Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF PARIS ARISTOTLE AO

I, Paris Aristotle AO, Chief Executive Officer of the Victorian Foundation for Survivors of Torture (Foundation House), of 4 Gardiner St, Brunswick VIC 3056, say as follows:

1 I make this statement on the basis of my own knowledge, except where otherwise stated. Where I make statements based on information provided by others, I believe that information to be true.

2 I am authorised by Foundation House to make this statement on its behalf.

Background

3 I am the founding Chief Executive Officer of Foundation House.

4 I have over 30 years' experience in the field of supporting refugees and asylum seekers, particularly in the provision of services to survivors of torture and other traumatic events.

5 I have served on, and chaired a wide range of State and Commonwealth Government bodies advising on refugee and asylum seeker policy and multicultural affairs. I am currently the Chair of the Commonwealth Government's Refugee and Migrant Services Advisory Council.

6 Attached to this statement and marked 'PA-1' is a copy of my curriculum vitae.

Foundation House

The role of Foundation House in providing support to refugees and asylum seekers who are survivors of torture and other traumatic events

7 Foundation House is a specialist service assisting refugees and asylum seekers who have experienced torture and other traumatic events in or while fleeing their countries of origin, while living in refugee camps or in countries where they have sought asylum. Our clients are people who have arrived in Australia through the Commonwealth Government's Humanitarian Program, or who have arrived by other means and are seeking asylum.

8 We provide a wide range of psychosocial services including mental health services in the form of trauma counselling and psychotherapy, psychiatric care, natural and tactile

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

therapies and community capacity building programs. In addition, Foundation House leads several programs designed to improve the capacity and responsiveness of other sectors and systems such as primary health and mental health services. We also provide services to early years programs, primary and secondary schools, adult English language and vocational training programs, settlement services, youth and other community services. A substantial component of our work entails providing an extensive range of professional development and training programs across these different service systems.

9 We also undertake independent and collaborative research and provide specialist policy advice to help improve service provision to refugees and asylum seekers. Our advice is provided to government and other service sectors including health and mental health, public health, education and training, early years and youth and community services.

10 Foundation House has a diverse client base that varies in size according to the number of people arriving in Australia through the Humanitarian Program or as asylum seekers. Naturally, our funding also dictates the level of services we can offer. On average, in any one year Foundation House assists over 4000 clients from around 40 different countries and ethnicities.

11 We are often confronted with not being able to respond to some cases for periods ranging on average from four to eight months, and longer on occasions. At the time of writing we had approximately 300 individual and family referrals awaiting intake and/or assessment. With increased funding we could respond in a more timely manner.

Foundation House's implementation of a trauma-informed and trauma-focused care approach

Trauma-informed care

12 Trauma-informed care relates to organisations understanding the nature, severity and psychosocial consequences generated by the trauma history of their clients. Trauma-informed organisations use that knowledge to determine how their services should be oriented and how they can best engage with their clients and client communities, and to guide the processes they use to support improved access and client outcomes.

13 A trauma-informed approach is critical not only in services for refugee survivors of trauma, but also in services assisting people whose traumatic experiences may have occurred in various contexts such as active military service, victims of crime, natural and other disasters, domestic violence, child abuse and sexual assault.

14 At Foundation House, trauma-informed care principles underpin everything we do. This means that all staff, regardless of their roles, are supported through induction and training programs to have a shared understanding of the impact of trauma for clients, their families

and their communities. It is also reflected in our understanding of how the nature of this work can affect our staff and through our systems of supervision, debriefing and professional development that have been designed to support staff in undertaking their roles.

15 Foundation House's *integrated trauma recovery service model* captures the principles of trauma-informed care. It presents the recovery goals for clients that guide our work and illustrates how all staff can function within their roles to support the attainment of those goals. The recovery goals are:

(a) to restore safety and enhance agency and control;

(b) to restore secure attachments, promote connections to others and enhance a sense of belonging;

(c) to restore meaning and purpose to life, rebuild identity and promote justice; and

(d) to restore dignity and value and reduce excessive shame and guilt.

16 Much of what I describe throughout this statement can be linked back to these recovery goals.

Trauma-focused approach

17 A trauma-focused approach is the application of specialised interventions and services for working in-depth with severe disruptions to mental health and daily functioning caused by exposure to traumatic events. As a specialist agency, in supporting refugees recover from torture and other traumatic events we provide interventions to reduce symptoms characteristic of post-traumatic stress disorder and other common disorders such as anxiety and depression. We also focus on major disruptions due to emotional, psychological and behavioural characteristics of complex trauma, including emotional dysregulation, interpersonal difficulties and personality disorders.

Assessment and provision of appropriate care

18 The initial key to providing appropriate trauma-informed and trauma-focused care is comprehensive assessment that has regard to clients' pre-arrival history and experiences; 'identities', such as ethnicity, faith, gender and sexuality; and post-arrival and current circumstances, such as visa status, employment, family composition and family functioning. I will elaborate on these and provide case studies from our work that illustrate the importance of holistic approaches.

Pre-arrival history and experiences

19 We ensure our service provision is properly informed by a thorough understanding of the nature of the conflict clients (and client communities) have fled, and the extent of exposure to torture and other traumatic events such as the death of loved ones in violent circumstances.

20 For example, one of the key features of refugee trauma derives from the objectives of the persecutory regime from which people have fled. Such regimes use torture to deliberately remove control from people's lives in order to subjugate and make an example of them, thereby suppressing challenges to their authority by others.

21 In some conflicts, torture is used to enforce the ambition and ideological views of resistance movements or insurgency groups. A recent example of this is the activities of ISIS in Syria and Iraq, where members of religious groups not aligned to ISIS have been tortured, killed or forced into sexual slavery and servitude as a means of forcing them and others to convert to the extremist ideology of ISIS. Victoria has resettled thousands of people from these conflicts in the past five years alone, many of whom are clients of our service.

22 The loss of control and constant threat of violence, characteristic of the refugee experience, creates a chronic sense of fear, intense anxiety and loss of hope for the future, often leading to severe depression. Trauma-focused service provision therefore maximises control in the way assessments are conducted and in the joint planning of goals and interventions. It is therapeutic in itself to provide survivors with choice about the type and timing of assistance as this supports greater self-agency throughout their recovery process.

23 The mass and targeted killings that many people of refugee backgrounds have experienced commonly create consequences for survivors such as post-traumatic stress disorder, and depressive and anxiety disorders. Traumatic events that occur during childhood can produce long-term developmental effects and a range of mental health symptoms; grief, changes to identity, loss of meaning, and shame and guilt are frequent psychological sequelae. However, there are also particular impacts reflecting different experiences depending on the region of origin. Such differences influence how we work with certain groups.

24 As an example, when working with people from some conflicts, one of the most traumatic things for them was the realisation that their entire society had crumbled. They witnessed people they trusted, such as the person who ran a local shop or a teacher at their local school, becoming soldiers or military leaders who then perpetrated horrific violence against them and others. That shattered their perception of humanity and their society as being a safe place for them. The absence of safety was debilitating and affected their trust in other people and services. This was compounded by the reality that, in many

instances, the perpetrators were also government officials or part of government systems including the health and mental health system.

25 In most conflicts, families are faced with impossible choices. For example, women from a region in Africa, both mothers and daughters, who were our clients, spoke of government soldiers and officials forcing the men of their ethnic group, including their sons and brothers, to rape them. If they refused they were hacked to death in front of the women and children. A number of interventions were considered important in this context, including individual counselling and family therapy, group work programs and advocacy on their behalf with other essential services. This process led us to also develop a health promotion project to identify General Practitioners (**GPs**) and specialist gynaecologists who would see women rape survivors with sensitive regard for both physical and psychological injuries.

26 Other clients survived long periods in harsh 're-education camps'. Once they were freed they were forced to make an arduous journey by foot across the country to find safety. They talked about their elderly parents being unable to make that journey and having no option but to leave them by the side of the road with whatever portions of food they could spare and beg for forgiveness from them as they left. Even though many years had passed since that time the psychological pain, grief and trauma remained.

27 In other circumstances, clients were forced to flee during raids on villages and towns while some family members were away working. They became separated and, in many cases, still do not know the whereabouts of their family members or, even if they do, they are never able to be reunited. In both of these circumstances our clients blame themselves for having to leave and for failing to protect those separated family members.

28 These stories are typical of our clients' experiences and exemplify why a specialist service with a trauma-focused approach is essential when dealing with them.

Family focus

29 Family-focused assessment and service provision are imperative, particularly as family systems are vital to how well most people function. Understanding the importance of family and the intergenerational relationships that are culturally ascribed is crucial in informing how mental health services engage with communities and clients. For example, in some cultures a son or daughter is considered to be a child in their relationship to their parent until they are much older than is the case in the Anglo-Australian culture.

30 Having a family-focused and inclusive approach requires a greater emphasis across the mental health system. Assessment processes and interventions need to be inclusive of and support families as a whole. For example, in some refugee communities it is common to find families with large numbers of children being cared for by a single parent (usually

a single mother) trying to deal with all the issues confronting their family while settling in Victoria. They often have little English and are on very low incomes. Simply addressing the mental health problems of the person initially referred without understanding how they intersect within the home context, including what support others at home might need, makes it difficult to achieve positive long-term outcomes.

31 The assessment and provision of care should be adapted appropriately for the various stages of the lifespan. While this is already well understood by mental health services, incorporating a sound appreciation of cross-cultural issues and how they affect interventions across the life span are not as well appreciated. For example, the intergenerational gap between children and parents that emerges with settlement increases the risk of family conflict and breakdown, which in turn increases the risk factors for the mental health of several family members. In other cases we have worked with older siblings in their mid to late teens who are required to take on a parenting role due to the death of one or both parents, in addition to dealing with their own traumatic experiences.

Identities

32 People of refugee backgrounds are drawn from a diverse range of ethnic, cultural and religious groups as well as people who identify as LGBTIQ+. Working effectively and appropriately with diversity requires recognition that every encounter may be a cross-cultural one. This means service providers need to be aware of their own (and their organisation's) world-views, values, philosophies and explanatory models, as well as those of service recipients and their communities. Failure by an agency to take on these issues is a critical factor in people deciding not to take up a service or to withdraw quickly due to a lack of confidence that the agency will understand them or be of assistance.

33 Factors that are important to consider include language and communication; understanding of beliefs and practices related to help-seeking behaviour; experiences of discrimination; expectations of practitioners; and gender and LGBTIQ+ identity.

Post-arrival experiences

34 At Foundation House, we also incorporate how the challenges and opportunities of settling in a new country affect clients in relation to their trauma. For example, experiences of racism or discrimination can trigger traumatic memories, feelings of helplessness and a lack of safety.

35 The factors impacting the mental health of clients may involve both pre-arrival and current circumstances. For example, we may have someone who is struggling with pre-arrival mental and physical experiences of torture who is also trying to deal with insecure housing and concerns about how to support their children's education. Limited English language

proficiency and difficulty getting former qualifications recognised make it more difficult for them to secure employment than it is for the general population. Other issues for people of refugee background, such as persistently being worried about their family in their country of origin, or the uncertainty of their immigration status, add complexity to dealing with the mental health consequences of trauma. Ignoring these contextual issues diminishes the formulation of assessments and therefore compromises the effectiveness of subsequent interventions.

36 Asylum seekers who applied for protection after arriving in Australia have often been detained in immigration detention facilities, commonly for very long periods, and this can result in serious adverse impacts on their mental health. This practice continues to be the case today and there is little indication that the situation will change in the future.

37 Being able to develop the trust needed to explore and understand the causes of mental health issues requires a willingness on the part of services to address those broader determinants. In our experience, comprehensive assessments commonly identify pressing needs that are not the primary function of Foundation House or other mental health agencies. Mental health services therefore need to collaborate with a wide range of other services in order to facilitate the assistance people require. However, resource constraints and/or an organisational failure to prioritise such approaches weakens the capacity of an agency to assist individuals and the effectiveness of the mental health system overall.

Case studies illustrating the importance of comprehensive approaches

Communication and gender

38 An example of how we apply both a trauma-informed and trauma-focused approach at Foundation House is our commitment to enabling clients to use our services by ensuring they can communicate with confidence in their primary language. We do this via the use of professional interpreters and/or bicultural workers who provide greater accuracy and objectivity, rather than relying on family members or a friend to undertake that task which unfortunately is often what happens in other service settings.

39 The language proficiency of interpreters is only one aspect that requires attention for clients to communicate confidently. Communication about traumatic events is usually complex and distressing for clients. The nature of their traumatic experiences may mean that they have not told their family everything that happened to them, or they may be relating events for the first time when they speak with a mental health professional. As a consequence, they are unlikely to disclose critical issues they are facing if a family member or friend is interpreting. This means the information the mental health professional needs to address the severity of their client's symptoms may not be

forthcoming. Furthermore, requiring family members and friends to interpret may mean that they themselves become distressed due to their own experience as a refugee.

40 Over the years, Foundation House has assisted numerous women and men who had been sexually assaulted, sometimes on multiple occasions and by multiple perpetrators. In some cases, female clients have had a child as a consequence of rape and have not told their husbands how the child was conceived, or the husbands may not have wanted them to talk about it. Providing the opportunity for our clients to address the deeply traumatic consequences of such experiences, including complex trauma symptoms, feelings of guilt and shame, difficulty with partner intimacy or relationships with their children requires specialist and skilled counselling and focused support.

41 In applying our understanding of trauma in such cases, coupled with appreciating the background of our clients, we also know that trauma-informed services must place a premium on the importance of trust. As trust takes time to establish and is vital to creating a safe therapeutic environment, Foundation House ensures (as far as possible) that when clients are comfortable with their interpreter, we negotiate to secure the same interpreter for each session throughout their care. In the case of bicultural workers, they would generally be employees of Foundation House and we ensure the same principle is applied.

42 In cases of sexual violence in particular, the gender of the counsellor and interpreter are also important considerations. Ensuring the client can choose the gender of their counsellor and interpreter is fundamental to enabling the client to feel safe and more comfortable. The ethnic and faith background of service providers may also be pertinent.

43 Trauma-informed approaches in this context would also recognise the complexity associated with interpreting this subject matter and the potential impact that such material can have on interpreters and bicultural workers. Allowing time to check in with how they are coping following sessions is important to recognise and appreciate.

44 We recommend that the Commission considers how interpreter services can be better resourced and encouraged to take this complexity into account in terms of the support and training they provide for their employees and contractors.

45 Furthermore, we recommend the Commission considers the need for increased funding for interpreting and translating services to enable greater responsiveness across the mental health system. There is a proposal to this effect in our submission.

An illustration of dealing with diversity

46 A woman who had been imprisoned sustained very severe injuries as a result of being sexually tortured. An initial detailed assessment helped identify the severity and nature of

her trauma and how that manifested in terms of reactions and symptoms of severe depression and anxiety. That assessment enabled a coordinated response to her needs inclusive of the provision of counselling and liaison with her GP and medical specialists. However, she did not improve to the degree that we would have expected.

47 Following further counselling to review her progress and explore her trauma in greater depth, aspects of her faith emerged as particularly significant. She blamed herself for what had happened and felt profoundly shamed and unworthy in the context of her religion.

48 Taking this into account, the counsellor connected the woman to a nun from the woman's religion who was able to provide reassurance that what had happened was not her fault and that from her faith's perspective she would not be seen in a negative light. The affirmation and comfort this provided from within her own faith was of critical importance and her responsiveness to interventions improved.

Investing in trauma-informed and trauma-focused capabilities

49 We welcome the Commission's view in the Interim Report that providing trauma-informed care and practice should be embedded throughout the mental health system. However, as the Commission has found, significant work remains to be done to realise the principle.

50 I would like to provide an overview of the internal systems adopted by Foundation House to enhance its trauma-informed and trauma-focused services, and its support to other organisations to develop their capacities to work with people of refugee backgrounds. I would also like to make some general observations about how trauma-informed care in Victoria's mental health services might be strengthened.

Internal Foundation House systems

51 In 1998 Foundation House produced a guide to working with refugees titled Rebuilding Shattered Lives (**RSL**). RSL was one of the first resources produced in Australia that described an overarching framework for understanding the refugee experience and the psychosocial impacts of those experiences on individuals, families and communities. It provides the basis of our integrated trauma recovery service model that guides our work with clients and their communities. A second edition of RSL has now been prepared incorporating the collective experience and expertise developed since the original edition was produced. This new and comprehensive resource will be published by the end of this year.

52 RSL is also the basis for the practice development framework that we use to build the capacity of our staff, to enable them to consistently apply our trauma recovery model and to maintain a culture of continuous improvement and achievement.

53 The framework includes a leadership program, operational and reflective supervision for all staff and measures to support their wellbeing. It contains an induction and continuous professional development program for all staff focused on their role in supporting the recovery process. It provides access to resources and literature on trauma-informed and trauma-focused practice and ensures access to a team of practice leaders who support and help guide the work of practitioners.

54 Establishing and documenting our integrated trauma recovery framework and recovery goals, coupled with a strong commitment to applying our practice development framework, are important in retaining staff and increasing expertise.

Foundation House's work to promote trauma-informed services externally

55 Externally, the Foundation House framework is used to support other organisations and service providers to develop their capacity to work with survivors of torture and other traumatic events in a trauma-informed way. This is achieved through our professional development, secondary consultation and consultancy services and other collaborative approaches, and production of resources such as a guide to working with refugee young people and guides for GPs and other primary health workers. At this point I will focus on professional development and describe other aspects in the context of the relationships between specialist and generalist service providers.

56 Foundation House delivers professional development and supervision each year to thousands of professionals in Melbourne and in regional and rural Victoria. These professionals work in a diverse range of settings such as primary care, mental health, the hospital system, education, community and family services, settlement services, and youth and adult justice.

57 The modes of delivery vary from offering a structured calendar of training workshops, to designing and delivering training for middle management teams overseeing staff working with refugees and asylum seekers, and providing reflective supervision to settlement staff assisting refugees to establish new lives in Australia.

58 We also have a well-established program funded by the Victorian Government to help schools and early years services adapt their practices and the way in which they engage with children, young people and their parents from refugee backgrounds.

59 The program provides teachers, school counsellors and other staff with training that focuses on understanding the pre-arrival and settlement experiences of children and young people so they can better support their educational development, and to identify those who may need to be referred for assistance by Foundation House or other mental health services.

General observations about embedding trauma informed care in Victoria's mental health service system

60 The Foundation House submission proposes several measures that the Commission can consider to strengthen the adoption of trauma-informed care in Victoria's mental health service system. One is the development of a standard for mental health services on trauma-informed care; another is enhanced collaboration between specialist services such as Foundation House and mainstream services, which I say more about below.

61 A key aspect of any strategy to achieve this objective is that services are able and committed to investing in more trauma-informed development of their staff. This has implications for funding to promote knowledge transfer across the mental health system.

62 One option for achieving this could be to establish a dedicated stream of funding, perhaps via the proposed Collaborative Centre. It is important that an investment of this nature is significant enough to enable a disciplined commitment to drawing on intellectually rigorous expertise, literature and sound research.

63 Looking ahead, I think Foundation House has the potential to contribute significantly more to the development of Victoria's trauma-informed and trauma-focused mental health service system. This could very well be an area for fruitful dialogue with the Collaborative Centre.

Responding to diversity

Differences in the ways in which refugees and asylum seekers seek information and advice about their mental health, compared to the general population

64 Compared with the general population, two key factors affecting people who are recognised as refugees and asylum seekers in accessing mental health services are health literacy and cultural understandings of mental health problems and means of addressing them.

65 By health literacy I mean that by virtue of coming from other countries with very different types of services, refugees and those seeking asylum are less knowledgeable about the types of services available for mental health issues and how to access them.

66 With respect to culture, I refer to the fact that diverse cultures have understandings of mental health issues and healing models that differ from the dominant 'western' approach in Australia.

67 Resettled refugees have secure residency and access to a range of excellent health and other services from the time of their arrival. Nonetheless, they also have substantial

challenges to settle well, including dealing with the impacts of torture and other traumatic events. Additional pressures, such as learning a new language, securing employment and adjusting to a new culture with different laws and expectations, can be very stressful. These stressors and cultural differences (in comparison to the general population) further complicate their awareness, ability and, at times, preparedness to seek advice about their mental health.

68 There are also significant differences between the experiences of refugees who have been resettled under the Australian Government Humanitarian Program and people who seek asylum after having arrived with a non-refugee visa or without a visa. In particular, asylum seekers are constantly facing fear about the possibility of their visa applications being rejected and thus being sent back to the countries from which they are claiming protection. Resettled refugees do not have to live with such fears.

69 Asylum seekers endure other circumstances adverse to their mental health. The process of status determination can take years; many experience prolonged periods of immigration detention during which they often report negative perceptions or experiences of mental health services that were available to them while being detained. Many also endure years of separation from family members.

70 Commonwealth Government policies restrict asylum seekers' access to welfare and health services. Some fear that seeking assistance for their mental health will be communicated to the authorities and negatively affect their applications for protection. Importantly, the corrosive public discourse about asylum seekers and at times racist commentary can be humiliating and cause them to feel acute distress and fear.

71 I appreciate that the Victorian Government enables access for asylum seekers to the state government mental health system. I also welcome the recent funding grants to organisations such as the Cabrini Asylum Seeker and Refugee Hub, Monash Refugee Health & Wellbeing, the Australian Red Cross, the Asylum Seeker Resource Centre, Refugee Legal and Foundation House. Those grants have enabled important assistance to be provided to vulnerable asylum seekers by improving mental health care and by preventing destitution.

72 I recommend that a funding stream of this nature continue to be provided by the state government beyond this initial generous contribution.

Supporting individuals, communities and groups with diverse needs to overcome stigma and improve access to mental health services

73 The essential starting point for improving the access of people of diverse backgrounds to mental health services is an understanding of barriers such as those I have mentioned;

for example, the different explanatory models for mental health issues and healing models; fear and shame about acknowledging mental health issues; apprehension about using services, such as whether confidentiality is assured; whether services do or not have a reputation for being culturally sensitive; and using interpreters when required.

74 In particular, stigma associated with mental illness can create a significant barrier when it comes to the issue of access. As we know, stigma about mental health issues is prevalent across society generally; however, there are additional issues for some refugee and other migrant communities. Overcoming stigma can be very difficult without building positive relationships into the wider communities that clients are from.

75 This is important because of the way in which their community's perceptions of mental health may influence clients' decisions about seeking assistance. For example, in some communities newly arrived families have been actively discouraged from acknowledging mental health difficulties or talking about how their traumatic experiences were affecting them due to the exertion of subtle and overt pressure to not disclose their trauma.

76 This discouragement can be attributed to a belief that if they were seen to be having difficulties this would reflect badly on the whole community, given that having mental health problems is regarded as a weakness and would therefore bring shame on the family and community. In particular, there was a perception that if they were seen as a burden due to issues such as mental health, it would have a negative impact on the Australian Government's willingness to resettle others from their community in the future. As you can imagine, this would be a very strong inhibitor to individuals and families acknowledging difficulties and seeking assistance for their mental health needs.

77 Active engagement with community members is essential for service providers. This allows them to gain a proper appreciation of mental health needs and issues of stigma within different communities, how to improve mental health literacy and what adjustments they may need to make to ensure potential clients feel they can approach them with an adequate degree of trust.

78 It is also more than holding one-off consultations with the formal community leadership, although this is of course very important. It is essential to identify who within a community has connection with the more vulnerable members and to engage with them over time. Consultation can be difficult in some cases because of the sensitivities with respect to confidentiality for clients when their communities are small and emerging. It is also important to appreciate the need to draw on the information that clients reveal in the privacy of counselling sessions, where deeper personal experiences and concerns are more likely to be revealed.

79 By linking that kind of information with broader information and perspectives from their wider communities, it is possible to achieve a more sophisticated understanding about how services should be structured and delivered. Where there is an ability to co-design programs and services with feedback from and input from client communities, it has a positive impact on their receptivity to those services.

80 Foundation House is constantly trying to enhance its engagement with communities and improve its capacity to secure client feedback – these can be challenging to do well and require dedicated resources.

81 To effectively communicate their services, mental health agencies need to appreciate that simply translating and disseminating the material they provide in English may be ineffective in reaching people with diverse cultural understandings of mental health or who may have relatively low levels of literacy in their own language.

82 The first proposal in our submission is that the Commission considers recommending that the Victorian Government provide funding to support the engagement of people from refugee backgrounds to undertake mental health literacy work.

83 There are several ways this can occur. One is through the funding of ethnic community-based organisations directly to do this work. Another is through providing funding to specialist and general mental health services for the employment of bicultural workers. Both approaches have merit and when applied properly can be complementary and efficient.

84 A further strategy that we have found to be effective is through establishing advisory groups drawn from members of the particular communities we want to reach to obtain advice on communication strategies, co-design components of service delivery and build the capacity of people within the communities to recognise mental health needs and how to access services.

85 Let me provide an example of a current Foundation House activity that combines a couple of these approaches – the Al-Rafahiya Al-Sehiya (which means Healthy Wellbeing in Arabic) mental health literacy project, which is funded by the Victorian Government. Two advisory groups with members drawn from the Syrian and Iraqi communities were established and healthy wellbeing sessions delivered to community members, facilitated by bicultural workers.

86 Our project team worked closely with advisory group members to develop community engagement strategies and the co-design of community-based sessions in relation to mental health and wellbeing. Primary and tertiary mental health service providers are included in the group program to increase reciprocal understanding and improve the communities' access to mainstream mental health services and their responsiveness.

Inherent in the model is the enhancement of knowledge and skills of bicultural workers who then become an ongoing resource to their communities and to other services.

Assisting a service to be responsive to diversity at individual, family and community levels

87 Further to the information I have provided so far and to flag issues I will elaborate on, I would summarise the key elements that assist a service to be responsive to diversity and intersectionality as:

(a) service leadership that adopts explicit principles and policies about responsiveness to diversity and ensures these are communicated to staff;

(b) resources that are clearly allocated to ensure responsiveness through, for example, professional development and ensuring interpreting is provided as a matter of course when required and key information is translated;

(c) community engagement strategies including partnership with key community members in the co-design and development of service responses;

(d) monitoring who the service's clients are and whether they reflect the diversity of the population intended to be served, whether the service is place–based or otherwise based;

(e) adopting mechanisms to hear what clients think about the service and to ensure that these views are considered by management and disseminated; and

(f) external accountability of services to their governance bodies, funders, audit agencies, accreditation bodies and the community at large – service responsiveness should be routinely published.

The ideal roles of specialist services including culturally-specific organisations in a future community-based mental health system

88 Based on our experience, I believe there are several roles that specialist services can and should undertake in the mental health system of Victoria. In particular, they are:

(a) providing specialist trauma-focused interventions for complex cases;

(b) building and documenting learnings from our work through research and evaluation and sharing that expertise via different forms of knowledge transfer;

(c) referring individual and family cases to each other and working collaboratively where their complementary skills are required; and

(d) workforce development.

89 I have already addressed points (a) and (b) previously. Looking at point (c), that's a relationship we commonly have with health professionals such as GPs on a case by case basis.

90 Over the past decade our relationship with Royal Children's Hospital Mental Health (**RCH Mental Health**) has been formalised and extended. We have a memorandum of understanding between the two agencies regarding how to collaborate.

91 The arrangement encourages Foundation House and RCH Mental Health to share with each other clinical and other kinds of advice around providing support to individuals and families of refugee backgrounds and identifying where there are appropriate referrals to be made between the services. For example, Foundation House may undertake the assessment of a child and identify the need for consultation with RCH Mental Health and then facilitate a referral. Through this partnership both agencies also identify cases that they can appropriately work with together to maximise positive outcomes.

92 I can illustrate how this works effectively with a case study of a young girl I will refer to as Sandra, which is not her real name. Sandra was referred to Foundation House by her school, which had noticed that she had been showing signs of withdrawal and shyness individually and in groups. She was often very fearful and there was little verbal communication.

93 When we assessed Sandra it was clear she had experienced extensive trauma. When Sandra was an infant her family had to flee the conflict in their country of origin and they were resettled in Australia shortly afterwards. Both parents consented to the referral because of the relationship that Foundation House had with the community. We had workers from that community facilitate a family-centred assessment by our staff that identified that during Sandra's early years the family had experienced prolonged war and displacement. This was compounded by a pattern of violence perpetrated by her father against her mother. Both of the parents were presenting with their own trauma symptoms in that process (which goes back to the family-centred approach I discussed above). Sandra was showing signs of disrupted attachment and that was manifesting in a kind of selective mutism. This was impacting how she was able to perform and work at school.

94 It was decided that the first priority was to establish a sense of safety for Sandra and her mother. Contact was facilitated with a family violence service that started working with Sandra's father via a referral to a behavioural change program. He attended it voluntarily. Both parents were also linked to one of our staff members for individual trauma therapy. As a consequence of these combined interventions the situation reached a point where the family violence had stopped and any concerns relating to potential risks in this regard were being well managed with other support services built into the family care plan.

95 At that point, we referred Sandra to RCH Mental Health to deal with the issues of selective mutism and other psychological manifestations of her trauma. RCH Mental Health worked very closely with her, provided her with medication to reduce the most severe anxiety symptoms and a range of other therapeutic interventions to support Sandra's ability to function daily with greater confidence. This all occurred in consultation with her parents and in collaboration with Foundation House. Sandra's anxiety symptoms reduced dramatically with the support of this collaboration. She can now talk quite comfortably and easily with familiar adults. She's able to talk with groups, and with other kids at school so she's able to establish friendships. The family is together, both parents continue to engage with Foundation House and there has been no recurrence of the concerns around family violence.

96 Foundation House has approached several other metropolitan mainstream mental health services to develop similar relationships and the response has often been that they do not have the resources or the capacity to do so.

97 In relation to our workforce development role this has a number of aspects. When the Commonwealth significantly increased the intake of refugees from Syria and Iraq in response to the humanitarian crisis in that region, the Victorian Department of Health and Human Services funded a partnership between Foundation House and Orygen Youth Health to deliver three projects to provide better access to mental health services for the surge in arrivals of children, young people and their families from those communities. I have previously mentioned the mental health promotion and mental health literacy project, Al-Rafahiya Al-Sehiya, which we provide. Another project is the establishment of a community of practice managed by Foundation House to undertake workforce development of local and regional health services. The third project, delivered by Orygen Youth Health, provides triage and assessment for people aged 0–24 years, as well as secondary consultation with local settlement and specialist services.

98 A steering group was established to provide oversight of the three projects with a focus on how the learnings of the projects could be incorporated into mainstream mental health services. Key partner agencies represented on the steering committee include ourselves and Orygen, RCH Mental Health, the Austin Health Child and Adolescent Mental Health Service and headspace.

99 The funding for this work is due to end soon. We recommend that the Commission supports the provision of recurrent funding for such activities in the future as a practical strategy for strengthening collaboration between specialist services and the community mental health system.

100 As I have previously described, Foundation House has a long-standing professional development program that provides a range of opportunities for professionals, volunteers

and community workers to develop their skills and knowledge in working with survivors of torture and other traumatic events from refugee backgrounds. I would like to say more about professional development later on.

101 I think it important to mention our relationships with mainstream agencies are not confined to metropolitan Melbourne. With funding from the Commonwealth Government, we provide capacity building, professional learning and secondary consultation to health services in rural and regional Victoria, and work in partnership with a number of agencies to provide counselling services. We anticipate this area of our activity will increase in coming years as it is Commonwealth Government policy to encourage more refugees arriving under the Humanitarian Program to settle in rural and regional areas, where mainstream services may have limited or no experience working with this population.

102 To sum up, specialist agencies like Foundation House have very important roles to play to ensure that mental health services are responsive to our diverse community. Our submission proposed to the Royal Commission that it explicitly recognises and supports the complementary roles of specialist and mainstream agencies.

103 Foundation House welcomes the recommendation of the Royal Commission in its interim report for the establishment of a new Collaborative Centre to be both a provider of excellence in the area in which it is located and to drive improvement across the system. Among other considerations, we welcome that the Commission recommended that the centre's name refer to collaboration as we see the development of partnerships between the centre and specialist agencies as an efficient and effective means of achieving its aims.

How services can be responsive to different cohorts within culturally and linguistically diverse communities

104 I think there are a variety of ways in which services can be, and be seen to be, responsive to different cohorts within culturally and linguistically diverse communities. The starting point has to be an awareness of the particular needs of the cohorts and being open to developing and adjusting services as we learn what works and what does not.

105 Let me provide examples of two very different programs that Foundation House has been running, one for young people of diverse backgrounds and one for women from a particular background.

Ucan2

106 The youth-oriented program is called Ucan2 and has been running for more than 10 years. Ucan2 recognises the disruptions to education, family and social connections and future vocational and employment pathways for young people of refugee backgrounds,

aged 16–25. Ucan2 also incorporates a groupwork program to address mental health issues and when required facilitates referrals for individual care to Foundation House and other mental health services. Underpinned by theory and evidence concerning effective ways to support recovery from trauma and promote successful settlement, it has three core elements:

(a) contextualised and experiential learning focusing on work skills, with opportunities for part-time work experience or volunteering;

(b) psychosocial support; and

(c) development of social connections through contact with peer volunteers, work experience, increased knowledge of support agencies and group processes that create strong connections among Ucan2 group members.

107 The program is delivered by Foundation House in partnership with the Centre for Multicultural Youth and an on-arrival education provider, for one day per week for 16 weeks, in educational settings. Participants who would benefit may then be linked with mentors for 12 months to assist them in further developing their skills, confidence, pathways planning and networks, and to increase their chances of finding work.

108 Since its inception, Ucan2 has delivered programs for over 3000 recently arrived young people of refugee and migrant backgrounds from many countries of origin and ethnicities, both female and male, and worked in partnership with numerous education, community, employment and support services. People who participated during a couple of semesters in 2019 were from 35 countries of birth and 47 nationalities. There were 207 who identified as female, 107 as male and 1 other.

109 A 2017 evaluation by the University of Melbourne found that UCan2 effectively supported young people of refugee backgrounds by providing a holistic response to the challenges they face, including fostering participants' wellbeing and resilience and building confidence, and supporting their engagement in education and employment. The evaluation is accessible on our website.[1]

The Mammas Group

110 In 2019, Foundation House collaborated with South Sudanese community members to instigate a group for mothers, grandmothers, carers and female community leaders to support them in their roles amidst a spate of youth suicides, murders and individuals becoming involved in the criminal justice system. Community members were reeling with

[1] Dr Karen Block, Dana Young and Robyn Molyneaux, 'Ucan2: Youth Transition Support - Evaluation Report 2017' <http://www.foundationhouse.org.au/wp-content/uploads/2018/08/UCan2_evaluation_Full_Report_Final_May2018-1.pdf> [accessed 18 June 2020].

feelings of helplessness and grief and, for some, feelings of shame stemming from having their children labelled as criminals.

111 With Victorian Government financial assistance, the group aimed to address concerns raised about mental health, family wellbeing, health and understanding the legal and education systems.

112 To date, more than 50 women aged from their mid-20s to mid-70s have participated in one or more of 10 sessions, and most sessions had between 18 and 22 attendees.

113 It was vital that the group be run in a culturally responsive way to ensure accessibility and engagement. To this end, the group was facilitated by two Foundation House counsellors who belonged to the South Sudanese community. Community members were also employed to assist with the logistics, recruitment, and facilitation of access to the group. Provision of childcare was essential, and women were assisted with transport costs to further support access. Sharing a meal of traditional food was also an important consideration as, culturally, this was seen as a vital aspect of coming together.

114 Although group members had been living in Australia for many years, there were varying degrees of knowledge about where and how to seek help, so external speakers were invited to develop participants' service system literacy.

115 The women have been prepared to talk and address significant issues. They strongly identified that behind many of the troubles in the community lay significant mental health concerns for themselves and their families, and they decided to rename the group 'South Sudanese Mammas speak on mental health'. Language used to describe topics and themes was informed by the group members; for example, the mental health component was referred to as 'Matters of the Heart'.

116 The facilitators reflected that the willingness of the women to talk within the group is due to a combination of factors. Perhaps the most important is that they had shared experiences around loss and separation and other struggles. The strong relationship of Foundation House in working with the community over an extended period was seen as essential, and the involvement of participants in co-designing and facilitating the sessions has provided a sense of agency, control and trust. Using language that resonated on a more spiritual level, and incorporating rituals such opening and closing the group with prayer, are also considered to be significant beneficial aspects.

Workforce diversity and responsiveness

Attributes, skills and capabilities needed in a workforce for a service to demonstrate responsiveness to diversity

117 I have previously mentioned the importance Foundation House places on training and support for our staff and its significant provision of professional development and learning for a wide range of people in external services.

118 Trauma-focused work is a specialised area of practice. It is worth the Commission considering whether the content delivered by tertiary training institutions adequately prepares people to deliver these services well. In the context of Foundation House, we have developed a two-year evolving training program for all staff in recognition of the limited training available in this specialised area. It is also an indication of our commitment to continuous improvement and staff support.

119 The aim is to ensure that staff develop the theoretical and practical framework to understand and respond to the people they are supporting. It starts at induction to provide staff with a base level of knowledge and skills. As staff develop in their areas of practice, and move towards implementing more advanced approaches and interventions, or into leadership roles, we provide more advanced training; in addition they may also need to access external professional learning.

120 We also recognise the demands that the work can place on staff, and so established systems of reflective practice, supervision and debriefing. I believe that service agreements and funding arrangements in any area of trauma and/or mental health should recognise and allow for appropriate levels of funding to be available for such areas.

121 In my view, there is a critical role for the Commission's proposed Collaborative Centre to drive change and improvement in tertiary training courses and for professionals across the mental health service system.

The benefits of bi-cultural workers

122 At Foundation House we employ bicultural workers who are also of a refugee background in various roles. They include Counsellor Advocates with appropriate qualifications and expertise, Peer Workers, Bicultural Workers and Community Liaison Workers.

123 Skilled bicultural workers bring a wealth of knowledge about and links with their communities and a closer understanding of the beliefs and attitudes within their community about mental health. They can support clients from their communities to engage with organisations and build trust and understanding about the services that are being provided. They can also enhance the clinician's understanding of the client and

how their presentation might be influenced by pre-arrival experiences, including membership of particular groups, attitudes that might be influencing engagement and how to talk about mental health concepts.

124 Most refugee background communities are collective in character and tend to see themselves, including their problems, in relation to their family (immediate and extended) and wider community. Knowing that someone of their community is working in a mental health service can contribute to significantly improving client access by increasing confidence that the service is safe and understanding of their needs.

What they offer that translators/interpreters do not

125 It is important to recognise that both interpreters and bicultural workers are essential to a well-functioning and culturally responsive mental health system. They are different roles and compliment the delivery of services in different ways.

126 Bicultural workers provide a vital bridge into the communities with which we work and provide invaluable insight and guidance to Foundation House staff about the nature of their communities. They are able to provide a window into how community experiences of persecution and trauma affect individuals and families and what strategies can be employed to address mental health issues caused by those experiences. Integrating the bicultural worker role into our organisation and properly valuing their contribution improves our cultural responsiveness overall.

127 One of the advantages of having a bicultural staff member undertaking joint work with a Counsellor Advocate is that they are able to share with their colleagues the subtleties of communication, meaning and conceptual understandings in relation to mental health. They are also able to help contextualise what is being said by clients as they may have had firsthand experience of the challenges themselves or observed others from their communities in similar circumstances. This is highly advantageous when building trust and confidence and aids the assessment process and the formulation of goals for clients.

128 This is the primary difference and additional benefit that bicultural workers bring to organisations as opposed to interpreters. It would be considered professionally inappropriate for interpreters to perform a similar function as they are generally not trained to do so and the interpreter services that engage them are not designed to support them to do so.

Priorities for strengthening the skills, training and development of peer workforces to support people and communities that have experienced trauma

129 Peer workers are increasingly being embedded in the delivery of mental health support services, although they are relatively recent within refugee background communities.

Peer workers in our context are those who have a shared refugee experience and have an understanding of the impacts of these experiences on mental health and wellbeing. Central to the role is the building of trust between refugee community members and service providers, and the enhancement of refugee community members' knowledge and understanding of what services are available to them and how to access them. Engaging peer workers improves the opportunities for building the conversations within refugee background communities with a view to greater understanding of mental health needs. The also effectively support processes for early referral and seeking of help when required.

130 It is important to develop the capacity of individuals from refugee background communities to be trained and have the skills to be engaged as peer workers. The shared experiences would primarily be as a person from a refugee background who has faced the challenges of rebuilding a life after resettlement and is wanting to support others within their communities. Professional development, reflective practice, supervision and debriefing for refugee background peer workers should address some of the challenges of working within their communities, such as managing the communities' expectations of them, as well as their own experiences of trauma and the implications for the work they undertake in their roles.

131 I believe there is significant scope for Foundation House to contribute to mental health service agencies undertaking these activities.

Commissioning

Payment incentives to encourage service providers to deliver more inclusive, culturally appropriate care

132 I have spoken earlier about factors that assist and hinder services to be responsive to diversity at individual, family and community levels, and these are the subject of specific proposals in Foundation House's original submission to the Commission.

133 The need to respond to diverse communities is reflected in the mental health accreditation requirements of the National Standards for Mental Health Services and in Victoria's 10-year mental health plan. There are also requirements in the *Mental Health Act 2014* (Vic).

134 However, there are significant obstacles that impede the delivery of services to diverse communities. One factor is likely to be that mental health services are usually a smaller part of large health services. This is likely to result in the attention of health service Executive Directors being drawn very closely to the key performance measures articulated in their annual Statement of Priorities. Without key measures associated with responsiveness to diversity and intersectionality being included in these, the risk is always

present of resources being directed to areas that attract greater departmental, ministerial and public scrutiny.

135 If services are to be more accessible and responsive to diverse communities there should be specific articulation of that objective in agency funding agreements, with explicit expectations and accountability requirements. For example, funded agencies should be required to collect and report:

(a) demographic information about their clients, such as countries of origin, so it is possible to assess the extent to which they are meeting the needs of the population they are expected to serve; and

(b) whether their clients required interpreters and whether interpreters were in fact provided when the clients were seen.

136 For its part, the Victorian Government should acknowledge that effectively meeting the needs of our diverse population has implications for the costs of providing services and provide funding accordingly. These costs relate to for example:

(a) professional development;

(b) realistic caseloads for professionals to allow for comprehensive assessment and responses to the needs of clients;

(c) the appointment of bicultural workers;

(d) the use of accredited interpreters when required; and

(e) consulting with consumers and consumer communities about the accessibility and responsiveness of services and how to improve them.

137 Foundation House supports the implementation of financial incentives that recognise the true costs involved. They should be explicitly incorporated in funding agreements and services required to report against them.

138 There are implications as well for the Victorian Government. For example, the identification of gaps in provision will be informed by the data collected by services, but ensuring the measures required to address them are implemented is ultimately a governmental responsibility.

139 Research will be required to advance this work and should be commissioned and supported by government to ensure it addresses the key issues in a timely manner. This could be a role undertaken by or with the advice of the Collaborative Centre.

sign here ►

print name Paris Aristotle

Date 30 June 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT PA-1

This is the attachment marked 'PA-1' referred to in the witness statement of Paris Aristotle dated 30 June 2020.

CURRICULUM VITAE

Name: Mr Paris Aristotle AO

Position: CEO, Foundation House

Address: 4 Gardiner Street, Brunswick, VIC 3056

Employment:

1987 to date: Chief Executive Officer, Victorian Foundation for Survivors of Torture Inc. (Foundation House)

Advisory councils:

2019 to date: Chair Refugee and Migrant Services Advisory Council

2014 to 2018: Chair, Settlement Services Advisory Council (SSCA, formerly Refugee Resettlement Advisory Council)

2012: Member, Prime Minister's Expert Panel on Asylum Seekers

2009 to 2019: Chair, Minister's Council for Asylum Seekers and Detention (MCASD, formerly the Council for Immigration Services and Status Resolution)

1996 – 2015: Member, Refugee Resettlement Advisory Council (RRAC)

2001 – 2007: Member, Immigration Detention Advisory Group (IDAG)

2001: Ministerial Advisory Council on Cultural and Linguistic Diversity

1998 – 1999: National Mental Health Prevention and Promoting Working Group

1996 – 1998: Member, Ministerial Advisory Council Multicultural Human Services

1995 – 1997: Bureau of Immigration and Population Research National Advisory Council and State Reference Group

1994 – 1996: Member, Ministerial Advisory Council Ethnic Health and Community Services

1994: National Task Force on Refugee Resettlement

1993 – 1995: Australian Refugee Council

1990 – 1993: Settlement Advisory Council

Relevant experience:

2002 to date:	NGO Delegate member of Australian Government Delegation to the United Nations High Commissioner for Refugees Annual Tripartite Consultations on Resettlement
1995 to date:	Convenor, National Forum of Torture Trauma Rehabilitation Services
1994 to date:	Executive Member, Forum for Australian Services for Survivors of Torture (FASSTT)
2008 – 2010:	Member, McCaughey Centre Advisory Committee (University of Melbourne)
2004 – 2012:	Member, Centre for Multicultural Youth (CMY)
2002 – 2010:	Part-time Commissioner, Victorian Law Reform Commission (VLRC)
2001 – 2010:	Member, Adult Multicultural Education Services (AMES)
2000 – 2002:	Northern Health Service Network Board Member
1994 – 1997:	Executive Member, International Society for Health and Human Rights
1985 – 1988:	Manager, Kensington Community Centre
1987 – 1988:	Community Services Officer, Melbourne City Council
1982 – 1985:	Program Coordinator/Community Youth Worker, Kensington Community High School

Awards:

2017:	Officer in the Order of Australia (AO)
2017:	Victorian Australian of the Year
2003:	Australian Centenary Medal
2002:	Member in the Order of Australia

Educational qualifications:

2017:	Doctor of Social Science *Honoris Causa*, RMIT University
1980-1982:	Diploma of Youth Work, Philip Institute