevention Project with 4 refugee communities – Hazara, South Sudanese, Tamil and Arabic-speaking. Although the project is currently being evaluated, it has been reported that several potential suicides have been prevented through the engagement of peer support workers and working closely with the community and its worldview.</p>
QUESTIONS ON WORKFORCE AND INFORMAL CARERS	
<p>Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current</p>	<p>In the experience of FASSTT services there are a number of critical issues related to the configuration and capabilities of the professional health workforce that are important to acknowledge.</p> <ul style="list-style-type: none"> • The configuration of the public mental health system is often a barrier to engagement. The public mental health is often structured along individual appointments, often far into the future, requires a diagnosis for ongoing support to occur, has a rapid turnover of clinical staff such that no continuity is available and erodes trust in the system and the individuals within it. • Capacity to understand the socio political and historical context of patients from refugee backgrounds. The use of cultural consultants or bi-cultural staff in mental health settings is a useful model to be supported. FASSTT members

³¹ Colucci E, Minas H, Szwarc J, Guerra C, Paxton G. In oro ut? Barriers and facilitators to refugee-background Young people accessing mental health services. *Transcultural Psychiatry*, 2015, 52(6): 766-790

<p>arrangements? How would this improve population mental health, participation and productivity?</p>	<p>all employ multi-lingual staff who speak over 40 languages. Some staff are clinicians and others provide cultural, socio political and historical information to clinicians.</p> <ul style="list-style-type: none"> • Importance of close collaboration and partnerships with refugee communities and peer leaders. In addition to the examples mentioned above, another example of such project is the African Mental Health Learning Circle project (based in STARTTS, NSW) which brings together African community leaders and mental health service providers for the purpose of mutual learning. • Capacity to use professional interpreters - There is still an alarming degree of reluctance to use professional interpreters in health services. A recent Evaluation of the QLD Refugee Health and Well Being Policy and Action Plan revealed only 63% of patients who needed an interpreter in primary care setting were offered one. The statistics are worse in ED. Similarly, the Victorian Foundation for Survivors of Torture undertook a 2-year study in response to regular reports that clients with low English proficiency were not being provided with a credentialed interpreter when accessing health care. Reports from other sources indicate that the issue is widespread and longstanding in Victoria and nationally.³² • Stress and turnover of professional workforce – working with trauma can lead to Vicarious Traumatization, stress and eventual burnout. Vicarious Trauma³³ should be treated as a Workplace Health and Safety issue rather than a sign of individual weakness. Sufficient resources need to be allocated for supervision, debriefing and ongoing professional development to ensure maintenance of quality and support vicarious resilience
<p>QUESTIONS ON SOCIAL SERVICES</p>	
<p>How could non-clinical mental health support services be better coordinated with clinical mental health services?</p>	<p>FASSTT services recognise that the experience of their clients requires a framework of understanding which brings together awareness of historical, political and social influences, both past and present, which affect lives on a daily basis Non clinical support is coordinated with clinical mental health support based on an understanding that survivors’ wellbeing is affected by a complex interplay of their history of torture and other traumatic events, the risk and protective factors they encounter in Australia (the host country), and cross cultural factors at play in a new settlement environment.</p> <p>Examples of the ways in which support is conceptualised along a continuum from non-clinical and community interventions through to individual clinical mental health support can be found at</p>

³² <http://www.foundationhouse.org.au/promoting-engagement-interpreters-victorian-health-services/>

³³ <https://www.blueknot.org.au/Workers-Practitioners/For-Health-Professionals/Resources-for-Health-Professionals/Vicarious-Trauma>

1. STARTTS - <http://www.startts.org.au/about-us/how-we-work/>
2. Victorian Foundation for Survivors of Torture - http://www.foundationhouse.org.au/wp-content/uploads/2018/08/INTEGRATED-TRAUMA-SERVICE-RECOVERY-MODEL_cr.pdf

Both organisations have implemented numerous interventions on various levels of social system from individual, through to family, social group, refugee community and Australian community at large. Three project examples are provided below.

1. Bridge to Justice

Bridge to Justice was a legal project that operated at STARTTS between 2009 – 2017 (funded by various funding sources) aiming to improve access to justice for survivors of refugee trauma. It sought to do this through the provision of holistic, trauma informed and culturally sensitive legal support (a lawyer was placed within a torture and trauma service) as well as through the provision of consultancy and training for other legal practitioners engaging with survivors of trauma thus ensuring their legal practice is trauma informed. STARTTS counsellors report that the impact of receiving support and assistance with legal issues from the legal project was often the key contributor for clients to be able to focus on their recovery. The placement of the lawyer within a mental health service enabled a holistic, wrap-around service and a close collaboration between the lawyer and a clinician. The evaluation findings indicated that a holistic approach that allows people with complex needs to access legal support within a familiar counselling setting, can provide positive legal outcomes and improve clients’ circumstances and well-being.

2. Families in Cultural Transition (FICT) – STARTTS

FICT is a group based psychosocial intervention designed to assist refugees and people from refugee like backgrounds to develop understanding of conceptual frameworks underpinning Australian society, identify and manage challenges to family dynamics associated with the cultural transition and develop appropriate coping strategies. FICT works both on a practical level and at the level of the emotional transitions families can go through while adjusting to life in a new country. STARTTS FICT team recruits and trains bicultural facilitators to deliver the program with members of their community, in their community language. The team currently supports over 90 groups a year. The program, based on a kit of materials, consists of 11, 3hr sessions, comprising case studies, discussions and practical activities on the following topics: Support Systems, Money, Trauma and recovery, Families, Children, Gender, Youth, Enjoying the New Environment, Employment and Reconnecting with Our Children/Attachment and Parenting. The evaluation of the FICT program noted that the program and the context in which the program is delivered, is conducive to the formation of close social relationships which builds social capital while reducing social isolation. Participants report feeling generally happier, more relaxed and less anxious as a result of participating in the program.

	<p>3. Youth Transition Support (YTS) – VFST</p> <p>The YTS program was funded from 2016 for four years as a pilot program and participating agencies are located in Victoria, NSW and Queensland. Foundation House leads the delivery of the Ucan2 program in Victoria. The Ucan2 program aims to facilitate and support the social inclusion of newly arrived young people of refugee backgrounds, aged 16-25 years. It has been developed to support learning and employment pathways that connect young people of refugee backgrounds into the Australian community. The program is underpinned by theory and evidence concerning effective ways to support recovery from trauma, integration and successful settlement.</p> <p>It has three core components</p> <ul style="list-style-type: none"> • Contextualised and experiential learning focussing on work skills, with opportunities for part time work experience or volunteering; • Psychosocial support, which assists with recovery from trauma and building resilience, identity and belonging; • Development of social connections and networks through contact with peer volunteers, work experience, increasing knowledge of support agencies and group processes that create strong connections amongst Ucan2 group members. <p>An evaluation of Ucan2 conducted by the University of Melbourne³⁴ indicated the program</p> <ul style="list-style-type: none"> • Promotes English language learning; • Supports engagement in education and employment; • Increases participants’ social networks; • Fosters wellbeing and resilience and builds confidence; • Builds teachers’ capacity to respond to the needs of young people of refugee backgrounds.
<p>Are there significant service gaps for people with psychosocial disability who do not qualify for the NDIS? If so, what are they?</p>	<p>Many FASSTT clients who could be diagnosed as suffering from a psychosocial disability require intensive casework/case-management support to ensure they are able to manage various aspects of their lives including employment, tenancy, education, banking, bill payment and access to health services. The psychosocial disability is often a result of compounding factors including impact of trauma, challenges associated with settlement process and normal life cycle issues. While refugees and humanitarian entrants can receive casework support up from settlement services until 5 years following their</p>

³⁴ Block K, Young D and Molyneaux R. (2017) Ucan2: Youth Transition Support – Evaluation report. University of Melbourne: Centre for Health Equity

http://www.foundationhouse.org.au/wp-content/uploads/2018/08/UCan2_evaluation_Full_Report_Final_May2018-1.pdf

	<p>arrival, for many this is insufficient while for others need for additional support can be triggered by issues such as illness, family conflict or ageing.</p> <p>The NDIS framework with its emphasis on self-directed advocacy is failing refugee clients who would otherwise qualify for NDIS. There are a number of refugee background people with a psychosocial disability who would not be able to access NDIS due to their inability to self-advocate, or may not qualify due to the fact that they are non-permanent residents or are outside of the “diagnosis” list.</p> <p>Personal Helpers and Mentors (PHaMs) is an Australian Government initiative administered by the Commonwealth Department of Social Services (DSS). PHaMs services aim to increase recovery opportunities for people whose lives are severely affected by their experience of mental illness. In Tasmania, the FASSTT service, Phoenix, has found this program extremely helpful for people with complex psychosocial needs but who do not qualify for NDIS. However, PHaMs is being phased out with the introduction of the NDIS. PHaMs has been extended for 12 months for current PHaMs clients only. There is a cohort of people whose psychosocial needs are complex, who are not existing PHaMs clients and will not be able to access NDIS. FASSTT services note the need for programs such as PHaMs to be continued to address the needs of that cohort, whose needs are complex but who either do not fit the criteria for NDIS, or are unable to access it because of the reliance on self-advocacy.</p>
QUESTIONS ON SOCIAL PARTICIPATION AND INCLUSION	
<p>Are there particular population sub-groups that are more at risk of mental ill-health due to inadequate social participation and inclusion? What, if anything, should be done to specifically target those groups?</p>	<p>FASSTT services cite people from refugee backgrounds and particularly survivors of torture and trauma as population groups who are more at risk of mental ill health due to inadequate social inclusion. There are specific sub-groups within this group who may be more at risk of mental ill-health due to inadequate social participation and inclusion such as</p> <ul style="list-style-type: none"> • young people (particularly those disengaged from the education system) • women • families who have been separated • LGBTIQ+ people, • older people. <p>· <u>Young People</u></p>

Both pre-migration trauma and post-migration stressors are consistently linked to refugees' mental ill-health³⁵. Refugee and asylum seekers can be particularly vulnerable to mental-ill health due to social exclusion. The Good Starts Study, a longitudinal study with newly arrived young people from refugee backgrounds living in Melbourne (conducted in partnership with the Victorian Foundation for Survivors of Torture, the FASSTT agency in Victoria), found that "the key factors strongly associated with wellbeing outcomes are those that can be described as indicators of belonging – the most important being subjective social status in the broader Australian community, perceived discrimination and bullying"³⁶. A follow up of this cohort of young people, 8 years after arriving in Australia, found that experiences of social exclusion such as discrimination still have a significant impact on their wellbeing³⁷.

Overall, this longitudinal study has shown that the factors that best predict wellbeing among this group of refugee young people are

"those that can be understood to promote a sense of belonging, becoming at home, being able to flourish and become part of the new host society. Wellbeing and resettlement cannot be addressed without explicitly taking account of the broader social environment of the host society (...) Too little attention has been given to the broader social structures of the host society beyond the resettlement period. Ultimately, successful resettlement – reflected in a young person's subjective sense of their wellbeing – will be determined by the extent to which they are able to become a valued citizen within their new country. The opportunity to flourish, to become at home, to belong is powerfully shaped by the prevailing social climate and structures that are openly inclusive or that exclude"³⁸.

Women

The Building a New Life in Australia research found that the mental health of newly arrived refugee women may be significantly poorer than that of the men. Certainly there may be gender barriers to their participation in work as well as

³⁵ Fozdar F and Hartley L. Refugee Resettlement in Australia: What we know and need to know. Refugee Survey Quarterly, 2013, 32(3): 23-51; Porter M and Haslam N. Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis. JAMA, 2005; 294(5): 602-612

³⁶ Correa-Velez I, Gifford SM, Barnett AG. Longing to belong: Social inclusion and wellbeing among youth with refugee backgrounds in the first three years in Melbourne, Australia, Social Science & Medicine, 2010, 71 (8): 1399-1408 <https://doi.org/10.1016/j.socscimed.2010.07.018>

³⁷ Correa-Velez I, Gifford SM, McMichael C. The persistence of predictors of wellbeing among refugee youth eight years after resettlement in Melbourne, Australia. Social Science & Medicine, 2015, 142: 163-168. <https://doi.org/10.1016/j.socscimed.2015.08.017>

³⁸ Correa-Velez et al. 2010 (p.1406)

	<p>other social domains. Women from refugee backgrounds tend in general to be less proficient in English. They most often have obligations as primary carers for children and find attending classes and securing work difficult.³⁹</p> <p><u>Families who have been separated</u></p> <p>An important issue that impacts on refugees' mental health is the restrictions on family reunification. Although the UNHCR strongly promotes family reunification as a key component of refugee settlement⁴⁰, current migration policies in Australia impose significant barriers to family reunification for people from refugee backgrounds⁴¹. Among refugee populations, family separation has been found to be associated with poor mental health⁴²; greater difficulties in accessing English classes, higher education and the labour market (in particular for women); social isolation; and financial strain⁴³. Thus, restrictions on family reunion contribute to social exclusion.</p> <p><u>LGBTIQ+ people</u></p> <p>In 2014, La Trobe University published the "Nothing for Them - Understanding the support needs of Lesbian, Gay, Bisexual and Transgender (LGBT) young people from refugee and newly arrived backgrounds". This and a number of other reports indicated a lack of research into the needs of LGBTIQ+ refugees and asylum seekers. The la Trobe University research flagged the lack of support of LGBTIQ+ inclusive practices by both migrant/refugee services and mainstream health. According to UNHCR, in recent decades, the number of LGBTIQ+ refugees and asylum-seekers has increased, with majority qualifying as 'members of a particular social group' under the 1951 Refugee Convention. Currently, 77 countries in the world criminalise same-sex relations and seven countries punish it with the death penalty. In 2018, NSW STARTTS has consulted with a group of LGBTIQ+ refugees and asylum seekers who indicated that this group are at risk and that their issues need to be regarded as intersectional and cross cutting as well as group specific.</p> <p><u>Older people</u></p>
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³⁹ Building a new Life In Australia - <https://www.dss.gov.au/settlement-services-publications/building-a-new-life-in-australia-bnla-the-longitudinal-study-of-humanitarian-migrants>

⁴⁰ UNHCR. Resettlement Handbook, 2011. Division of International Protection, UNHCR, Geneva <https://www.unhcr.org/46f7c0ee2.html>

⁴¹ Settlement Council of Australia. Issues Paper: Refugee Family Reunion. Canberra: SCOA, 2016. <http://scoa.org.au/wp-content/uploads/2017/03/SCoA-Issues-Paper-Family-Reunion-August-2016.pdf>

⁴² Schweitzer R, Melville F, Steel Z & Lacherez P. Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. Australian and New Zealand Journal of Psychiatry, 2006, 40(2): 179-187

⁴³ Wilmsen B. Family separation and the impacts on refugee settlement in Australia. Australian Journal of Social Issues, 2013, 48(2): 241-262

	<p>In 2017, NSW Refugee Support Network (RSN), prepared an issues paper on the needs of older refugees based on a survey with service providers working with this cohort. The report argues that in addition to challenges faced by all refugees, the older refugees experience the following challenges and barriers to social participation</p> <ul style="list-style-type: none"> • The likelihood that if they had no English prior to arrival, they are not likely to ever become proficient; • Confusion about Australian culture and concerns about their family losing traditional culture; • A range of traumatic losses; • Dependency on their family or sponsor – which sometimes does not line up with their family’s capacity to support them; • Potential for elder abuse; • High settlement and recovery needs particularly compounded by physical health issues; • Symptoms of depression, anxiety and post-traumatic stress can be confused with that of dementia making assessment difficult; • Lack of friends and social networks and the difficulties in establishing these leading to severe social isolation; • Grief about having everything for which they worked all their life for disappear, along with their expectations for their old age and their vision about where they would lie at rest. <p>All these population sub groups are at risk of not being able to participate fully in society with the associated risk of not enjoying positive mental health and wellbeing. Specific and targeted programs that address the particular issues faced by these population sub groups need to be encouraged and resourced.</p>
QUESTIONS ON JUSTICE	
<p>To what extent does inadequate identification of mental health and individual needs in different parts of the justice system increase the likelihood and extent of people’s future interactions with that system.</p>	<p>FASSTT services are aware that there are young people from refugee backgrounds who are engaged with the justice system. FASSTT services know that traumatised young people are likely to live in a context where their families and their communities are also traumatised. Trauma, disengagement and non-inclusion are not uncommon and can lead to anti-social behaviour and contact with the justice system.</p> <p>Various risk factors affecting FASSTT clients can make them more vulnerable to being victims of crime or committing crime, while also limiting their capacity to protect their own legal rights. Traditionally, clients of FASSTT have found it difficult to access and negotiate the legal system, due to:</p> <ul style="list-style-type: none"> • language and cultural barriers; • difficulties with memory, concentration, expression and associated cognitive functions due to the impact of post-traumatic stress symptoms;

	<ul style="list-style-type: none"> • fear and mistrust of the legal system and figures of authority (such as judges, lawyers and police) due to negative experiences in the country of origin; • lack of understanding of the Australian legal system, legal rights and avenues for seeking legal help; • lack of literacy; • lack of data or supporting documentation; • lack of legal information in community languages; • stigma attached to seeking ‘outside’ help; and • the perceived cost of legal services and a lack of personal financial resources. <p>Legal issues frequently escalate due to lack of early intervention, timely advice and support. Furthermore, unresolved legal problems can interfere with successful trauma counselling, making it more difficult to recover from their traumatic experiences and settle effectively in Australia. Access to justice can be an essential factor in the recovery of many FASSTT clients. The Youth Transition Support program described above, seeks to promote social engagement, integration and employment with the inclusion of a psycho-social dimension. ⁴⁴ This work points to the need for greater emphasis to be placed on strategies which promote engagement in the wider society, effective citizenship and belonging.</p>
QUESTIONS ON CHILD SAFETY	
<p>What, if any, alternative approaches to child protection would achieve better mental health outcomes?</p>	<p>Many of the factors associated with parenting difficulties in Western countries (e.g., parental mental health problems, poverty, physical health problems, social isolation, children’s behavioural problems) are experienced by refugee parents. Research also shows that refugee parents experience additional stresses associated with the experience of torture and trauma, changes to family roles, separation or death of family members, language difficulties and different cultural expectations about behaviour⁴⁵.</p> <p>Recently arrived parents of refugee background are faced with child rearing issues that are unfamiliar to them in their new community and it is the experience of the FASSTT services that parents will often feel inadequate and deskilled in the task of parenting in a Western cultural context. At a recent community meeting in one FASSTT agency, called in response to a series of suicides and untimely deaths of young people in one community, parents frequently voiced their fears that they no longer</p>

⁴⁴ See report of the UCan2 initiative <http://www.foundationhouse.org.au/ucan2-youth-transition-support-evaluation-report-executive-summary/>

⁴⁵ Lewig, K., Arney, F., & Salveron, M. (2009). *The working with refugee families project*. Adelaide: Australian Centre for Child Protection, University of South Australia http://earlytraumagrief.anu.edu.au/files/124112%20accp_refugee%20report.pdf

	<p>knew their children and no longer knew how to support, appropriately discipline and raise their children. The fear for the future and for their children at that meeting was palpable.</p> <p>The long term and inter-generational effects of trauma are well documented.⁴⁶ Trauma impacts on a person’s capacity to form meaningful mutually supportive relationships and on a parent’s capacity to parent effectively. So the process of disengagement from family and community typically may begin at an early age.</p> <p>FASSTT services have developed extensive and flexible parenting programs to support families. It is the belief of FASSTT services that community engagement with refugee background families and communities should be preserved with a focus on parenting, family relationships, the impact of cultural transition and addressing the effects of war-related trauma. FASSTT services have found parenting programs for refugee communities to be an effective means to implement early intervention and prevention of behaviour pursuant to social alienation in later life. The above mentioned Families in Cultural Transition (FICT) Program is implemented in a number of FASSTT agencies. Child safety and protection messages are embedded throughout the program modules. Additionally, in 2018, NSW STARTTS has developed a new module called “Reconnecting With Our Children”. The particular focus of this module is impact of trauma on attachment and assisting parents to rebuild/build attachment with their children thus supporting their parenting.</p>
<p>QUESTIONS ON EDUCATION TRAINING</p>	
<p>What are the key barriers to children and young people with mental ill-health participating and engaging in education and training, and achieving good education outcomes?</p>	<p>A recent report published by VFST regarding insights from students from refugee backgrounds on the barriers and facilitators to school engagement and learning⁴⁷ identified racism and discrimination as key barriers to school engagement among this group of young people. Similarly, an analysis from the Good Starts Study of the predictors of secondary school completion among refugee youth 8 to 9 years after resettlement in Melbourne found that those students who experienced discrimination while living in Australia were 0.205 times less likely to complete secondary education⁴⁸. Racism leads to negative wellbeing and settlement outcomes. This highlights the imperative of programs that address racism and discrimination in school settings and in the general community.</p> <p>In addition, older age on arrival decreased the odds of completing secondary school. Across Australia, newly arrived secondary school age refugee background youth can attend an English language school for up to 12 months. They then enrol in a mainstream school where they are placed in grades based on their age rather than their level of capability, which can</p>

⁴⁶ Van Der Kolk, B. *Psychological Trauma* Massachusetts : American Psychiatric Publishing, 1987.

⁴⁷ Victorian Foundation for Survivors of Torture. School is where you need to be equal and learn: insights from students of refugee backgrounds on learning and engagement in Victorian secondary schools. 2019, VFST: Melbourne

⁴⁸ Correa-Velez I, Gifford SM, McMichael C and Sampson R. Predictors of secondary school completion among refugee youth 8 to 9 years after resettlement in Melbourne, Australia. *International Migration & Integration*, 2017, 18: 791-805

	seriously impact on young people’s ability to settle well in their new educational environment. There is a need for more comprehensive and flexible approaches to facilitate young people’s transition to mainstream schools such as intensive support programs that include bridging courses in numeracy and literacy, homework clubs, study groups and mentoring programmes. ⁴⁹
QUESTIONS ON FUNDING ARRANGEMENTS	
Can you provide specific examples of sub-optimal policy outcomes that result from any problems with existing funding arrangements?	<p>The sector has been subject to a number of reviews and changes over the last few years leading to a lack of stability of services with one change not being given time to be bedded down before the next.</p> <p>Existing funding arrangements in mental health services are confusing and do not account adequately for</p> <ul style="list-style-type: none"> • early intervention recovery services where no diagnosis needed; • sub-acute care; • programs that target wellbeing and employment recognising that some people require wellbeing as a pre-employment strategy; and • programs that focus on place based approaches but overlook the identification of people who seek services as cultural rather than communities of place. <p>The Stepped Model of Care has been sub-optimal for many of the needs of FASSTT clients. It assumes that services existing at each step with referral between services. It does not encourage services to provide care/support at different levels ie that the services can step up and step down according to client need.</p> <p>New PHN commissioning arrangements has made stepped care models difficult to fund. The NEXUS program of QPASTT is a program that has been designed to provide services across the health promotion, early intervention, low intensity and high need continuum. Components of the program are designed to engage young people, build trust and allow for “soft entry” as well as respond to people referred who are actively suicidal or who have attempted suicide. Clients may engage at any stage and move between different components of the program according to need. The program has been extensively evaluated and was funded under the previous NSPS but has struggled to gain funding under the PHN model due to reluctance/difficulty in funding services that step across the funding expectations for low intensity/severe complex.</p> <p>Current arrangements for commissioning via PHNs – do not appear to deliver outcomes effectively for the FASSTT client group. Some PHNs are struggling to understand links FASSTT services have with refugee communities and prefer mental</p>

⁴⁹ Correa-Velez et al. 2017 (p. 802)

	<p>health services on a sessional basis with referral from a GP. In Queensland mental health service provision has been concentrated on severe and complex at the expense of early intervention and low intensity services. This has led to:</p> <ul style="list-style-type: none"> • Funding concentrated on diagnosis and use of mainstream “tools” which have little relevant to some groups • Reliance on GPs interest and understanding of mental health particularly in the refugee context; • Inconsistent referral and funding arrangements across regional boundaries even where those regions are separated by a street – leading to fragmented and poorly understood services; • Services designed for business models rather than client need; • PHN reporting mechanisms are cumbersome, onerous, do not effectively seek client feedback and do not align with other reporting systems. <p>Another challenge has been that current mental health projects commissioned by PHNs are largely short-term. It is challenging to create a significant change on a grassroots level in 12-18 months. This highlights the importance of closer and strategic connections between FASSTT members and relevant PHNs.</p>
	<p>An additional area of concern resulting from sub optimal funding policy relates the ability of people from CALD and refugee backgrounds to access services due to language barriers. People not proficient in English face significant barriers when health providers do not engage accredited interpreters as a matter of course. The provision of interpreting services is fundamental to ensuring effective access to health, welfare and other key services for people who are not proficient in English, which for understandable reasons is more common among humanitarian entrants than other migrants generally. “Communication” is stipulated as one of the seven rights in the Australian Charter of Healthcare Rights, adopted by Commonwealth and state and territory health ministers in 2008. Working with credentialed interpreters is a strategy identified in the guidance material to support both users and providers of health services to achieve this right.⁵⁰</p> <p>It is of significant concern that there a number of Commonwealth programs that do not provide funding for interpreting services. These include Better Access to Mental Health Care Initiative, the Medical Benefits Schedule allied health item numbers for people with chronic conditions and complex care needs who are being managed by their GP under an Enhanced Primary Care plan, and Headspace services. In relation to Headspace, while many young people may have English language skills, the lack of interpreting services means that parents with low English proficiency cannot engage with the health professionals around the care of their children.</p>

⁵⁰ A study by the Victorian Foundation for Survivors of Torture <http://www.foundationhouse.org.au/promoting-engagement-interpreters-victorian-health-services/>

QUESTIONS ON MONITORING AND EVALUATION

Which agency or agencies are best placed to administer measurement and reporting of outcomes?

The experience of FASSTT services is that there continues to be significant inadequacies in the compilation, analysis and dissemination of evidence about outcomes and program effectiveness. This the case for the three tiers of government. Ongoing data collection focuses on outputs and quantitative KPIs and while this allows for service output monitoring, it says very little about outcomes, impact or effectiveness.

It is recommended that public, private and non-governmental service providers receiving funds to provide services should be required as a condition of funding to collect, analyse and report (whether to the contractor and/or publicly) data about the outcomes of their services. The data should include demographic and related information to provide indicators of their accessibility and responsiveness to the diversity of the population e.g. whether clients required an interpreter; whether qualified interpreters were provided when required.

However, it is essential that every funding contract have embedded into it an evaluation component and that the evaluation methodology takes into account:

- Ethical issues specific to working with refugee populations
- Low English and computer literacy
- Low literacy in first language for some groups
- Need for translated and validated psychological instruments ensuring that concepts explored are relevant and understood across cultural, linguistic and educational backgrounds.
- Impact of torture and trauma on clients' ability to engage with and respond to lengthy questionnaires
- Issues of stigma associated with responding to mental health/psychological instruments
- Potential impact of intrusive data collection on client engagement in intervention particularly at the pre-intervention data collection stage.
- Need to involve refugee community individuals and organisations in outcome design and evaluation planning and implementation to ensure cultural appropriateness and uptake of the evaluation.

It is also recommended that funders should periodically commission independent evaluations to ensure that the providers are efficient and effective.

APPENDIX 1

FASSTT Member Agencies

ASeTTS: Association of Services to Torture and Trauma Survivors

Address: 286 Beaufort St, Perth, WA 6000

Companion House

Address: 41 Templeton Street, Cook, ACT 2614

Melaleuca Refugee Centre: Torture and Trauma Survivors Service of the Northern Territory

Address: 24 McLachlan Street, Darwin NT 0800

Phoenix Centre

Address: Level 2, 1a Anfield Street, Glenorchy TAS 7010

QPASTT: Queensland Program of Assistance to Survivors of Torture and Trauma

Address: 28 Dibley, Street, Woolloongabba, QLD 4102

STARTTS: Service for the Treatment and Rehabilitation of Torture and Trauma Survivors

Address: 152 The Horsley Drive, Carramar, NSW 2163

STTARS: Survivors of Torture and Trauma Assistance and Rehabilitation Service

Address: 81 Angas Street, Adelaide, SA 5000

VFST: Victorian Foundation for Survivors of Torture

Address: 4 Gardiner St, Brunswick, VIC 3056

Correspondence to: FASSTT: P.O. 6254, Fairfield, Brisbane. 4103