



**Submission from the**

**Forum of Australian Services for Survivors of Torture and Trauma**

**to the**

**Productivity Commission Paper on Human Services: Identifying**

**service sectors best suited for reform**

The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) welcomes the opportunity to contribute to the Productivity Commission's Issue Paper on Human Services: Identifying service sectors best suited for reform.

## **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 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 2014 – 2015, FASSTT member agencies provided psychological support to just under 15,000 people who have arrived in Australia under the Refugee and Humanitarian Program from more than 72 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 26 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 in building their capacity to access to a range of general/mainstream services.

### **The unique context of FASSTT**

Torture <sup>1</sup> has a specific definition and methods of torture are well documented<sup>2</sup>. It is estimated that world-wide up to 35% of refugees have been physically tortured or psychologically violated<sup>3</sup>. 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 kinds<sup>4</sup>. 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 enduring 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

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<sup>1</sup> 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.<sup>2</sup> IRCT <http://www.irct.org/what-is-torture/defining-torture.aspx>

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<sup>3</sup> R Baker, 'Psychosocial consequences of tortured refugees seeking asylum and refugee status in Europe', in M Basaglu (ed), *Torture and its consequences: current treatment approaches*, Cambridge University Press, Glasgow, 1992, p85.

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

population.<sup>5 6</sup> 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**

Refugee and humanitarian entrants, particularly survivors of torture and trauma, have particular needs and are accordingly appropriately treated as a special needs group within the mental health service context. These needs arise from the fact that their circumstances are commonly characterised by the following:

- 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 well-being of children and young people can be particularly affected because of disruptions to schooling 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. The top refugee producing countries in 2011 were Afghanistan, Iraq, Somalia, Sudan the Democratic Republic of Congo and Myanmar. In 2015, there were increased intakes from Somalia and Syria. Specialist torture and trauma services are essential in order to continue innovative and responsive service approaches based on an understanding of the broad impacts of torture and trauma for ever changing client populations.

### **What makes FASSTT unique**

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<sup>5</sup> K Alden, Paper presented to the International Conference for the Reception and Integration of Resettled Refugees, Sweden, 2001.

<sup>6</sup> 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.

FASSTT member agencies have been delivering services for between 18 and 26 years. Throughout this period FASSTT members have remained focussed in 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.

There is also a clear commitment to working in partnership with government. For example, the Victorian Refugee Health and Well Being Plan was developed by the Victorian Foundation for Survivors of Torture in partnership with the Victorian State Government and has led to a significant policy commitment including creation of 18 Refugee Health nurse positions working across the state.

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 also 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 this past 26 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; 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.



## **IMPACT OF MARKET DRIVEN PRINCIPLES OF COMPETITION, CONTESTABILITY AND INFORMED USER CHOICE FOR THIS CLIENT COHORT**

FASSTT agrees with the Productivity Commission Paper on the importance of services to provide quality services in ways that are client focused and use innovation and efficiency to best utilise limited resources and funding. However FASSTT recommends exercising caution in relation to the introduction of market driven principles of contestability, competition and user informed choice, which could potentially result in negative outcomes for clients from refugee and humanitarian backgrounds for a number of reasons.

1. While the motivation behind increasing competition between service providers may be intended to offer clients a greater diversity of choice, competitive tendering often results in funding being awarded to larger organisations with the resources to compete. This may lead to less diversity in the marketplace as smaller organisations that are not able to compete cannot sustain their services, resulting overall in less choice for the client.
2. Introducing competition between multiple services is not likely to result in real increased choice because the informed user model does not in reality allow this client cohort to shape the services they receive, only at best to choose between them. The capacity for services to be flexible and responsive to specialised needs people from refugee backgrounds would still be tied to the government funding arrangements and prioritise contractual requirements and agency's internal organisational capacity to effectively respond to this client cohort
3. The capacity of market driven principles of competition to enhance quality of service and efficiency is based on the assumption that equitable and informed consumer choice is possible. This is not evidence based and is not possible for all client groups in the reality because:
  - Not all clients are equally able to make informed choice either - the context of their lives limit their capacity to make informed decisions; their personal circumstances mean that they are in need of immediate assistance; they have poor access to the information or knowledge needed or they do not have access to quality independent information and the time to digest and make sense of this information.
  - The capacity of refugee survivors of torture and trauma to make choices and decisions that are authentically informed is severely limited and may not be possible for multiple reasons: language and cultural barriers; lack of understanding about Australian systems and cultural context of making choices within contexts of authoritative systems and experts; lack of self advocacy skills that are critical to making informed decisions; significant levels of vulnerability due to the impacts of torture and trauma exacerbated by the settlement processes. Additionally, accessible information provision for this client cohort would require objective, comprehensive and specialised communications strategies that would be costly and difficult to establish and maintain.
  - The provision of effective and efficient services to this client cohort is highly specialised and mainstream human services agencies generally do not have the skills, knowledge, infrastructure or flexibility in their service model and frameworks. Effective work with refugee communities requires long term sustained community engagement and the existence of content free funding would not necessarily enable better service access or

provision. Examples of this can be found in the current failure of the NDIS and Aged Care systems to ensure people from CALD backgrounds have access to the scheme let alone to the service outcomes that they may desire. In the NDIS sites to date only 4% of people who have successfully received a package come from CALD backgrounds.

4. The majority of human service sectors operate within the context of higher demand than availability. As the majority of funding is currently grant based and capped, services manage this by prioritising service delivery. While this may mean that not all people asking for a service may receive the one requested - this is generally considered within the context of need. In reality one of the unfunded roles of the community services sector is to manage the allocation of services according to need within a limited budget on behalf of government. Should these services move to a contestability model, the government needs to consider:
  - Whether it will allow open ended funding (and the possibility of a budget blow out) or whether it will cap funding in the absence of consideration of need. In the case of the NDIS, there has recently been considerable publicity pertaining to whether places will be limited or not, given that the demand is exceeding places allocated and unless new funding arrangements are negotiated there may be a hold on allocation of new places – under this model there is no way to consider comparative need meaning people with high needs may miss out or the program needs to become uncapped.
  - Because community based services are currently funded within a capped arrangement and demand exceeds supply, they have a built in incentive to consider and provide early intervention services in order to reduce the number complex clients seeking assistance at a later stage. Where funding is uncapped and provided according to complexity there is an incentive for agencies to ensure that more people enter the system and receive maximum service delivery. This is compounded by the difficulties in measuring early intervention outcomes compared to outcomes at a more acute stage. The NDIS is a prime example, where in order to receive maximum services people need to receive the most severe diagnosis possible. Another example is the health system where the incentive is to treat at the acute end of the system rather than address issues within an early intervention model.
  - Uncapped service delivery could potentially lead to over servicing. It would mean that services would be incentivised to see more clients, where a need might not exist. This potentially leads to less flexibility as the system attempts to limit costs and over servicing. For example, under the Better Access Programs clients can receive 6 + 6 sessions in 12 months regardless of actual need. Consequently the majority of clients receive this number of sessions. Under more flexible arrangements which are not user choice a service may provide one client a couple of sessions but another client 50 sessions dependant on complexity and need. The overall sessions available (capacity) may remain the same but a formula is not used to determine eligibility or services delivered.
  
5. The current tendency is for mainstream services to focus on less complex clients in order to meet targets under current contract arrangements and not equitably engaging with more complex client cohort (*ACOSS submission says “difficulty in aligning contracts and funding arrangements with program goals” and uses the employment services as an example... “evidence suggests providers have engaged in ‘creaming’ and ‘parking’ of clients, concentrating their*



*efforts on more straightforward cases while failing to assist those with more complex problems.”) (p.10)*

6. The dichotomy between competition and collaboration is significant. Competitive models and tendering can threaten collaboration. One of the greatest costs of competition is the loss of partnerships developed around client need and client outcomes. This has been clearly evidenced in the sectors already subject to competitive tendering. Organisations, such as the FASSTT agencies which are currently funded to work with a specific highly vulnerable client cohort, undertake as part of their role, capacity building of other agencies in order to enable client access to a range of mainstream services. The capacity to undertake partnerships across sectors according to client needs and priorities is invaluable and irreplaceable.
7. There are clear impacts on workforce.–
  - In a number of user choice/contestability models, the cost of the model (and efficiencies gained) has been borne by the workforce. In the NDIS, for example, a highly skilled permanent workforce is being replaced by a casualised low skilled workforce. The long term cost of this to the Australian community has yet to be determined.
  - Competitive tendering models could come at a cost in terms of specialised skill sets and investment. Commonwealth and State Governments have invested heavily in ensuring specialised skills are developed and maintained across a number of highly specialised service areas particularly when working within areas such as complex trauma. The introduction of competitive tendering would see a potential loss of this specialisation as funding moves from one organisation to another in each tender round.
8. Communities are not all the same and not all people within one geographical area (place) have an equal voice. Community service agencies work with highly vulnerable people often with complex needs. By assuming that single mainstream service points determined via a competitive process can adequately service all groups is a fallacy and in this current context, an increase in the number of agencies providing therapeutic and support services to this client cohort would not increase the possibility of real choice.
9. The danger of competition is that services focus on delivery of contracted KPIs or outcomes rather than looking at the holistic needs of the clients. This means that where clients are highly vulnerable or have complex needs - looking at underlying needs is not a service deliverable. For example, an employment service may be contracted to provide employment support however the underlying issues in relation to trauma or wellbeing go unresolved or counselling hours may be delivered however the client may be in crisis around housing.

Contestability assumes that a viable market exists and is accessible. In addition markets are usually only considered within a one dimensional framework and there may be multiple market failures underlying a market that may appear robust. For example a region may have an adequate supply of GPs but only one bulk bills and you happen to be on a healthcare card, you have no choice. If GPs chose not to see people from refugee backgrounds because they are “too expensive” then the market has failed this group. The NDIS uses contestability however this is based on the premise that clients have equal access to GPs and medical specialists in order to

receive a diagnosis or evidence of disability, however if you do not have access to a GP or specialist you cannot access the NDIS.

### **RECOMMENDATIONS FROM FASSTT**

1. FASSTT supports the Productivity Commission recommendations that:
  - Governments improve the way they select, fund, monitor and evaluate providers of family and community services in order to improve outcomes for the users of those services.
  - Governments could deliver a better mix of services if they took a systematic approach to identifying the community needs based not only on geographical communities but also on communities of interest.
  - Engagement with service providers and users at the policy design stage could increase the quality and efficiency of services.
  - Contract arrangements that are focused on outcomes for service users could increase the incentives for service providers to deliver services that meet people's needs and provide more scope for innovation in service delivery. This includes longer contact periods to enable innovation and evaluation.
  - Better use of data could help service providers and governments identify and disseminate effective practices.
2. FASSTT recommends that in considering which services are suited for reform, governments recognise the value and critical necessity of specialist service provision to clients from refugee and humanitarian backgrounds, and do not include them in the services to be renewed.
3. Further, FASSTT recommends that should further competition or contestability be introduced into the community services sector consideration be given to strategies that will enable highly vulnerable and complex need cohorts to continue to access services equitably.