ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Melbourne Town Hall, Yarra Room,
90-130 Swanston Street,
Melbourne, Victoria

On Thursday, 18 July 2019 at 10.00am

(Day 13)

Before: Ms Penny Armytage (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Ms Lisa Nichols QC
Ms Georgina Coghlan
Ms Fiona Batten

MS COGHLAN: The focus of today's hearing is on culturally and linguistically diverse communities.

Victoria is Australia's most culturally diverse state, with almost one quarter of the population born overseas. Victorians come from over 230 countries, speak over 200 languages, and follow more than 120 different faiths.

The number of people with refugee backgrounds settling in Victoria is also higher than at any time during the past three decades.

This diversity brings huge opportunities for Victoria and should be widely celebrated, yet many people describe difficulties in overcoming the significant barriers that exist for individuals, families and communities when seeking culturally responsive mental health care.

Much of the feedback from community consultations centred on the need to recognise and tailor services to Victoria's diverse cultural CALD communities and to address the significant barriers to access that they face.

Refugees and asylum seekers in particular are at greater risk of developing mental health conditions than many other population groups in Victoria. This is due to the compounding disadvantages they face, including trauma and disconnection, discrimination and socio-economic risk factors such as unemployment and unstable housing.

When compared to the Australian born population, culturally diverse communities can often face greater stigma about mental health challenges, language and cultural barriers, and limited knowledge of the social services system and available mental health care.

There also needs to be an improved data and evidence base in order for services to address known barriers to access and provide quality care and more responsive services. Doing so will ensure Victoria's culturally and linguistically diverse communities can be confident to seek help and receive the services they need.

The first witness to be called today is Adriana Mendoza. She's the manager of the Victorian Transcultural Mental Health. VTMH is a statewide provider of organisational development, community engagement, workforce

education, and support and research and evaluation.

Her evidence will cover the fact that people from CALD Communities are less represented in the mental health system and in services. She will address the barriers encountered when addressing the mental health system too.

Her evidence will cover how the mental health system can be more suitable for and inclusive of CALD groups.

You will also hear from George Yengi. George was born in South Sudan and came to Australia when he was 14. He will talk about his own mental health issues and access to services. He will also speak more broadly about the views of and challenges faced by members of the South Sudanese community in Melbourne in relation to mental health.

Kylie Scoullar will be called. She's the General Manager, Direct Services, at Foundation House. Her evidence will focus on refugee and asylum seeker groups. She will talk about the mental health issues affecting those groups, barriers to accessing the mental health system, and how the system can be designed to better respond.

You will also hear from Adwin Town. Adwin is a member of the Chinese community. He is a pastor and will talk about his experiences assisting people as a migration consultant. He will share his perspective of mental health not being acknowledged in conservative Chinese culture. He will talk about community leaders needing to obtain knowledge about how to recognise mental health issues and refer people for help.

This afternoon the video submission of Kali Paxinos will be played. Ms Paxinos will talk about her role as a carer for her son and her experience in the context of the Greek community.

Then you will hear from Marie Piu, CEO of Tandem. She will talk about the challenges faced by carers more generally and the additional challenges faced by those from CALD backgrounds.

Ms Batten will call the first witness.

MS BATTEN: The first witness is Ms Adriana Mendoza. I

call Ms Mendoza.

<**ADRIANA MENDOZA, affirmed and examined: [10.07am]**

MS BATTEN: Q. Thank you, Ms Mendoza. Have you, with the assistance of lawyers, prepared a witness statement for this Royal Commission?
A. That's correct.

Q. I tender the statement. [WIT.0002.0004.0001] Could you outline for the Commission, please, your current role and your responsibilities?
A. Absolutely. Thank you for the opportunity. I was appointed as Manager of Victorian Transcultural Mental Health last November, and prior to that I worked as an education consultant within VTMH. I have 10 years of experience working with communities and mental health workers, which of course informs my current role, and my main responsibility is to support VTMH's program areas and service to make sure that as an organisation we continue supporting the system to be more inclusive and to address inequity.

Q. Thank you. Can we first understand what is Victorian Transcultural Mental Health, and that it is also referred to by the acronym VTMH; is that right?
A. Absolutely.

Q. Could you tell us about that service and what it does, please?
A. Absolutely. Victorian Transcultural Mental Health is a mental health capacity building unit. And our main mission, as I was saying before, is to support the workforce to increase its capacity to be more diversity-responsive, with the overarching objective to support individuals, families and communities.

We work through four specific program areas. Would you like me to talk about the program areas?

Q. We will come to that, I just need to ask you some more background questions first but we will come to the programs. Before we get to the programs, can you explain to us why you focus on culture, why is culture so important?
A. Thank you. Culture represents the perspective through which individuals interpret the world, so of course, it is

our main focus. And culture also represents how the society supports migrants, communities, individuals and families. Sometimes there is the assumption that culture is equal to ethnicity, and from our perspective as VTMH, this represents risk of generalising that people from the same country will have the same expectations from the mental health system or will have the same views about life or about what is mental health: recovery and trauma.

That is why, when we think about culture, we suggest the mental health system to also think about intersectionality as a way to respond to diversity, as culture represents more than our ethnicity. For example, it represents social diversity such as age, gender, our life experience, religion, our sexual orientation and more.

And then the intersection between these social categories or identity points may result in advantage or disadvantage for the person, because the society will see this person in a particular way depending on the intersection between these categories, and at the same time the person will form their mental health experience and will give meaning to their own mental health experience depending on these identity points.

Q. We may return to that. Before we come to that, can you clarify for us which groups fall within the definition of culturally and linguistically diverse?
A. I am referring to individuals, families and communities who have diverse backgrounds such as asylum seekers, refugees, international students, skilled migrants, emerging communities and established communities.

Q. Does VTMH advocate on behalf of all of those groups?
A. Absolutely.

Q. You mentioned that VTMH has four main program areas: they're organisational development; education, professional development and workforce support; community engagement; and research evaluation and projects. I'd like to ask you about each of them in turn.

Can you start, please, with organisational development and explain to us what VTMH does in relation to organisational development?
A. Absolutely. I would like to start by saying that, for us as a capacity building unit, it is very important to

form collaborative relationships with organisations; this is not about VTMH telling organisations what to do or how to engage with communities, but it is more about guiding their self-assessment and their possibility to reflect on their policies, their strategies, their practices, how they are involving consumers, carers, and how they are working with people who have lived experience.

So this particular area concentrates on what we call partners in diversity. This is a solid partnership and long intense process in which we support a particular organisation to identify challenges and then think about strategies in terms, to be more culturally responsive and diversity responsive, and we do it through different ways such as training or conversations in which we reflect on challenges and opportunities.

We have a specific model that incorporates the standards that were mentioned in 2009 by the government, by the mental health system, so we incorporated these standards and we support them to go step-by-step and think about how to implement these new strategies. So, it is not just about thinking of what is possible, but about supporting the process of implementing these new practices and that's why this process takes around three years. Then, after the intense partnership process, this is followed by the sustainability stage in which we support organisations to think how to sustain their learnings and their new practices.

Q. Thank you. The second program area is education, professional development and workplace support: could you please explain for us what that involves?
A. Absolutely. This involves understanding the situation of each organisation, group and workers, and think about their learning opportunities. We have different strategies that are available for mental health and community workers such as training, which involves workshops, and we cover topics such as how to work with interpreters which, as we know, is a big challenge in the mental health system.

Also, how to engage with communities; recovery, assessment and diversity, and we also have our introductory workshop to support people to think about these big concepts that are connected with culture responsiveness, but to put them on the ground and then think how to practice these concepts.

We also have online resources that are free and that are available for the whole sector, and of course these resources are totally connected with the workshops that I just mentioned.

We facilitate forums. For example, in August we are going to facilitate a forum about innovative programs that community organisations have identified to put community at the centre of mental health services. This is a good opportunity for different sectors to get together and learn from each other.

We also have seminars, and this represents a good opportunity to inform the sector about different strategies that organisations are utilising.

We have also what we call reflective conversations as we strongly believe - and this is based on evidence and feedback - we strongly believe that being culturally responsive is not just about accruing knowledge but also our reflecting on the way we understand consumers, the way we understand ourselves as practitioners, how to negotiate power, how to hold different perspectives when you are interacting with a consumer who might have a totally different perspective than the clinician or the worker. So, we provide this space to reflect on meaningful challenges.

And, the other strategy that I would like to mention is called transcultural clinical discussions. This particular opportunity concentrates on the identity of a client with support teams to think about how to assess the mental health of this particular client in a way that we are considering the context and the cultural identity of the person.

Something that we hear very often is clinicians and mental health workers saying, "We don't know if some symptoms are actually symptoms, or if we are referring to a cultural identity of the person." The question itself is positive because this means that workers are trying to avoid stigmatising the person. Then as a strategy we put together the session to concentrate on the cultural identity of the person and how to assess that.

Q. One follow-up question from what you just said. With

the forums and the innovative programs, is that different services sharing what they're doing, or is that coming from VTMH?
A. This is different services sharing what they are doing.

Q. The third program area is community engagement: what does that involve on behalf of VTMH?
A. This is a program area that supports services and organisations to think how to engage with communities and what it is important to consider when we are supporting individuals, carers and communities who have different mental health difficulties.

Q. The final area is research evaluation and projects: are you able to tell us about a recent project example that's relevant to the mental health system?
A. Absolutely. For VTMH it is always very important to keep updated regarding different initiatives that are happening within the mental health sector, and this specific program allows us to do that.

I can give you an example of our latest evaluation report and it was based on 13 programs. These services were supporting migrants, refugees, asylum seekers, and of course they heard from different communities, they heard their concerns, and also how communities are looking after each other.

VTMH was in charge of writing a report and this process was supported by the Department of Health and Human Services, and it was managed by the main big bodies that represent consumers and carers. So, as you can see, it was a collaborative process, and our role was to evaluate and support organisations that were facilitating the process.

Q. Are you able to tell us any of the key findings from the report?
A. Yeah, totally. I have incorporated the main key findings as part of my witness statement. For example, one of the main barriers identified is lack of consultation and collaboration with communities, and we have written some recommendations that, if you like, we can revisit when we talk about barriers and recommendations during this session.

Q. Thank you, we will do that. Before we get there,

could you briefly explain to us what the Victorian Cultural Portfolio Holder Program is?
A. The program involves different service providers, different workers that represent organisations within the mental health and community sector. We share challenges that we are facing as well as opportunities. One example can be how we are involving lived experience in our programs.

Feedback says - for us at VTMH it is very important to evaluate our services and think how to enhance them, and we went through a whole evaluation process of this particular program - and feedback says that workers find this space very meaningful in terms of understanding what different services are doing, how to support each other. It also provides a platform to learn about different strategies.

However, something that feedback is underlining is that workers are finding that it is not very easy to generate organisational change. So it seems that the platform is very good in terms of accruing knowledge, in terms of sharing the challenges, in terms of thinking out opportunities, but not necessarily in terms of generating meaningful, big organisational change.

And when we went through that to understand why, why was the reason, then they were very clear in terms of explaining that sometimes there isn't the authorising environment within organisations to make sure that good practices and trauma-informed practices don't depend on individuals. So, this is something that I will mention also as part of the barriers that we have identified at the organisational level, because good practices are dependent on workers and this creates a lot of barriers.

Q. Just before we get to the issue of barriers, are you able to comment on the level of engagement by CALD people with the mental health system as compared to the general population?
A. Absolutely. As I was saying before, VTMH engaged with different stakeholders within the mental health system, also statewide organisations, national organisations and research units and, of course, people with lived experience, communities, families and consumers, and the common message that we are receiving is that migrants and people from diverse backgrounds are not very well represented within the mental health sector from the acute

services to community care.

Q. Not very well represented in terms of, there are not very many of them: is that what you mean?
A. Exactly.

Q. Let's discuss the issue of barriers. I would like to deal with barriers in two different parts: first at an organisational level, and then we'll come to the community level. You've identified five barriers at the organisational level, one of which you mentioned earlier. The first one is good and culturally responsive and trauma-informed care depends on individual workers.

Could you explain that barrier for us and then I understand you'd also like to suggest some solutions for each barrier?
A. Absolutely. I would like to start by saying that today I am going to concentrate on five barriers, but this doesn't mean that these are the only five barriers within the system. Because I am time-limited I chose these barriers to be expressed today.

As you were mentioning, we have identified that trauma-informed practice and culturally responsive practices often depend on specific individuals and that creates the situation that if individuals who are very good workers leave the organisations, the organisations are not going to have a proper structure to sustain their learnings.

The other situation is that, if good practices depend on workers, then they are not going to have enough power to make organisational change while they are part of the organisations. Because of that solution, or more than solution, a recommendation that I would like to put on the table is to think about the possibility to make sure that cultural responsiveness is a mandated - or becomes a mandated component for organisations that are supporting individuals, families and communities who have different backgrounds.

The reason why I am suggesting that is because we believe that cultural responsiveness and trauma-informed practice is something that underpins everything: the interaction with clients, the culture of the organisation, the policies, the strategies, so it is not an element that

you can add on.

Additionally, we believe that it is important that the leadership sector becomes more involved, because most of the time they make decisions that frontline workers are not able to make, and also because we are thinking in terms of supporting systematic change, not just individual change.

If this becomes a mandated component, then I think that perhaps this is going to allow different organisations to understand what culture is and what cultural responsiveness is, because sometimes we get the impression that there is the assumption that, if you don't work with migrants, then cultural responsiveness is not important. Whereas, from our perspective it's different; we need to make sure that the setting is ready, is ready to support migrants instead of the other way.

Q. The second barrier that you've identified is that training is sometimes perceived as the main and only space to recruit good culture. Could you tell us about that barrier, please?

A. We have identified that sometimes in the mental health sector there is the belief that, to be culturally responsive or trauma-informed, then you need to accrue knowledge. And, of course that's important, accruing knowledge is extremely important, but the message that we are trying to give to the mental health sector is that cultural responsiveness is not just about accruing knowledge about a specific culture or specific ethnicity or specific concepts, it's also about self-assessing ourselves and understanding - I'm going to give you an example - understanding how we hold different perspectives; understanding, for example, how we feel, let's say, as clinicians or mental health workers when we are with a person who is different than us, or when we are with a person who is similar to us.

Q. Thank you. The third one is the danger in assuming that culture is the same as ethnicity. You touched on this before, but can you expand on why we need to approach the association with caution?

A. If we don't approach the association with caution, then we'll be stigmatising communities and generalising that people who come from the same country are going to need the same.

I can give you an example. If we go to a specific community with this assumption, then we are going to treat every single member of the community in the same way, which means that we'll provide exactly the same strategies and the same service for every single person, so it is not very person-centred.

You can go to a community or we can go to a community and, if we don't think about all these intersecting points that form our identity and the way society understands each person, then we are missing everything, and we are not able then to provide the service that people need.

For example, you may work with a person from a particular community who has a status within the community; whereas you may work with a person from the same community who has been stigmatised because of mental health issues. That itself is extremely different.

Q. And so, is this where the concept of intersectionality comes in? And so, it's not just a particular culture or ethnicity that needs to be cared for, but the different components of each individual: is that how it works?
A. Absolutely.

Q. The fourth barrier that you've identified is the limited recognition of lived experience practitioners. How does that present a barrier for the CALD community?
A. Lived experience practitioners have a very meaningful role. They have the opportunity to raise voices, concerns, and opportunities that we might not be aware of. I think that it is very important to have a proper structure for them to feel that there is a sense of belonging and that there is a right space and safer space for them to participate in the decision-making process.

We honestly believe that there should be more qualifying projects with people who have lived experience. It is also important to think in terms of how to make sure that there are permanent positions and not casual positions when we think about lived experience workers, to make sure that there is continuity.

Q. Can you expand on the safe space: is that as a result of co-designing the space or does safe space encompass other things as well?
A. When we talk about a safe space or when we talk about

cultural safety, we are referring to our responsibility as services to make sure that people who have lived experience feel welcome and feel able to express themselves and to express their identities. So, this goes beyond kindness. It is more about being able to offer a proper structure and relationships that allow a person to express their identity.

Q. The fifth barrier at an organisational level that you've identified is continue supporting the mental health system to learn how to maximise the possibility of working with interpreters.

Could you expand on that barrier for us?

A. We have noticed, and this is also based on engagement with different organisations and also based on our work with communities, we have noticed that working with interpreters is a challenge within the mental health sector and that's understandable. Because, in an encounter where we have an interpreter, mental health worker and a client, and potentially family members, each person is bringing a different perspective; that means that each person is interpreting what the other is saying. So, this represents a lot of challenges.

From our perspective as VTMH, it is important that interpreters and mental health workers enhance the capacity to work together and think about specific strategies to keep in mind prior, during and after the encounter.

Q. They were the main barriers that we were going to cover at an organisational level. Were there any other barriers you wanted to raise at an organisational level before we move to a community level?

A. Perhaps that it is important that there is even more collaboration between organisations within the mental health sector, because the mental health sector is very big and sometimes seems a little bit segregated. And there might be very good things happening, for example in the community sector that the clinical sector is not aware of, or in the clinical sector that the community sector is not aware of, so I believe that we need a solid platform that supports this interaction and learning from each other.

Q. Can we turn to the barriers at a community level. You've identified four main barriers, though I understand that these are not the only barriers, these are just the

four main ones.

The first one is a lack of consultation and collaboration with communities: can you explain to us how that presents a barrier?
A. Absolutely.

Q. When I mention communities, I am talking about individuals, families and communities who are engaging with the system and also those who would prefer to avoid engaging with the system because of different reasons.

As an opportunity, if we think about how to turn this barrier into an opportunity, it is clear that we need to consult and work more with communities. When we talk about consultation something that we always say to organisations when we support them, is that, consultation is beyond asking what they need. Because the question itself can be very disempowering when you know what the system is offering.

So, it is very important to think about a setting where communities feel safe to explain, to express themselves. It is important to explore, not just their need but also how they look after each other, because communities have their own ways, their own ways to heal, and it is important that as a system we become more aware of their own ways to heal to build on that.

For example, there can be rituals, rituals that can be incorporated within the mental health sector, rituals that we can have as workers in our mind to continue supporting what is working for them.

The other thing that I would like to mention in relation to this opportunity is that, we would recommend the mental health system as a system to be less focused on diagnosis and more concentrated on how to build trust when we work with communities, and that starts from the first interaction with a community member, and that's why I was referring before to the trauma-informed perspective.

If we design and co-design more projects with the communities and for the communities, there is going to be more sense of belonging, and then they are going to feel part - part of the system and this is more likely to support them to feel ready to engage with the system.

If we don't understand how they are perceiving mental health illness, recovery and trauma, then communities are going to feel that we are speaking different languages even if we are talking in English.

Language can be a massive barrier too. Sometimes it is our thinking of working with professional interpreters and sometimes can be to allow communities to express themselves in a way that is connected with their identity, so in their own language.

Q. Another solution is the importance of feedback: did you want to talk about feedback in this context? When you're involving the CALD community, how the feedback can play into developing solutions?
A. This is also connected with the point that I was referring before, which is co-designing projects and evaluating projects with communities. After a specific program it is always important to ask individuals, families and communities how they are feeling, how they are feeling now with the service, how this is supporting them in their healing process or recovery process, and if there are other elements to be incorporated, elements that we might not be aware of.

Let's remember that sometimes, as we are talking about migrants, sometimes migrants feel very isolated. Sometimes there are not carers or family members, but there might be other members of the community that can be part of the discussion. A good example can be a spiritual leader. If it is a community that is religious, a spiritual leader might be a key person to connect with.

Q. The second barrier that you've identified as a community level is a "cultural barrier": could you explain to us how the cultural barrier plays out in the mental health system?
A. Absolutely. This is connected to what we were mentioning before regarding the meaning of culture. As culture is the perspective through which individuals interpret the world, then for sure it is expected that clients are going to come with their own view of life, with their own expectations, with their own way to understand trauma and recovery.

We always believe that, prior to thinking about a

specific diagnosis or a specific treatment, it is extremely important to explore what we call explanatory models.

Q. Can you explain what they are for us, please?
A. Yes. Explanatory models refer to the way we give meaning to trauma and recovery. So, for example, where we think that the mental health condition is from our perspective - from our culture we may think that mental health issues are in our mind, whereas a client may think that health issues are in their spirit: that itself is, this example itself shows how important it is to understand their perception and their view to be able to support them.

Explanatory models also refer to preference that individuals, carers and communities may have about treatment, and how treatment would look like from their perspective can be very different, and then it is not about ignoring our own explanatory model, but it is about making sure that both perspectives are in favour of the client.

Q. The third difficulty at a community level is difficulty in navigating the system: can you explain how this presents a barrier for the CALD community?
A. It is very common to hear from consumers and carers that the mental health system is very difficult to navigate and seems a little bit segregated, and as a result of that sometimes they are in charge of building bridges between different sectors. One example can be a person who has mental health difficulties but as a coping strategy the person might be also taking drugs: so, now we are talking about two sectors. And let's say that the person is also having some issues with housing: now we are having a third one. Let's also say that the person has engaged with the education system as this person is an international student: so now we have a lot of sectors. What consumers are saying is that most of the time they are in charge of building bridges between sectors, which is itself disempowering and very discouraging.

Additionally, there is a lot of rapid change within the mental health sector, and one example is the National Disability Scheme. So, it is important that we have a platform in which all sectors can talk with each other, and of course it is important to invite people who have lived experience to be part of this platform.

Q. You've also mentioned that there's a lack of

accessible information relevant to experience of CALD people. Can you explain that for us and how does that impact on people getting the treatment that they need?
A. Information is crucial. Information is crucial to be able to navigate the system. Without information, they wouldn't be able to ask for help or they wouldn't be able to know where to go. And sometimes information can be even very difficult to understand, so we have to think about the language that we are using.

And it is recommended that when we think about translating a document for migrant communities, we also include the communities in this process to make sure that the language we are using resonates with their identity basically.

Q. The fourth and final barrier that you've identified at the community level is social stigma. You've referred to this a little bit earlier, but can you explain to us how this presents problems and a barrier?
A. Social stigma exacerbates the mental health condition, and also impacts on the way a person or a community might engage or disengage with the mental health system. So, what I'm trying to say here is that, when we think about the social stigma, we are talking about a very complex situation that is beyond the mental health sector, and therefore our recommendation would be to think about more education opportunities for our Victorian society, and I believe that the education sector has also a very big role and there is the opportunity for the mental health sector and the education sector to work together and to design programs.

When I am talking about programs, for example psychoeducation programs, I'm thinking about the possibility to raise awareness of mental illness stigma, and also the possibility to continue supporting the society to admire and celebrate differences: different points of view, different ways of understanding life, different rituals, different expectations.

Q. Just --
A. Can I say another thing?

Q. Please go.
A. I also believe that when we put psychoeducation sessions together, we also need to normalise mental health

difficulties, because we are all humans and this is not just about migrants experiencing difficulties, this is about being human and facing challenges that perhaps affect our identity. At the same time people who face challenges are also equipped to recover themselves if they are receiving enough support.

Q. Still with this issue of social stigma, you've said:

> "The concept 'mental health' may also be foreign to some CALD groups particularly in communities where mental health is quite stigmatised."

Can you tell us a little bit more about that, please?

A. When we work with communities and when we consult with communities we need to keep in mind that mental health - the concept of mental health - can be very foreign or even negative: it can have a very negative connotation within communities. So, it is complex because we are talking about social stigma, but we might be also talking about a stigma within communities that, of course, would prevent individuals and families from asking for help.

And this itself reinforces how important it is to involve communities in the mental health sector, because otherwise individuals who have been stigmatised are not going to ask for help.

Q. Thank you, Ms Mendoza. You've outlined a number of recommendations for how the system could be improved. Just before we finish, are there any other recommendations or opportunities you wanted to mention before we finish?

A. Perhaps this allows the opportunity to say that Victorian Transcultural Mental Health is ready to continue supporting this process, it's available to continue supporting the workforce to be more culturally responsive, and also to work with other sectors that would like to continue joining efforts.

Q. Thank you. Thank you, Chair, are there any further questions for Ms Mendoza?

CHAIR: No. I think that was a very comprehensive overview. Thank you very much for your assistance in providing the witness statement and your evidence here today.

MS BATTEN: Thank you. May Ms Mendoza please be excused?

CHAIR: Yes, thank you.

<**THE WITNESS WITHDREW**

MS COGHLAN: The next witness to be called is George Yengi and I call him now.

<**GEORGE YENGI, affirmed and examined: [10.52am]**

MS COGHLAN: Q. George, you've made a statement with the assistance of lawyers for the Commission?
A. Yes.

Q. I tender that statement. [WIT.0001.0031.0001] George, I'll ask you to sit forward a little bit so we can hear you, or perhaps lift up the microphone. Thank you.

You're here today to talk about your own experience with mental health: that's one thing?
A. Yes.

Q. But also your observations of the South Sudanese community and some general responses that you see within that community to mental health issues?
A. Yes.

Q. I'm going to ask you about both of those things. Can I ask you first, though, about your current role. You work with Reclink Australia?
A. Yeah, I work for Reclink Australia, a not-for-profit organisation. We tend to use sports as a vehicle to try to bring communities together and also open up opportunities for them to be able to kind of like filter into the mainstream sports and also employment and other agencies.

Q. Does that particularly work with young people or whole communities?
A. Part of our engagement is funded by State Government which is basically to work with 16, up to about 100.

Q. Can I take you to asking about your personal experience?
A. Sure.

Q. You were born in South Sudan in 1985?
A. Yes.

Q. Can you just tell the Commissioners what life was like for you there before you came to Australia?
A. So, prior to coming to Australia I was a - I'll just say my dad had about three wives and I was the youngest, and when he passed away I would have been about 3 or 2. Because of that, his brother took care of me out of the other nine brothers that I have, stepbrothers, so I ended up living with my uncle and having to learn a new language, because they spoke completely different.

My dad married outside of our culture, so he married into a Chorli community, so that's a whole different language. But because my dad wasn't around that often I was actually speaking my mum's dialect, so when he passed away I had to learn his side which was when I was living with my uncle.

Q. You talk in your statement about at one point being in a refugee camp in Uganda?
A. Yes. So, due to the civil war I ended up in a camp called Oligi, it's about an hour and a half from Adjumani which is a little town in Uganda.

Q. In your statement you refer to some experiences there being traumatic for you?
A. Yes, there were several moments growing up that were, I guess at that time I didn't understand and kind of locked it away, that happened to neighbours and friends within that community that were lived in, as you all have seen through the TV. As you look at refugees, everybody's really tight together because that's the space you're given to work with, so therefore there's a lot of issues that happen that you're kind of exposed to within those communities.

Q. You came to Australia with your sister in 1999?
A. Yes.

Q. How old were you then?
A. I would be 14, I believe.

Q. You were included in a cousin's fourth application attempt to come to Australia?
A. Yes. Due to events that happened before my dad

passing away, and me moving across being looked after by my uncle, kind of helped me with the opportunity to come to Australia because I was there so they couldn't fill out the form without me and leave me behind, because there was really not much left for me back at home, and obviously the fourth time they tried and I had gotten through, so it was good.

Q. You believe that you were accepted into Australia, you say in your statement, under the refugee Humanitarian Program?
A. To the best of my knowledge, yes.

Q. You also talk about being fostered by a family here in Australia who treated you like their own son?
A. Yeah. So, I think, I came here to Australia with seven - well, all of us seven together plus my cousins, my uncle's children, and in a gap of two years the family split up. So, me and my sister kind of got left without nowhere to go, and there was a tutor that tried to help me with my English, and my sister as well, who ended up taking us in for about two years.

In that time I had to build a relationship with my foster brother, David, who went to the same school as me and the family put their hand up to try to adopt me, but then eventually they asked me and I said, you don't have to, because I was pretty much hanging out at their house every day, so pretty much like my mum, so there's no point for you to adopt me, so all good.

Q. So in that way, it was an informal adoption anyway?
A. It was.

Q. You've talked about, I guess, some of the traumatic experiences in your childhood, and you say in your statement that, and I'll just read this for you:

> "The way that I dealt with the trauma of my childhood at that time was to pack all those experiences down tightly in a bag and not discuss them with anyone."

A. Yeah, it's the best way I could have, I think, tried to cope and tried to set a new beginning, a new start, and it worked for, I guess, for some time but didn't really think it was gonna open up one day.

Q. Can I ask you about that opening up one day?
A. Well, I think it started off with my cousin who also was taken care of by uncle at that time, at the same time, and she made it to Australia way before me. I remember back from Adelaide to Melbourne to go back to Uni, she was in Melbourne already, so she became the only close family here, and she went through some difficult times and she was in a hospital, as I said on the paper.

I was at Uni and working and having to go to the hospital all the time, and it didn't go very well, she had a miscarriage - it wasn't a miscarriage actually, she had a prematurely born baby, and that pretty much started us triggering because we lost the baby. And I didn't know what to do, because I was trying to balance everything, but what I found out was, I was driving to school and I just tears coming out of my eyes and I wasn't actually sad or even remotely close to being sad.

So, I started asking what's going on, and eventually I spoke to my lecturer and she booked me in to see someone, it was actually a psychiatrist, and she was really cool. Because I went there and asked the question, I don't know what's happening, why is this happening? So she asked me the questions and basically gave me some tools to how to deal with it, and I thought that was it because I was alright after a couple of sessions, and that became, you know, my introduction to seeing someone with regards to what's going on. I think that's where the crack started happening in that little bag that I tucked away so far.

Q. You talk about in your statement that you felt that you could relate to this particular - she was a psychiatrist or a psychologist?
A. Yeah, I could relate to her because she was from a Russian background, she was a migrant as well - I think maybe not Russian, but she was from somewhere around, so she was basically a migrant.

She understood what I was saying because I think what I was trying to tell her is that I'm supposed to be a man without even having to say it. You know, part of our culture, you gotta be strong and you're not meant to cry or, you know, dig deep into your feelings, you're meant to try to fix things. So, me going to her and asking her for questions without her trying to dig into - you need to look

deeper where this is coming from, it kind of helped, because she gave me the tools to explain what my body's trying to react to and try to work on, and that kind of helped and eased me up a little bit.

Q. Can I ask you about a time in 2016, when the university that you attended awarded you a scholarship to attend the European Innovation Academy which was in Nice.
A. Yes, I was lucky enough to get a scholarship, an entrepreneurship scholarship through the EU, because the EU threw a little bit of cash into trying to come up with innovative - like, to promote young business and ideas. And part of the scholarship was, I had an idea of taking all the stories that I've read while I was learning English and trying to write stories that, you know, migrants can relate to, especially young people can relate to.

They thought that was a great idea and sent me across to this beautiful I think one month in Nice, where we got to hang out with some of the most clever kids and web designer/coders, and try to sit together and come up with good ideas on some of the issues.

While we were there, I guess - I was there when the Nice attack happened, so I was there for a couple of weeks. We were living in a school accommodation where there was about almost 300-plus students from around the world, so I built some friendships and hung out with people that I became really close with and, when that happened, I ended up losing three of the closest guys that I was supposed to be with that day. The only thing that stopped us was, luckily, a lovely girl who thought as a VU student we should all catch up for a pizza.

And we ordered the pizzas and the pizzas are - the store that we were gonna order it from which was close to us was closed, and then we ordered from somewhere else. The pizzas were late for five minutes, by just five minutes. And, when we got there, we were supposed to all go down together, but some of the boys went early and one of them grabbed the pizza and walked down; I said we'll see them there soon, and then by the time we finished our pizza everything happened. So, yeah, there was a few friends ...

Q. Take your time, George.
A. So, I lost a few friends and got to see a lot of

people - sorry. It's all good, I'm good.

Q. Perhaps if we move on to the time that you came home after that and how - as a result of what happened?
A. I think living in Nice was really interesting because I got on a plane and I think when I got on to go onto the Qantas flight, and heard the pilot and the Australian accent, it felt really cool. I felt like I just wanna come home because my flights - I booked my flights, they were about a couple of days late, so I had to wait in Nice by myself for a bit, and I stayed in a - sorry.

I think staying back in Nice for an extra two weeks after what happened helped, because I got to walk down the promenade, and it gave me a time to reflect on how lucky I was living in Australia. At the same time, that also opened up a lot of questions, but I think getting on the plane in Dubai and onto that Qantas flight and hearing the pilot's voice and the Aussie accent, it was pretty cool and I felt like I was safe, and I think I stayed awake the whole time until I got home. It made it really - I was like, yep, I kind of felt like I was safe. But that was pretty much the beginning of a lot of stuff that happened.

It was when I started asking questions about my own childhood and when the stuff that happened is normal or not, and it is at that moment when you know that, wow, all of that stuff that happens is not okay. So, somehow living here for 20 years plus, I think I've got used to the custom of being safe and that became my gauge of what life should be like and what safety looks like, and I think that's when the questions started happening.

Q. After you returned home to Australia, you went to see the same psychologist that you had previously seen?
A. Yeah, so that was really cool because, again, she didn't dig and she basically gave me tools again. What made it really cool was as well the fact that we were just talking normally. There was no couch, I didn't have to lie down or anything like that, and she wasn't saying, "So how does that make you feel? Can you elaborate a bit more on this? Could this be because of your upbringing?" No. She just basically said, no, you're operating, you know, this is where your brain was operating, it's a high level, and now you're home you'll just have to analyse a little bit more stuff. She didn't try to talk to me about the flashbacks and what's going on, she just worked on the fact

that, you know, I need to get back to normal, so I need to start doing the stuff that I used to do and just give it time. That was really good.

Q. About two years later?
A. Yeah, two years later I had to - it's been on the backburner since I arrived in Australia, I needed to go back and see my mum. I hadn't seen her at that time for almost 20-plus years, and I thought, you know, it's about the right time. I got married, let's take her home to see my mum, she needs to see the person that I'm married to, my wife Courtney, and it just kind of unravelled.

Because I'm going back, not only I don't feel safe, I don't feel it's going to be safe, I'm going back to the home where all the trauma happened, and on top of that I'm taking someone who I need to be - I can't guarantee that I can keep them safe.

Of course, I kind of went back to the zone where I couldn't sleep, I watched TV, I don't know what I watched. I tried to keep busy and, as we all know, planning going overseas is really great when you're on your own because you can look after yourself, but if you have to look after someone else as well, keep someone safe, especially when I know that being here I've forgotten about four languages that I'm supposed to know, so communication became an issue. And every time I tried to think of cool words, and I tried to remember some of the basics, my brain gives me the most elaborate word that does not help me in that situation.

So I say, how do you say hello? And it tells you, oh, this is how you say, something, something, something: that's not how it works. But that added to the stress, and my partner, our relationship wasn't probably the easiest due to the fact that it was two different cultures as well, and that's not on our behalf I think more like the family, and also my culture is really difficult to get into. And especially with me, I think my family always thought I'd end up with an African woman, but you can't really choose who you like. It's been really great that they're all from around so they're on board.

But I was very worried to meet my mum. Not only she wouldn't remember me, because she wasn't allowed to see me when my dad died, she couldn't come and visit. So, I just

thought she'd forget who I am and I wouldn't know who she is.

We spoke on the phone. Even our phone calls when I was in Australia was difficult because, there were two different languages and she spoke a language that I don't know any more and every time we spoke on the phone I would get pretty much - I think I'd get angry because what I thought was - just to get angry and get frustrated and just say, give it to my sister because she knew how to talk to my mum. Looking back now I think she's covered for me so many times in regards to, I couldn't express myself to my mum and I got frustrated and usually that made it easier to not talk to her, but this time I had to face that.

Q. And you did face that?
A. Yes, I did. I met my mum. Flew into Uganda, went all the way to the refugee camp and my sister and I are trying to buy a plot of land to build something for her. And she remembered who I was, and she's learnt my dad's language, a little bit of it, so we can kind of like have that broken communication. But it was good, it was really good to spend some time with her for a week and meet my other sister's daughter, my niece who I have not seen, she is 15 now, and yeah, it was really good to be home.

Probably one of the best things was walking down the street and for once I was at peace. It felt really good to be in Africa, it felt good to be amongst everybody where you feel like you belong, so it was an unusual feeling as well, because for me it was like, what the hell is this feeling? Because I just felt really at peace with myself.

Q. Eventually, after those events with your mum and the lead up to that, you decided that you wanted to see the same psychologist again?
A. Yes.

Q. But that wasn't available to you because you no longer attended that university?
A. Yes. So, the session that was given to me when I got back from Nice was great, it worked really well, and she gave me tools, but yeah, I wasn't able to go back to that same psychologist. And it wasn't through the school system either, because that's when I know - that's the only way I knew that I could get to her, and it was kind of like a kick in the gut, but I kind of had to be okay with it, I

had no control, so I tried to use what she's given me and push on.

Q. Another thing that helped you was to play soccer?
A. Yeah. So, sports has always been one of those things that helped me with that baggage from years, it's the one place where I can go. Once I cross the line, I'm just in my zone and I'm in a place where I have control of certain things as well, and what I'm good at, and I feel happy. When I finish, I feel like someone's pressed a reset button, so start all over again.

Q. Can I ask you about more generally mental health in the South Sudanese community here in Melbourne and just your observations of what you've experienced and what you've seen. One of the things you say in your statement is that:

> "Mental health is stigmatised in our community."

Can you just explain what you mean?
A. I'd have to say, because of my experience in Australia and the families I've lived with and of being exposed to external communities as well, it's been really cool to see how each family and communities respond to things like mental health. Because, for us, mental health is almost like a taboo thing, it's not a thing. And it's like, you know, it's called a Westerner's illness. So, it's like a white person's thing, you know, because we don't know what it is; it's never explained to us when we're growing up and never explained that you may feel this because this is what's happening.

It's a taboo because we don't talk about it: you're either sane or you're insane, and either you're possessed by the devil or someone's got to pray for you. That's the problems that we deal with at the moment.

A lot of young people might understand mental health due to the fact that they went to schools here and this is something that they've learnt over the years. It's actually true, your body can do different things and a chemical imbalance may cause something in your brain to act differently and it can be that you need to see someone and talk about some of the emotional stuff that you can't.

I feel like we, as young Africans, we grow up in an environment where we're not allowed to talk about stuff that is quite sensitive or personal, and this becomes the issue, so you just put them back somewhere.

Q. You say in your statement that you have:

> "... observed that if people are mentally unwell, they're usually shunned by family, friends in the community because they're misunderstood."

A. Yeah, because we don't know how to deal with it, so we'd rather hide it or push it away, you distance yourself. It's almost like that whole, you're a bad smell kind of thing, we'll disown you to the family; or this family doesn't deal with him any more, he's not part of us and he has to go and fend for himself and he's left out there to try and sort himself out.

Q. One of the things you talk about in your statement is that:

> "The way people live in Australia is also very different to South Sudan."

A. Yeah, because naturally, we come from a community upbringing whereby, even if you look at it, I think a lot of people would have seen on TV, you've got the Boma's, Maasai, Sudanese, we all live really closely together. So, you would see a compound where there will be at least multiple huts all facing to the centre, so all these huts would be different families and family members and they play a role in raising everybody. Because, if mum and dad are going to do some farming or brothers are going out to take the cattle out to eat, because we don't have such massive lands where you can just fence it; one week they can eat here, the next week you put it into the next one, we have to actually go out there with the livestocks.

So, the kids are raised wherever it is in that - available that day in the house. So, it becomes like, you've always got someone, there's people to play with, there's people to have a chat with, there's people to see. Because, if something's not right, someone will know straight away, kind of, what's going on?

Where here, we go from living in one room where there's four, five to seven people, to like, you've got a four bedroom and it's just you. And you go to work and at work you have to make friends. No-one feels like they're automatically friends, you're just there to make money and then pay your bills and go to sleep and wake up again. So, unless you create time and space within your busy day to try to do extra-curriculum just to make friends, yeah, you're alone most of the time.

Q. What's the impact of that on communities, that change in way of life?
A. I think isolation is one of the biggest contributors to health issues, and not only due to lack of people around you, it's also one of those things that kind of take away your - it just eats away a part of you because you're constantly fighting a battle between your own self, and by being out I think making friends it gives you a little bit more of a purpose, because without people around you there's no purpose and, if there is purpose, it's driven with success, which is cash, but eventually you get that - and you end up like pretty much a lot of people who find themselves who are isolated after working so long: they don't have true friends and connections, real connections is what everybody really need.

So, if you have a real connection that will really help, and things like recreational sports and getting out there and meeting people usually helps build those connections.

Q. One of the things you say in your statement is that:

> "Racism and discrimination also play a big part in contributing to mental health issues in my community."

A. Yes. I think both of those goes really hand-in-hand with mental health. Because, not only racism creates a sense of othering, or not belonging, or not connected, and you're not better enough, you're not good enough to be here; that itself goes into someone going home and worrying about, what's going on, how can I do better, and the world doesn't like me, so what do I do? Maybe I'm just gonna sit on my bed and try not to go out.

My experience is, I know the reason why I find it was

weird to feel the sense of belonging in Africa was because, for years of being here, one of the biggest worry is constantly having to be aware of where I'm walking into, what people are seeing me as, and trying not to spend more time trying not to look threatening to a lot of people, and this constant notion that someone will meet you and say, "Oh, you're different from the other", so there's already a picture of me that I don't even know what it is, so I'm constantly trying to make sure that I kind of like, you know, keep myself in this little cage so that no-one can be afraid of me, and that is taxing, constantly taxing, and that's something that each of us has to kind of like work with and it's quite difficult to do that constantly for 20 years.

The sad part is, without the support that I've got and exposure to external community and sports and stuff, I don't think I would have been where I am at today because I'd still be out there trying to work out how to be - you know, trying not to be intimidating to a lot of people.

Q. In your statement you suggest some recommendations for change. Can I just ask about those. The first being that:

> "The need to ensure that members of the community are aware of mental health services and that they are accessible for people."

A. Yeah, because part of what we do as well, we're given this, I don't know, it's almost like a, go out there and speak to your community in regards to, you know, mental health is a real thing. So, the reason why I ended up at the consultation was to work out whether the system actually works and if it works for the extended wider community. And being there and listening to some of the stories, it just kind of gave me this disappointing feel because we are pushing our community to learn about mental health and being okay with it, but the truth is the system is not even working for the group that it - community deemed it's a white thing, for that community itself. So, it's really difficult, it made it really hard because it means our elders are right in regards to, mental health is not for us.

And the community itself is not aware of what mental health is and we struggle to do that, and if the system

doesn't work for the current community now, then we've got a problem because they're not gonna believe us, they're going to keep going with their belief that mental health is actually not for us.

This year alone we've lost so many people, especially young Africans, who find themselves in the position where they can't actually speak to anyone in regards to mental health because no-one believes them, no-one thinks it's a problem, no-one thinks it's a matter that they need to focus on or worry about.

And we've got a generation of young Africans who were born in Australia now, or came here at the age of 3, and all they know is this new context. This new context itself, the parents don't believe it, they don't see this as a home because they're constantly trying to prove to themselves that they're Australians but they're not good enough.

And, with everything that's happening, parents not only get judged for the fact that they don't know how to look after their kids, and our image itself gets put in - we all get painted with the same brush, all of this stuff adds to everything else that's happening within the home and also within our communities and also within external communities.

So, it's one thing to say, you know, the community needs to play the game, or assimilate or culturally relate with us, but it's harder to jump into something like this without actually knowing what it is. So, by getting the community to actually understand what mental health is, it might help us and help the generation, like, you know, younger than me to actually be okay to have those conversations with their parents and it's really important that we bring them on board and get them actually involved in understanding this.

That's the only way for the next lot also to feel free to speak out in regards to what's happening within our community, because they know a lot and that's why the working groups, they go in groups, because it's easier to feel safe, it's easier that you can actually have a laugh with your mates. They might be the closest people that understand you, even though they're not really deemed as going somewhere with their life, but they feel like they

belong at that moment that they've spent with them.

MS COGHLAN: Thank you, George. Chair, do the Commissioners have any questions?

CHAIR: No. Thank you very, very much, George, for coming and sharing your experiences with us. It was incredibly powerful and helpful for us to understand not only your journey but reflections on behalf of your community. So, thank you very much for coming.
A. Thank you for the opportunity.

MS COGHLAN: Chair, is now a convenient time for a morning break?

CHAIR: Yes, thank you.

<**THE WITNESS WITHDREW**

SHORT ADJOURNMENT

MS COGHLAN: The next witness to be called is Kylie Scoullar, and I call her now.

<**KYLIE MICHELLE SCOULLAR, affirmed and examined: [11.49am]**

MS COGHLAN: Q. Ms Scoullar, you have provided a statement to the Commission with the assistance of lawyers?
A. Correct.

Q. I tender that statement. [WIT.0001.0053.0001] You are the General Manager, Direct Services at Foundation House?
A. Correct.

Q. And you have been employed in that role since October 2018?
A. Yes.

Q. Can you just describe that position in the context of other key members of the organisation?
A. Sure. So, that position as General Manager, Direct Services oversees the delivery of high quality services across Victoria to clients of a refugee background who have experienced torture and trauma overseas prior to arrival, it leads the delivery of those services and it's a member of the Executive of Foundation House.

Q. I'll just ask you to slow down a little bit. You were also employed by Foundation House from January 2014 to April 2015?
A. Correct.

Q. As the Child Adolescent and Family Program leader?
A. Yes.

Q. Can you otherwise just explain a bit about your previous experience?
A. Sure. So, my previous experience includes 20 years as a clinician, as a leader and a manager in mainstream clinical mental health services; project roles in those services bringing reform and innovation to mental health, and government and expert panel roles at the state and the national level in mental health, both in data and outcomes and in quality oversight.

Q. You've briefly described what Foundation House does but can you just go into a little bit more detail about really what its purpose is?
A. Sure. So Foundation House is otherwise known as the Victorian Foundation for Survivors of Torture. It was established in 1987 in Melbourne as a not-for-profit organisation. Its purpose is to assist people of refugee background who have experienced torture or other traumatic events pre-arrival in their countries of origin or while fleeing those countries.

Q. Specifically, Foundation provides a number of services?
A. Sure.

Q. Can you go through those one-by-one, please, starting with client services?
A. Sure. So, Foundation House provides client services to approximately 5,000 clients each year. It provides services to clients in the form of specialist counselling. That counselling includes children, adolescents, adults and families. It provides advocacy on behalf of those clients and systems work. It provides community-based psychoeducation among communities.

It provides complementary therapies to go alongside the counselling where that's necessary, and we provide services across the age range, so all of the things we talk about include children, adolescents, young people, adults,

families and aged people.

Q. In terms of --
A. I forgot one thing. As well as those services, we also have a mental health clinic which is really a private - it's like a private clinic within Foundation House where bulk billing psychiatrists can provide those clinical services, including prescription of medication where necessary.

Q. One of the things you mentioned was the provision of advocacy. Can you just explain the context of that?
A. Yes. So, our clinicians, if you like, rather than being called clinicians are called counsellor advocates, and the reason is that, in our cohorts that we deal with, that advocacy on behalf of clients is really important. So, in mental health language we might call it systems work, but in terms of the stressors that people of refugee background are experiencing, whether they're refugees and recognised as such, or whether they're still seeking protection and they're seeking asylum, there are so many issues that they face.

The role of our counsellors also is to get on the phone and talk with mainstream mental health services, where necessary link those people up with legal services where necessary, advocate within health services where necessary, talk with education providers, so it really helps us provide much more holistic care that's collaborative and so that's why it's specifically kind of described that way rather than only focusing on the specialist counselling which is obviously also really necessary.

Q. Can you now talk about working with communities and what Foundation House does?
A. Sure. So, in terms of its work with communities, it really works with communities to build their capacity, to identify members within the community who might be vulnerable, to help them navigate the service system, and also help them support better the members of their communities who are vulnerable; similar in a way to some of the work that's been described this morning by VTMH. We call that community capacity building and it's often got a mental health literacy focus.

The third area of Foundation House's work is

professional organisational development. So, we provide consultancy, education, training to many other service systems, including education, community services, employment and the health sector, to really build their capacity to respond more effectively to our clients.

Another area of work is that we work with Victorian state - Victorian and Commonwealth governments to basically help them develop programs that better and properly have regard to the needs of refugees in the design and development of those programs, and we undertake research to better meet the needs of refugee background people.

Q. Is that only in the context of mental health?
A. Not only in the context of mental health, no, more broadly as well.

Q. What about research?
A. So, in terms of research, we undertake research to see how we can better meet the needs of the community and the refugee background people. So, for example, one of the pieces of research that we've talked about is looking at what are the barriers for refugee community members when they come to accessing mainstream mental health services.

Q. I'll come to ask you about that. Foundation House is a statewide agency?
A. Correct.

Q. With over 200 staff?
A. Yes.

Q. And across five main locations in Victoria?
A. Yes.

Q. In terms of your role, what's really your primary function?
A. My primary function is really to lead and oversee all of those services that are described in terms of the direct client services, so that means it's direct client services to approximately 5,000 clients per year, about 100 staff delivering those services; it's the quality of those services, it's leading how we do that. And it's also contributing to the strategic direction obviously of Foundation House.

Q. You also contribute to the development of publications

and training programs?
A. Correct.

Q. Could you just describe that, please?
A. Sure. So, in my previous role as child, adolescent and family program leader I developed and designed a number of training programs. One of those for instance was training general practitioners to better understand working with young people from refugee backgrounds. Another was training and development for community health and refugee health nurses to understand particularly the impact of child refugee trauma in terms of children and their families.

Q. How prevalent are mental health issues among people of refugee backgrounds?
A. So, I'd like to talk about this, and we'd also like to comment that refugees, as we saw this morning from George, have overwhelmingly shown enormous courage and resilience in surviving the horrors of war, of persecution, of human rights abuses. And, just as the case would be for any person who has gone through those challenges, the consensus is that they have higher prevalence rates of mental health disorders than the general population.

There have been many studies looking at the prevalence rates of mental health problems in refugee populations, and those prevalence rates vary quite significantly. Partly the reason is that the refugee populations that they are looking at vary, so they have different levels of exposure to different sorts of stressors, different levels of exposure to war, different levels of exposure to trauma, different levels of support available to them, and also of course the methodology of the studies and the measures they use differ.

Overall, though, there's consensus that there's much higher prevalence rates for refugee background people in terms of mental health disorders. Would you like me to go through some of the studies or is that --

Q. Perhaps in an Australian context, is there a study that you can address?
A. Yes. So, according to data from the Building a New Life in Australia Longitudinal Study of Humanitarian Entrants, recently arrived humanitarian entrants they found were between about 31 per cent for women, 46 per cent for

men - sorry, other way round - 31 per cent for men, 46 per cent for women, were classified as having moderate to high risk of psychological distress in comparison to what they quoted as 7 to 11 per cent in the Australian population.

Q. What about a recent Foundation House analysis?
A. Our analysis of our own clients shows that when we've done assessments, about 80 per cent or so of our clients would have moderate-to-severe depressive symptoms; about 80 per cent would have moderate-to-severe anxiety symptoms; and approximately 76 per cent would have significant symptoms consistent with post-traumatic stress disorder or acute stress disorders.

Q. So, just bearing in mind those statistics, broadly what is the level of engagement with the mental health system as compared with the general population?
A. So, while accurate data is lacking, the consensus is that, while prevalence rates of mental health disorders are much higher, use of services is in fact much lower than the general population.

In terms of utilisation rates in Victoria, there isn't data available specifically about refugee cohorts, but we have reports from Victorian Transcultural Mental Health who presented this morning, and we've heard that immigrant and refugee communities have much lower rates of utilisation of mental health services.

International studies, again not refugee specific, also show lower utilisation rates of mental health services than the general population.

Q. One of the reference points in your statement is the Victorian Auditor-General's report on child and youth mental health, and you refer to certain findings that were made. If you can provide the Commissioners with some context for that.
A. Sure. So, the Victorian Auditor-General Office's report on child and youth mental health services which came out in June 2019, reported that people who were born in Southern Europe, Asia and the Indian subcontinent were under-represented in child and youth mental health services, and that young people from these regions risked not accessing the mental health services they needed, and the levels were really quite significantly different to the

rest of the population.

When we've looked at that, what we know is that these regions include countries from many refugee producing countries. So, it includes places like Pakistan, Afghanistan, Sri Lanka, Burma, now known as Myanmar, and Thailand, and if these countries were under-represented what we know is that there's going to be refugee populations within that who were not showing up in child and youth mental health services.

One of the difficulties is that they don't have data on that, so it's impossible to actually see who are refugees, who are actually of refugee background within the mental health service because there's no data that indicates that.

Q. You also refer in your statement to another recent study of Australian children?
A. Yes. So, this study was based on parent surveys. It was a sample size of 5,000 children between 8-13 years of age. It showed that children from non-English speaking backgrounds were the least likely to access mental health services for emotional problems for their children. Again, "refugee" is not identified, but what we would know really from our experience is that refugees are even less likely than that to access services.

Q. Can I ask you about barriers for people of refugee backgrounds to access and seek treatment within the mental health system?
A. Yes. So, in terms of barriers, what I'm thinking is that this Commission has heard a lot about barriers to access for the mental health service system, and all of those barriers are the case for our clients also, so we won't go into barriers that are more generalised that occur for everybody, but we will focus very particularly on the ones that are the case for our cohort.

One of the most important one of those is stigma, and we've heard about that this morning from VTMH, and we heard about that really powerfully from George as well. It's reported in research by us, it's commented on by community members frequently.

And I was struck by the evidence yesterday from Ro Allen, Commissioner For Gender and Sexuality; she talked

about stigma as a mark of disgrace that separates a person from others. For me, it's a really powerful way of thinking about stigma in the refugee cohort as well.

Community members have told us for instance that they're unlikely - many members are unlikely to access a service even if the words "mental health" are in the name of that service, among many other things.

In terms of other barriers as well as stigma which is very important, the concept of shame is another barrier. For example, with young children for instance, families might not want them to access mental health services, and it might be an issue of stigma, but it's also a strong issue of shame because those parents feel great shame, they feel responsible for their children's problems, they feel like they'll be blamed and judged for that.

Q. What about fear of authority or of doctors?
A. Sure, yes. This is another thing that's really specific to the cohort of people who we provide services to. So, fear is really strong. In some cases persons with refugee background are afraid of doctors, they're afraid of authority figures, and they do not trust them. In some cases doctors have actually been part of the trauma that's been perpetrated on them in their country of origin. It's very important and it's really quite powerful.

Q. What about some more, I guess, practical barriers in terms of inability to travel?
A. Sure. So, there's other much more general practical things: there's lack of knowledge about the mental health service system, there's other barriers to access such as just inability to travel to the mental health service system; previous negative experiences with the service system; inflexible approaches to appointments, appointment times, interpreter uses, all of those general practical things.

Q. What about some more quite specific barriers for, for example, humanitarian entrants into Australia?
A. So, these are quite particular. So, humanitarian entrants who arrive on refugee backgrounds with permanent residency, but in some cases they are still unlikely to want to disclose their mental health issues. They fear that it will be accessible to immigration authorities and they fear that it might well hinder their applications for

citizenship or hinder their capacity to support and sponsor family from overseas to come to Australia.

In terms of asylum seekers as a separate cohort, they're often also very reluctant to disclose mental health issues, and often because of concern that it will be accessed by immigration authorities, they will have access to their files, and it will put at risk their visa status, it will put at risk their applications for protection as refugees.

Q. Can I take you to the ways in which these barriers can be addressed?
A. Sure.

Q. You say in your statement there are a number of ways, and you then provide some examples. So, perhaps starting with working with communities.
A. Sure. So, working with communities is a really, really key - it's a really key factor. With training and support, people who are drawn from refugee and culturally and linguistically diverse communities can effectively bridge the gap between the communities and the service providers.

It really involves work both with communities to build understanding about mental health, to increase the knowledge of services, to lessen stigma, and to build trust. And, as well as work with communities, those members, those community members, can also then work with service providers to assist service providers to be more responsive and more effective in the care that they provide to refugee background people.

Q. Could you just talk about the psychoeducation classes that Foundation House holds?
A. Sure. This is another way that we've found very effectively can reduce the barriers. Again, it was mentioned this morning: we hold psychoeducation classes for new arrivals on an outreach base, we hold them in community health centres, in TAFEs, in adult education programs, in secondary schools, and they have a mental health promotion approach. They help to de-stigmatise mental health. They provide people with a way of really understanding and unpacking the experiences that they've been having.

They also help parents better support and understand

the experiences that their children are having and how to better support them. As well as providing that information and education to the members of the groups, what we've found is then our partners, the TAFEs, the secondary schools, the education providers we're partnering with then become much more responsive to the rest of their cohort that they're dealing with who might be from refugee backgrounds.

Q. And so, that's really seen as an ancillary benefit of helping to capacity-build?
A. Correct, it does.

Q. One of the other ways in which barriers can be addressed is that there are more outreach services: can you just explain that, please?
A. Sure. Outreach services are really important. Centralised services just by their very nature have significant barriers within them. So we do a lot of outreach in the person's community, in their home, for children for example in their schools, and those are needed and the mainstream mental health services can do that too.

We do that often with clients who are newly arrived, but also with many, many other clients, particularly for example women who might find it very difficult to travel and without an outreach service will not be able to access the care and treatment that they need, and those sort of barriers are often not well understood in mainstream mental health.

Q. One of the things that Foundation House does is to collaborate with mental health providers. Can you just explain that and perhaps provide an example of it?
A. Sure. So, this has been really important. Collaboration is really key, and it really points to the need for both mainstream and specialist services in the space. Foundation House collaborates with mental health providers such as child and adolescent mental health providers in Victoria, and this has really helped some of our clients overcome stigma and access the treatment that they need.

For example, we've got a partnership with the Royal Children's mental health system, their clinicians come out to our site in Dallas at Foundation House. It means that our clients can have a child and adolescent mental health

session with their trusted Foundation House counsellor, together with the mental health clinician, but at our service where the client is known and supported and understands.

It really provides continuity of care for that client and family, and it enables cross-fertilisation of the skills between the Foundation House expertise and the mainstream mental health expertise, and it means that client is very genuinely then in the centre of that care and can receive both services that they need without being disrupted in their therapeutic engagement.

Q. Do you find that to be an effective way of reducing barriers?
A. We've found that to be incredibly effective, and I can say as well from my previous experience within mental health, that was effective in other contexts as well. So, for example, I remember being a mental health clinician and providing primary consultation, for example, to a CASA, Centre Against Sexual Assault; being referred to a teenage girl with high suicidality, question marks about psychosis. Instead of getting that teenage girl, who had a lovely ongoing relationship with her counsellor, to come into the mental health service, I went out, provided a consultation with her and her family with the CASA counsellor, could provide an assessment, provide an opinion, provide reassurance about the suicidality, and then retreat and provide secondary consultation if needed.

The advantage of that for the client is that their therapeutic engagement is not interrupted and, at the same time, the specialist mental health input that they need is available, and from a mental health service system point of view it's very efficient. That was two hours of time for a mental health clinician, as opposed to receiving a referral, interrupting the therapeutic engagement and having another sort of client on the books in the mental health service system that could be treated elsewhere.

Q. I want to now ask you about the specific needs of people with refugee background when engaging with the mental health system. You say in your statement:

"Specific needs arise from the nature of the mental health problem, including its potential basis in the experience of trauma

and associated stressors and interactions with the mental health system."

Can I ask you about those two things one by one, starting with the nature of the mental health problem?
A. Sure. So, in terms of the nature of the mental health problem, the key need in this respect is that, the diagnostic process, the assessment of the person and the subsequent care must be trauma-informed. And by that we mean that they must enquire into and consider whether trauma is at the basis of that mental health disorder or maybe affecting recovery.

Q. Sorry, can you provide some examples of that?
A. Sure, I'm happy to. I'm aware of a trauma survivor, for example, who was admitted to a public mental health facility and treated for an eating disorder. She refused to eat and was very close to dying. With our work, it became evident, however, that in fact she did not have an eating disorder, she had been forced to eat terrible things in her country of origin as part of her torture experience, and without that key piece of information there is no way that mental health treatment could be effective for her.

So, evidence-based treatment we would understand for eating disorders involves basically making the person eat, because their brain is starving. In this case that was the complete opposite of what would facilitate her recovery.

Q. What about some other examples?
A. Sure. As another example, I'm aware of a student, for example at a school, who was referred on to mental health services because he showed depressive symptoms. His history wasn't initially taken in detail, and so, he was treated for his depression in the mental health service system, and it was only later discovered that this student had lost both of his parents, and in fact he had seen his mother blown up by a bomb in front of him.

This didn't come out immediately, as we heard from George; these stories do not come out immediately if they're not enquired into in a way which is culturally responsive and in a way which really understands trauma at a deep level.

Because this wasn't enquired into, the level of his post-traumatic stress was not uncovered, and his loss of

his parents was not uncovered until we became involved and explored those issues in detail, and then we were able to provide really effective care and support for him, for his family, and also within the school system so that they could better understand his needs.

As another example - examples are difficult but they illustrate things really effectively.

Q. Take your time. If it's too difficult we can move on to the next topic.
A. I'm aware of a woman who was treated for postnatal depression in the mainstream mental health service, and she was not making significant progress. What was uncovered gradually was that she'd had the experience of a child in her arms dying as a result of a bomb blast. Again, without that being uncovered as part of her mental health treatment, there is no way that mental health care could be effective, and that was only uncovered using trauma-focused treatment in a way that's culturally responsive, in a way that understands some of the experiences that happen in countries of origin.

Once that had been uncovered and that work was underway, as well as supporting her effectively, the family was able to be supported through this woman's further pregnancy, the birth of her subsequent child, and the attachment issues arising between her and her children was addressed so that she no longer feared being close to her children and the family system was strengthened.

And I would believe, understanding attachment and how important that is in early childhood, that no doubt that's contributed to the prevention or the amelioration of mental health disorders in her children and then the ongoing flowing effects of that into the second generation.

Q. You also say that, based on Foundation House's study into young people of refugee backgrounds using mental health services, you found that some of those people found it difficult to implement the advice that they were provided by practitioners.

A. Yes.

Q. Can you just expand on that?
A. That's really true. So, for example, in a

consultation a young person said, the common advice given is to undertake relaxation, relaxation can be extremely effective, it's a common cognitive behavioural treatment therapy. There is no way he could undertake relaxation kind of therapies or visualisation script because he was deeply anxious for his sister who was in hiding with nothing to eat in his country of origin. So, without that context, that advice around relaxation is going to be patently ineffective.

Q. You've talked earlier about some of the very specific barriers in the context of the process that asylum seekers might have to go through and their concerns about revealing any kind of mental health issues they might be experiencing. But there are also very distinctive stressors for that group?
A. There are. So, the asylum seeker process poses really distinctive stressors in terms of the effects of protracted detention and the really long processing times. And the language of mental health disorders just is insufficient to describe the powerlessness, the sense of hopelessness, the shattering of assumptions that people have about human decency that occur when people have had protracted and long-term detention, whether that's offshore or onshore in Australia.

There's a recent study - recent as in it's being published this week or next week, I believe - looking at self-harm rates in the asylum seeker cohort in Australia. It's a national records-based study. What that study highlights as best as they can estimate, is that, in the asylum seeker cohort in community, rates of self-harm are approximately four times what one would expect in the general Australian population. For asylum seekers who are in community detention, those rates are about 22 times what one would expect in the general Australian population, and for asylum seekers who are in detention, whether that's offshore or onshore, the rates are between 46 and 216 times more prevalent than they are in the general Australian population.

Q. Can you make that recent study available when it becomes available?
A. Sure. It's literally under publication now and I'm happy to send that through.

Q. Thank you.

A. I guess that goes to the effect that, particularly with that asylum seeker cohort, whether in community or in detention, without mental health professionals understanding that context and the effects that it can have, they really can't provide effective treatment, and sometimes they just give really unhelpful advice.

They say things like, "Well, surely you can just go and get this prescription", when the person might not have access to the Pharmaceutical Benefits Scheme. They say things like, "Well, you could go to the GP." Maybe that person has a Medicare card, maybe they can't, maybe they can't do that.

So there's a whole lot of things about that cohort that mean, without specialist understanding of it, health professionals, mental health professionals, can actually add to the stressors by simply not understanding the very real nature of the stressors that the asylum seekers are experiencing.

There are other things, so for example, temporary protection visa holders have also very specific stressors, and one of those is that persons have no right to family reunification, and we've all heard about the importance of family and being connected to family.

Both of these groups, the asylum seeker cohort and also the temporary protection visa cohort have recently been highlighted by a study, a report literally out this week by the Australian Human Rights Commission, it's called Lives on Hold: The Legacy Caseload, and that's been released this week.

Q. What about the need for protective factors particularly in the context of refugee backgrounds?
A. Sure. So, we know that protective factors are really important, and when we think about our work we understand it in the context of a history of trauma and traumatic events, the cultural factors at play and the risk and protective factors that are available in the Australian context.

So, protective factors are really important in terms of mental health wellbeing and recovery from a mental health illness, and this includes support from family obviously and community. Those things are so important and

sometimes they're lacking because of the experience the people have had. Particularly parents if they have their own experience of trauma, their capacity to then support their children through those experiences and really wrap that family up in nurturing and support can also be affected.

Q. Just on that, in terms of children and adolescents, what about the need for a greater understanding of their schooling, for example it might have been interrupted?
A. Sure. Look, with respect to children, adolescents, there's some very particular things also. So, it's important for mental health providers to understand schooling for this group is obviously often been extremely impacted in their country of origin given significant years of displacement and conflict. They may well have been traumatised by events such as witnessing bombings, witnessing family being killed, displacement and forced separation from family.

There are barriers to participating successfully in school in Australia. It includes parents' lack of knowledge about the school system, and it also includes, obviously, language difficulties and also includes difficulties which arise in the school environment because they're not adequately responding to the needs of those students. That's certainly some of the work that Foundation House does, is work in a whole-schools approach to support schools to better respond to the needs of their students who are from refugee backgrounds.

Q. Before moving on to ask you about interaction with the mental health system, can I just ask you to address the recognition of complex trauma?
A. Sure. So, the Commission has heard a little bit about this. We've heard for example from David Forbes a few days ago around the growing body of literature recognising complex trauma, which describes the exposure to multiple traumatic events, as well as the invasive interpersonal nature of those traumatic events. The literature indicates that the effects are wide-ranging and long-term and multiple domains of functioning are affected. So, it includes attachment issues, relationships, emotional regulation, social skills, cognitive skills, identity formation. And the effects of that complex trauma are cumulative without protective factors also being at play: for example, family and community supports, tailored

interventions.

Q. Can I move on then to ask you about interaction with the mental health system. In your statement you say this:

> "Trauma survivors are especially sensitive to how they're treated."

Can you just expand on that?

A. Sure. Trauma survivors definitely are particularly sensitive to how they're treated, and we've heard that evidence also from others. Treatments need to be respective, respectful, they need to be culturally responsive, and that really includes an understanding of the conflicts involved in juggling two different cultures and considering the culturally-based expectations about mental health views and about treatment.

We heard about that really powerfully from George this morning, and that relates not only to refugees but also other populations, but yes, refugee trauma survivors are very sensitive to how the system is treating them. And, if it's not treating them in a way which provides a recovery environment which is respectful, which promotes recovery, then it may actually do harm.

Part of the harm that it can cause, for example, is if people are not believed about the trauma that they've experienced. So, when people experience traumatic events, sometimes those events are outside the realm of the counsellor or the clinician who they're talking with. This clinician has never experienced something like that, they find it difficult to imagine that this has occurred to somebody and that can lead to feelings of disbelief in the person who is telling the story, and that is the antithesis of what will help promote recovery. In fact, it's really harmful when that happens.

Q. You say in your statement:

> "There needs to be effective communication between mental health professional and persons with refugee backgrounds."

Can you just explain what that means?

A. Sure. Effective communication means a whole lot of things in terms of, particularly around mental health and

the concepts involved which we heard about from VTMH this morning, and at a very practical level it involves qualified interpreters in a timely and routine way when that's needed, and it also requires the translation of health documents. So, it's quite common, for example, for discharge summaries and other documentations around the health information of a particular person to only be provided in English.

And the other thing I guess to say, is that, this is based on our experience, it's based on our experience in Foundation House, it's also based on my experience from within that mainstream mental health, but we don't have data on it because data's not provided about, you know, when was an interpreter required and not provided, we don't have that information.

Q. Can you give three examples of this in a real life context?
A. Sure. So, we describe this in our submission that Foundation House has provided to the Commission. A community member whom Foundation House consulted in order to inform our work for the Commission commented, and I'll quote them:

> "I know of someone in the community who was discharged from hospital after treatment for mental illness. The discharge plan was only in English and the family was only given 10 to 15 minutes explanation at the hospital of what the patient needed at home. There were no home visits once the person returned home and the family really struggled to manage. There was enormous pressure and stress for all the family."

My interpretation of that enormous pressure and stress is, that might be a bit of an underplay of what could have been happening on discharge from an inpatient unit.

Q. You also described a situation you're aware of, of a woman who presented at the Emergency Department?
A. Yes. So, we're also aware of a woman who presented at an Emergency Department. She was highly distressed with psychotic symptoms, a likely deteriorating mental state. Her pre-arrival history included being raped and her husband and son being captured. When she was finally

assessed at the Emergency Department after several hours, no appropriate interpreter was found, and at the very last moment a male security guard was brought into that session to act as an interpreter. I think it's fairly clear what that involves in that situation.

Q. And you give a final example.
A. Another example, again a torture survivor who was unwell, was highly distressed and required ambulance transport to hospital for a mental health admission. So, in that bundling into the ambulance situation, in the absence of an appropriate interpreter, the ambulance officers were trying to explain the process to this person by shouting at them slowly, as a way of trying to get across the cultural divide.

So, if we can imagine being shouted at in a language that one does not understand, in the context of being highly distressed, being bundled into an ambulance, this would have been extraordinarily re-traumatising for this person who had a history of torture and detention in their country of origin.

Q. Can I ask you now about how the mental health system can change or improve its approach towards people with refugee backgrounds?
A. Sure. Foundation House has made some really specific recommendations in this regard to assist the work of the Commission in terms of our submission. I'm really happy to summarise the key elements of those.

One of the important things that we've been discussing and is important to note, is that, the things that we're recommending are not only of benefit to the cohort of refugee background people for whom we provide services; they're also of benefit to culturally and linguistically diverse communities more generally, and also to people who have experienced traumatic events. So, all of these recommendations, if they were fully implemented, would be of benefit not only to our cohort, which it would make a huge difference to, but also in fact to the vast majority of Victorians who access the mental health system.

These include cohorts that are of a particular interest to the Commission in terms of their terms of reference, so includes young people in out-of-home care, people who have experienced family violence, people who

have experienced homelessness, all of those things.

In terms of our particular recommendations, the first one of those is how important it is to work with communities, and again, we've heard that this morning from VTMH and some of the other submissions to the Commission.

So, we would propose that there needs to be recurrent funding to train, employ, build the capacity of people from refugee communities to develop and deliver programs that reduce mental health stigma, that improves mental health literacy in their communities, and then also to work with service providers to enhance their responsiveness to those communities.

Certainly, there was a lot of rich detail in the evidence this morning from VTMH, and we would absolutely heartily endorse all of that detail that they provided around how to do that.

Q. What about trauma-informed care?
A. Sure. Trauma-informed care is critical. Trauma-informed care is articulated at the moment in the Victorian 10-year mental health care plan. However, my experience within mental health and our observations of our clients interacting with mental health is that it is not implementing meaningfully in the mental health system, and so that is really why we propose the development of a standard for mental health services around trauma-informed care and practice. That includes guidelines for the implementation in a very detailed way and ways of monitoring that this actually happens in terms of compliance.

In terms of some of the particular - people talk about trauma-informed care as this global kind of thing. We would say that, in terms of knowing whether that is actually in place, you need direct and anonymous feedback from service users, from their families, and in particular to include people from refugee backgrounds as part of that feedback that you are getting about whether your services are trauma-informed.

It means that the practice of mental health needs to include things like specific queries or a checklist at the triage process, in screening, particularly when a person is identified as being from a refugee-producing country, which

currently is not identified. It needs to include diagnostic and assessment processes where respectful and culturally responsive enquiry is made into the nature of trauma that may have occurred.

It needs to include education and training of the workforce, both clinical and administrative. It's often the receptionist who is that first contact that makes one of the biggest differences in terms of how someone accesses mental health services.

And, when we talk about whether this will actually happen, it needs systems to embed it into the requirements, the policies and procedures of the mental health services and to monitor and evaluate its implementation and effectiveness in practice and to what degree it's then affecting the outcomes of those people.

Q. What about a framework for the delivery of mental health services that embeds an acknowledgment of the importance of the social determinants of health?
A. Sure. So, this is also a very key factor and the Commission has heard much about the social determinants of health. Like others, when we were really reflecting on this deeply in terms of our cohort, we suggest the development of an intersectionality framework for the mental health services that promotes responsiveness, the multilayered diversities that occur within the Victorian community, and takes into account the social determinants of health.

If we did this, it would be consistent with the reforms which have occurred within the family violence sector, and it would provide a way to factor in and respond to the diverse and the multilayered factors which intersect for people and influence the course of their illness and promote their recovery.

Q. You also raise the importance of culturally competent and responsive services?
A. Yes. So, this again is incredibly important. Culturally competent, culturally responsive services which provide holistic care for people of a refugee background, which are family-centred, and which really take into account their family, their community and the context within which they live.

There's a multiplicity of things within this, and we would again heartily endorse what the Victorian Transcultural Mental Health said this morning about how to do that in detail, and obviously at a very minimum this includes easy, timely, routine access to appropriately qualified and trained interpreters, and appropriate translation of documents. Again, keeping in mind, translating documents is a complex process and you really need to think about how that is done and whether that's done in a way that actually is meaningful.

Q. What about funding of specialist services?
A. So, the other thing that really seems extraordinarily key is that, the funding for Victoria's mental health service system and also its design needs to very explicitly support the complementarity between specialist services on the one hand and mainstream mental health services on the other. I've provided some examples of how that collaboration works in practice.

It means that you could have specialist services, for example for torture and trauma like ourselves, for sexual assault, for family violence, for LGBTIQ+ people, and that those services can then get the mental health input and support that they need when needed, and that mental health can then get the consultation from those services about how to better respond to the needs of those populations.

This also includes but isn't limited to building and extending the capacity of community-based mental health clinics. So, capacity around bulk billing psychiatrists is really difficult and we've managed to do that within Foundation House, although we always struggle to fund and support it.

And, it also includes much better coordination of the mental health service system with all the other service systems as well, with schooling, education, housing, all of those services as well so that people have a coordinated system of care, not fragmented systems around them.

Q. One of the other things you mention is that there needs to be significantly strengthened data, monitoring, reporting and governance to ensure effective implementation and transparency.
A. Look, this is really very important, and I notice that data is in the terms of reference for the Commission, we've

mentioned data. I commend the work of the Victorian Auditor-General's Office to the Commission in terms of their recent reports out in 2019 looking at child and youth mental health services, looking at access more generally within the mental health service system.

In my experience both within mainstream mental health and outside it, we don't have the data to show what we're doing in the mental health system in terms of access for refugee background cohorts. It needs strong data, it needs to be monitored, it needs to be reported against, and there needs to be strong accountability that we're actually achieving those things.

We mention in our submission, we look at some of the data and we unpack it in detail, and when you look at some of the outcomes, the data that's used is really - it's not effective and it certainly does not include refugee background people in that data.

Lastly, of course, is the importance of research. We need to research what we're doing, we need to evaluate it. When programs are funded, they need to include an evaluation, a really comprehensive, thorough evaluation as part of that funding, and it's critical to assessing continuity of care and also the impacts of the reforms that hopefully will happen as a result of this Commission.

We'd also like to conclude by saying that, some of these terms that we've used - trauma-informed care, cultural responsiveness, family-centred approaches - these terms are well-known across the mental health landscape, they're not new to anybody. But my experience working within mainstream mental health, our experience at Foundation House when we see the interactions of our clients with mainstream mental health, is that these practices are not embedded in what is happening in mental health services: they're not embedded in the culture, in the processes, in the systems.

Where those practices do exist, and we highlight some really good pockets of really excellent practice, they only occur because of the leadership of particular individuals who are passionate about those things. They're not statewide, they're not required, they're not monitored, they're not accountable.

One of the very key things we believe that will really speak to the effectiveness of the work of this Royal Commission will be to what extent the implementation of recommendations are fully embedded in routine practice, and what mechanisms are put in place to really ensure that what is written in paper actually is experienced by clients who access those services.

MS COGHLAN: Thank you, Ms Scoullar. Chair, do the Commissioners have any questions?

CHAIR: Professor Fels.

COMMISSIONER FELS: Q. I just had one, and speaking of data, do you have any information about the numbers in the kind of catchment population you're talking about? I mean, you've already said you don't know the rates of access, but what proportion of the population have the background of torture or trauma?
A. That's a very good question. So, across Victoria - I'm trying to think of the exact rates. It was written up in a report recently, I can't remember the figure, but it was thousands and thousands and thousands.

Q. Maybe you could just send us a guesstimate?
A. I'm happy to take that question on notice. I think it's 40,000, 50,000 or so at a minimum, but I'm happy to get back to you with an exact figure.

The thing that's difficult with that as well is that, my recollection of that figure that I saw was possibly humanitarian entrants in the last 5 to 10 years, and of course there's people who have been here for 20 years or for 30 years, and sometimes the impact of trauma doesn't get unpacked until 20, 30 years down the track. So, I'm not sure that we'd even know what the rate is, but I'm happy to look into it.

CHAIR: Q. Ms Scoullar, I just have one other thing I'd like to ask you about, and thank you very much for your overview. You say in your statement, and really underscore the importance of needing to deal with the issues of trauma before you can put in place a good approach to recovery and in mental health care.

I think your examples have illustrated why that's so important, as was George's evidence this morning, and about

the triggers that people experience.

I just wanted to have a sense of what good quality mental health care then looks like in terms of intensity, duration, elements of continuity of care. What do you think is important for us when we're thinking about how to provide a more effective response as needed on those fronts?

A. That's a really good question. One of the very key things there you mention is continuity of care. So, the challenge there is that, because the service system has been fragmented, where someone enters the system or first rings up isn't necessarily where they will get their care, and then there's barriers at each point.

So, in terms of continuity of care, it's really important. It's really difficult for people to access help, to actually front up and say that they would like help, and it's really important that that's done at the outset.

In terms of the trauma-informed nature of it, one, we need to get much better asking routine questions around trauma histories, but if we do that it needs to be in a way that is in an environment that is safe, that's respectful, where that has been set up properly so that those questions come across as respectful, routine kind of questions; it's not an interrogation, it's not someone looking at a checklist, even though they might have a checklist kind of in their brain or in their notes.

And also an acknowledgment that sometimes - and George kind of illustrated this - there were times that he could not or was not in a space where he could unpack all of that trauma, but to recover well and to be provided with an appropriate service the person needed to be aware of it and be provided services in a way that took that into account, even where they weren't right now doing trauma-focused exposure therapy, for instance, and that's really important.

For example, with the person with an eating disorder in hospital: you know, if she's in intensive care on a drip, she's not right now going to be talking about trauma, right, in terms of her torture experiences. But, if the interactions of people around her realise that this might have occurred and are less controlling, they provide her

with more dignity, they give her choices: even the little choices make a big difference.

And so, one of the things we do is really try and make sure that all interactions with a client, with their family, are the antithesis of what the trauma might have provoked. So, instead of feeling humiliated, people are feeling respected; instead of their relationships being fragmented, we're working towards connection, so it's those sorts of things.

But it's really quite complex and it's really quite nuanced and it needs a lot of specialist kind of input and consultation

Q. So, you did mention earlier in your evidence about a secondary consultation role you played with a survivor of sexual abuse. How important is secondary consultation given the sophisticated understanding of trauma that you're describing as being required?

A. Look, I think it's a really under-utilised thing across mental health and across the service sector. I think that, because mental health services has been so underfunded and stretched and under so much pressure, when people are in that, they get insular, we all just go back to our little silos.

One, it's efficient, but it rarely provides that opportunity. So, if we as Foundation House, a torture and trauma expert, can go into mental health, we can provide a consultation around someone who's had that experience, and then provide secondary consultation to those clinicians that mean that they have a much better understanding of what might have occurred, that will help their treatment in that service.

Similarly, if we're providing treatment to someone who has experienced torture and trauma who has quite acute mental health needs that we might not be best placed to serve, we might be able to keep that client, provide an ongoing relationship with that client if the mainstream mental health service comes in and provides some consultation to our counsellors around, okay, this isn't psychosis, we agree with you, it looks more like it's a dissociative episode, give us a call if you're not sure, let us know if the mental state deteriorates, we'll come back, and in that way you're attending to that medical biological underpinning: is it psychosis? We don't want to

miss that, but in a way that doesn't break up that therapeutic relationship which is so important to recovery.

So, it just seems to me like a really underdone area across mental health and across all of the other service systems: primary consultations, secondary consultations and partnerships between service providers. We talk about wrapping services around clients, but we don't actually do it very effectively except in very small pockets of practice, but it's really effective.

MS COGHLAN: Thank you. May the witness please be excused?

CHAIR: Yes, thank you very much for your evidence.

<**THE WITNESS WITHDREW**

MS COGHLAN: The next witness to be called is Adwin Town, and I call him town.

<**ADWIN TOWN, sworn and examined:** **[12.48pm]**

MS COGHLAN: Q. Thank you, Mr Town. You have made a statement with the assistance of lawyers for the Commission?
A. Yes.

Q. I tender that statement. [WIT.0001.0052.0001] Mr Town, you were born in Shanghai and you were educated in Hong Kong?
A. Yes.

Q. You migrated to Australia in 1985?
A. 1985.

Q. You now work as a volunteer, as a senior migration consultant?
A. Yes. I start doing migration from 1981 from Hong Kong.

Q. In your role now, you help refugees and students and other migrants to settle in Australia?
A. Yes. So, right now I'm a migration agent and then I help in the church as a pro bono service to help members of the church, the community, refugees and many other people who need help and cannot afford to do it.

Q. One of the things you do with the church is, you manage the Praise Dance Group?
A. Pardon?

Q. You are the manager of the Praise Dance Group?
A. Yes.

Q. You are also a committee member of the Chinese Association of Victoria?
A. Yes. Chinese Association of Victoria, I'm the Public Relations Officer, yes.

Q. That association has over 1,200 members?
A. Yes. We have over 1,200 members and a lot of students, and we have a Chinese school, and we have a lot of activities helping the community.

Q. The association is based in Wantirna?
A. Wantirna, No.8 Ashley Street.

Q. Today you're giving evidence about your own opinions of what you've seen in the Chinese community?
A. Yes.

Q. You're also a voluntary committee member of the Multi-Cultural Commission Advisory Committee of the eastern region?
A. Yes, I'm the Advisory Committee of the eastern region and the Multi-Cultural Commission.

Q. Can I ask you about your knowledge of the attitudes towards mental health in the Chinese community? I'm just going to read you firstly a part of your statement and ask you about that.
A. Yes.

Q. You say in your statement:

> "I believe that many people in the Chinese community do not have enough knowledge about issues of mental health due to our conservative culture."

A. Correct. Chinese culture is very conservative, and when you touch on the mental health issue a lot of people really don't know what it is, how to deal with it, and

where to seek the knowledge about handling it.

Q. You say in your statement that:

> "Many members of the Chinese community do not even know what mental health problems are and could not recognise the early signs and symptoms of mental illness until a person explodes."

A. Yes. A lot of people, because of conservative, people like to back up, don't want to touch it, because they don't know what to do, and then, you know, they don't know where to seek help. And sometimes they are afraid to talk about it because, the moment they show that if they are having some mental problem, people will treat them as abnormal or back away and doesn't want to be friends with them, so they are afraid of being isolated.

Q. One of the things you say in your statement is that, given that people do not want to disclose, that this can mean that they don't get the help that they may need.
A. I can't hear, sorry?

Q. Sorry, I'll say that again. One of the things that you say in your statement --
A. Yes.

Q. -- is that this conservative culture that you've described often means that, when Chinese people have issues with their mental health, they do not disclose them to their friends and family or reach out for helplines.
A. Yes. Because of the conservative nature of the Chinese culture, their families, even themself, don't want to be known as if they have some problem. Because, even their family, when they saw their beloved one having some problem, but you know, they don't know where to get help or they don't want other people to know that their family member have problems. Yes.

Q. One of the other things you say in your statement, is that:

> "People in the Chinese community are much more likely to seek advice about their uneasiness and stress from community leaders that they trust, such as pastors,

youth leaders and teachers."

A. Yes. I've been in the community work for a long time. A lot of time some of the people, they come, they express what they have in heart; they try to let us know what do they feel, how they feel and the stress they have. And then, a lot of time because of the trust to the community leader, to the pastor and leaders, they tell them all about it, you know, they're willing to tell and seek help from all these sources, hoping that they can have a solution to help them, right.

But, like pastor, they're not trained to handle mental health. What the pastor and the community - we use love, hope, comfort, we use prayer, we bring the family together, we give them hope and try to soften up, you know, the various problems they have. It is a complex problem: sometimes family issue, children's issue, financial issue, work issue, marriage issue, you know, all of these can trigger and bring up this issue.

And then what I think is that, sometimes we need to - instead of looking at the symptom and trying to suppress it, and rather, how about bring in earlier and find out the cause and through the contacts of the people, we sort of, ah, there is some problem here, and then we try to work with the community; you know, there are so many help, but a lot of people doesn't know the clear path or the flowchart way to get the help.

That is why, you know, I very sincerely hope that the Royal Commission can give resources and some training to people on the frontline. I call them frontline soldier: pastor, youth leader, teachers, you know, community groups.

Because we, when we say, okay, there are courses that we can go: wow, so expensive and it costs a lot of time. So, people, a community leader, doesn't think that they should spend time and money to learn mental health. Because, if they are not going into the trade, they don't want to learn it. They still sense it's important but actually in their heart they want to learn, what is it, how can it help? How can it help our community people if just I know all these things and I can sense it and then, when I sense it, I know I can find people who are expert in that area to bring in to help together with the community leader using, you know, hope, love, comfort, prayers, and medical

solution.

Q. And so, what you're talking about there, you've described the frontline soldiers.
A. Yes.

Q. And those people being equipped with knowledge and the ability to access further resources.
A. Yes. Now, a frontline soldier, they don't want to be a professional mental health helper, but they need to be given an opportunity to learn what is mental health: how can we sense when it happens, and where are the helplines and what are the ways?

One area, you know, I also would suggest is, the Chinese Medical Association have their way of looking at mental health, and sometimes I look at it as, East meets West, sometimes is a very good solution. Because sometimes I see Western medical solution normally is dealing with the symptom with drugs or whatever on suppression. And then the way in Chinese medical way rather to have it a bit released.

I have shown an example, for example, children having high fever. Western medicine people used to put them into icy water: oh, cold. They subdue the heat. Chinese philosophy is to put a blanket on it, let the child to sweat, and the heat comes out. The solution at the ending is good: both the fever subdue, but what happens, you know. I give another example. If you use a red hot iron, you put to icy water: yes, cool down.

But if you put it in the windy way, let it cool down naturally, it cool down. But the red hot iron that dip into the icy water, you hit on it, it's brittle: that means there are permanent damage in the material. What happened to the children? What happened inside? You see, the terminal problem that's inside will stay. That is why, why not having a platform, let the Chinese Medicine Association come in and then we talk about it and find something which is helpful to both area, because ultimate benefactor is what? Is the community, is the people. We open our mind and let new ideas come in - well, at least we have 5,000 years of history of dealing on this, why not giving it an option to the community one more chance. This is my pledge to the Royal Commission. Thank you.

Q. Can I just ask you, just before we finish, in terms of the solution that you may suggest for community leaders to be educated in mental health first aid because that is something that they would be prepared to accept because it is something they can learn which is not expensive.
A. True. You see, like mental health: we have mental health diploma and all these things. Our community leader look at it is that, I'm not going into mental health in the profession, and, wow, so expensive, they don't want to spend the time.

But mental health first aid, when you look at the first aid: ah, people have the subconscious say, oh, it's only touching the base knowing what it is, easy to adapt. And I hope that the Royal Commission can be giving this opportunity that mental health first aid courses can be given to the community leader, pastor, teachers, even gymnasium, you know, lecturer, swimming lecturer, because they are the frontline soldier to the community, and they can sense it.

If they can be equipped with the basic first aid course mental health knowledge, once they saw it and they know it, ah, they have some problem. Maybe, you know, I find someone who is more professional: we work together, even bring in the pastor, using love and help and hope. We work together dealing at the core instead of dealing at the basic problem/symptom.

Q. Just one final question: you see that those people could then understand what services are available and have a way to refer people if they wanted to.
A. Yes. Actually though through my career and that, there are a lot of incidents - you know, I touch on, like the refugee people. Australia hasn't had any amnesty for a long time --

Q. Mr Town, sorry to cut you off. Can I ask you about the flowchart of services?
A. Yes, the flowchart, yes. Because there are so many individual helplines, right, so suicide, gambling, drugs, all these things, and everybody have their own school. And the frontline soldier, we don't know, there's so many. So, what we do is that we need a very simple flow line during the first aid courses that after they learn the nature of it and then indicating where to help, get help, then we can immediately get help from those help groups and coming in,

work together. This is what I would like to have.

MS COGHLAN: Thank you, Mr Town. Chair, do the Commissioners have any questions?

CHAIR: Q. Yes, I just have one. Thank you very much, Mr Town, for your evidence and your witness statement. In your introduction you talked about the role that your community plays in supporting a wide variety of people, including a lot of students.
A. Yes.

Q. Including international students?
A. Yes.

Q. Because we have heard in our consultations about some of the challenges international students can face. Do you think this sort of supportive frontline soldier work would be effective for international students as well?
A. International student come in, a lot of them first time leaving their family. They don't know how to handle themselves in life and mix up with a different culture, so they rely on the same culture.

In China there is a saying, "If you are in stress, go where the cross is, they will help you, and they will not just looking to get money from you, they will really help you from your heart." So that's why in church we have a lot of, you know, international student coming in trying to say, I've got problem in here, I've got problem in there, that's why you know. Sometimes, if they suppress too long and don't express it out, they lose hope, they will have different kind of thinking.

Sometimes the distress may cause them to go to gambling, go to drinking, go to drugs, and that is why I said, you know, we start from the core. Sometimes it's a very simple thing, but it triggers the wrong intention and going into the wrong way.

CHAIR: Thank you. Thank you very much, Mr Town.

MS COGHLAN: Thank you. May Mr Town be excused?

CHAIR: Yes. Thank you very much again for your evidence today.

<**THE WITNESS WITHDREW**

MS COGHLAN: Chair, is now a convenient time to break for lunch?

CHAIR: Yes. Thank you very much, we're adjourned.

LUNCHEON ADJOURNMENT

UPON RESUMING AFTER LUNCH

MS COGHLAN: The next piece of evidence that the Commission will receive is a video submission of Kali Paxinos. Now, she is in attendance today and it is proposed that she will be sworn in and that the video submission will then be played. I call her now.

<**KALIOPE (KALI) PAXINOS, affirmed and examined:** [2.04pm]

MS COGHLAN: Q. Thank you, Mrs Paxinos. You've provided a video submission to the Royal Commission?
A. Yes, I did.

Q. Thank you, I tender that. [SUB.0002.0029.0402]
We'll play that now. May I be seated?

CHAIR: Yes.

(Video played)

"My name is Kali Paxinos. Yes, I've been married for, oh, over 50 years, probably 60 years now. My husband has passed away, but I have five children: two girls and three boys and six grandchildren and a great grandchild.

Well, I was born in Australia, but my parents were from Greece. They came from the island of Ulysses, the famous Ulysses, called Ithaca, the island's called Ithaca. They migrated to Australia. Dad came in 1915 when the Second World War had started - oh no, it was the First World War had started and married my mother in 1922.

At first I wasn't involved with the professional, they didn't invite me to be part of that treatment program, but because I was a person who wanted to find out things, I went to a library which was run at the time by what was called in those days Schizophrenia Fellowship, it's now Mental Illness Fellowship.

I went there to find material to read and understand what this condition my son had, because I didn't know anybody else, around my circle anyway, who had a mental illness. So, by going to this organisation, it opened up many doors and, as time went on, I learnt more and more.

One of the things that was so important was how I had to handle the situation, how I had to have understanding of how to speak to my son when he was psychotic, for example. These were new experiences and I would suggest that not many people would really know how to communicate with somebody who's in a psychotic episode.

I just felt that the professional looking after my son didn't ask any questions about the incidence of how my family felt; they didn't include them in that conversation with me. They didn't ask to include the rest of my family, for example, which I think would have been a good idea in those early days.

They have made big transitions in their lives; a lot of them may come to family who are already here and they can be accommodated and have friendships, but a lot of them come without anybody. After a few years I met some of these women through the work I was doing when I was working in

mental health, and it was very interesting that the actual fact of them coming to this country without the language, without people, without knowing anybody, without partnerships was incredibly difficult for them.

And out of that I met one particular lady and she married and she had a baby, and the hospital contacted me and they rang me and they said, 'Look, she hasn't got anybody, she hasn't got a mother, she hasn't got a sister. The only one she talks about is you, can you come and visit her' and I remember going to visit her, and it was an incredibly emotional experience for her to see me as a mother figure, and I really realised how many people in this world need their mothers.

But I think, within the training of all our professionals who are particularly working in mental health, they really - I think they really have to have a really increased study program in the practical area of understanding, because a lot of our people are - they don't speak their English language very well, they need an interpreter when they're having discussions together, so I think that area has to be looked at very carefully and funded.

But one of the things I think that helped these families was that I was a mother, and whether they were parents or whether they were the people with the illness, I think that mothering figure was important. And I can always remember one client came one day, and he actually had a diagnosis of mental illness, and he came to where I was working at the Mental Illness Fellowship at the time. It was time for a break, it was nearly lunchtime and I was damn hungry. He opened up his little violin case and he had

an apple and a banana in it, and he said, 'Would you like a banana?' So, I thought, I can't say no, so we broke the banana in half and we had half each. And I thought, some people with these serious mental illnesses are lonely people, they may not have parents. I didn't know his background, but sometimes they just wanted you to do just normal, simple things. They didn't want great big explanations of theories about different things or treatment, they just wanted that simple feeling of being needed, and him giving me a banana, to him was great, it was greatest thing that ever happened to him I think.

And he started singing, and he had a beautiful voice actually but who knows where he is now. The Salvation Army had sent him which lends me to think that he may not have had a background of parents.

Firstly, they didn't understand what mental illness was. They thought particularly, they saw the behaviours, because mental illness does create difficult behaviours in most instances. So, because of that, they often thought their people were bad people, that they were influenced by people and doing these things, or they were doing it to annoy their mothers.

So, what they really were missing was to understand how to communicate, and that's one of the biggest issues in dealing with people with mental illness, is how do you communicate? So, professionals who are in the field really need to be able to talk with family and say to them, 'How about we discuss how you have a conversation with your person who has a mental illness', particularly when they're going through the psychotic episodes.

I think, during the time that I was involved with the mental health system, which is quite a long time ago, 20 years now, but we were able to have groups coming together of carers, and I was working within the system at that time, but nowadays there are others who would be working there, maybe could do the similar things, whether they're doing them or not, I don't know.

But we were arranging particular meetings together with carers, with families, to come and have a cup of tea and a scone, not a great big professional way of doing things, but a friendly meeting so that one mother would meet another mother, there would be a father who would meet another lady. We'd have similar issues and we'd talk about them and we weren't giving them a totally professional way of doing things. We would be giving them our experiences, what worked with some of our families: would it help you if you did a similar thing? So it was all around the people who cared for their family member who were talking amongst each other.

I mean, they were such simple, ordinary kind of things that needed to be discussed, but you didn't need a professional answer, it was just a common sense answer that you would be doing in your own family home. So, I think sometimes people/carers, need to hear just those simple kind of ways of helping their sick relative, because they're living with them.

I think it's terribly important because, once that father or mother and sisters, whoever they were, came to me, the first thing I would say to them, 'I'm Kali and I have a son who has this particular illness, so you can express yourself in any way

you'd like. But talk, open up. If I can't answer your question, I will tell you and I'll refer you on to somebody who can give you a more professional answer to it.'

And there were times when a few of them would bring some papers that different doctors or whatever gave them, and they were written in quite medical ways. These people, some of them didn't have much of an education. I mean, the world is very mixed, there are people educated, there are others who are not, all sorts of - we get a lot of migrants coming now with language issues.

So, I said, as professionals you've got to be very careful to understand that it's not a disgrace to use a simpler word when you're explaining something to people who don't speak English very well.

I think in some ways some of the professionals that I'd met at that time felt that they had to keep their professionalism in front, but I could see that they weren't connecting with that sick person, or the parents of them, and I think that's such an important issue so that mother or father, or even the patient them self, leaves that room, knows exactly what you were talking about.

Discuss with them the kinds of things that are going to help their person in the home. You're a professional, you know these things, and most of them are mothers and fathers anyway, yes. So, the point is, if you can give them some of those practical things that even you do.

Because a lot of us, when we have a person of our own flesh and blood who's mentally - we're at a loss how to help them, we want them to be like they were before, but

they're not like they were before, the illness has changed them. So, we often don't quite now how to respond to them.

So, when you have a professional who understands that and can talk our language, that simple - we're not clinical people, we're ordinary people: some of us are a little bit educated, some of us are not. To really understand that the world isn't - and they would have learned some of this in their training anyway, but expand on it, become a little bit - and the more professional you are, the more you should be able to bring yourself down to the level of the people that you're serving.

Families would often say to me, 'Why didn't the doctor listen to me? Why couldn't I have said something?' Or, 'Maybe it's because I don't speak English very well, they didn't explain it.' Or, 'They didn't bring the interpreter like I asked them to because it costs money.'

I think, if you've experienced something yourself you're able, or very likely able, to do the same thing and help that person, because you've experienced it. A professional who hasn't actually experienced the actual living with the person - they've learnt it in the professional way or the book form way, and maybe they've had some experience because they have to do some practical work as well.

Mental illness is very different from having a heart attack, or sore legs, or whatever it might be.

I think mental illness is now a little bit more acknowledged than it was when I first

entered the system, but it's really important that it is up on that top level, because the understanding by the ordinary people, most people who don't have mental illness, they don't understand about it.

So, I think there needs to be a lot more public education, and it could be done on the film, it could be done on television, it could be done by more articles written maybe, in places where the ordinary Joe Blow reads. It's good for people, for professionals to read things to be written in a professional way, but there's a group of people in our community who for one reason or another don't have that kind of education, don't read those kinds of articles in newspapers; they're the ones that we need to access and to give that simple way of talking and how to discuss with people.

Maybe as we've been discussing I recall the times when I first entered the system, and I realised that a lot of the professionals didn't always really understand the carer role, the role of the parent in these situations. So, it needed to be able to be understood by the psychiatrist, or the professionals in the system, that they deal with the client in their rooms, but then that client goes home but the illness doesn't go away.

They shouldn't be excluded from anything. I think everything that's available for people with physical illness should be available for people with mental illness as well. This is a particular kind of illness. These are physical problems that should be regarded like a physical problem and treatment given accordingly and services be available for people to understand what it is and for the doctors and professionals who are working with the

ill person to include the family.

That kindness and the compassion and to help that person, whether you're the psychiatrist or whether you're the case manager, whoever you are that's within that treatment team, if you don't show kindness and compassion, you've lost your patient, you're not treating them properly because, with particularly mental illness, medication sometimes isn't only the solution.

Q. Ms Paxinos, thank you for your insightful words. Chair, do the Commissioners have any questions?

CHAIR: Q. Thank you very much Mrs Paxinos for your presentation to us, it was very thoughtful and considered. When you think about how you make sure that message of compassion and care is given across the workforce, how do you think we best train our professionals in doing that?
A. I think it's important for them to have access to people like myself, for example, to go into the universities. I know I was invited quite a few times to go to universities and just give my - what I was talking about on the tape here. But I think a lot more should be done to explain to the professionals those elements that come from these illnesses that they need how to actually communicate.

There's a simplicity that can be profound, and sometimes - because I've witnessed quite a few times when professionals have actually spoken to me, and I don't have qualifications, I didn't go to university, so I don't have that upper level of understanding maybe. Nowadays as I grow older I understand more things, but the point is that sometimes, if you get the professional who get themselves to that level, bring themselves to that level of the person who's sitting in the chair opposite them, they're not pulling themselves down.

I think that's the greatest intelligence of all of a professional, to be able to bring their language down so that person can understand what you're really saying. Because there have been many, many times when I've spoken to families after they've seen the professionals and they say, "What did he say, Kali?" Or, "What did she say?" And

at first I couldn't quite put it together, but now that I'm this old they're beginning to come through and say, "No, it shouldn't have been done like that."

CHAIR: That's a very important message I think for us all to hear. Thank you very much, and thank you especially for coming and being with us here today.

MS COGHLAN: Thank you. May Mrs Paxinos please be excused?

CHAIR: Yes, thank you Mrs Paxinos.

<**THE WITNESS WITHDREW**

MS COGHLAN: The next witness to be called this afternoon is Marie Piu.

<**MARIE PIU, affirmed and examined:** [2.23pm]

MS COGHLAN: Q. You've made a statement with the assistance of lawyers for the Commission?
A. Yes.

Q. I tender that statement. [WIT.0001.0054.0001] I'll just ask you to speak into the microphone just so we can hear you. Thank you. You're a registered psychologist and have worked in community and clinical mental health, union, police and management consulting sectors?
A. Yes, that's right.

Q. Can you please describe your current role and responsibilities as CEO of Tandem?
A. Yes, I'm currently the Chief Executive Officer of Tandem, which is the peak body for mental health carers in Victoria. I have 12 staff and we predominantly work across systematic and individual advocacy. We also administer the Carer Support Fund which supports carers across Victoria, and we also run NDIS support, and engagement activities across the state.

Q. Today you will be talking about carers generally and their experiences with the mental health system and the way things can be improved, but you're also going to address the challenges faced by members of the CALD community?
A. That's right.

Q. I'm just going to focus first of all on carers more generally and then come to the specific topic.

So, what roles are carers and families assuming in caring for people with mental health issues?

A. Carers and families in many instances are de facto case managers, they're financial managers, they're property experts, or they try to be, trying to find housing; trying to deal with all of the socio-cultural issues that a person with mental health issues faces. And, carers can be any age: I guess we can go from childhood right through to twilight years, and when we look at Kali, perfect example. It crosses all the socio-economic barriers, it crosses all of the educational barriers, the metropolitan and rural.

I guess the one distinct feature of mental health carers that they talk about and that is covered in the literature, is about 67 per cent approximately of the support is actually emotional support, which is quite distinct in mental health as opposed to other illnesses or disabilities.

Q. What can you say about data from the economic value of caring?

A. Sure. Well, I can tell you that, in that particular study commissioned by Mind and done by the University of Queensland, it's probably our strongest piece of solid evidence that talks to the caring experience for mental health carers. It's known in that study that 21.7 per cent of those carers provide care to at least one other person with another disability type; that about 15 per cent are under 25 years of age; that about nearly 50 per cent have been caring for 10 years or more; that about 39 per cent of carers are not in the labour force; and that the care recipient is most commonly a spouse or partner, about 45 per cent, or child at 31.8 per cent; and, that 25 per cent of care recipients are aged between 1 and 24 years.

Q. What currently happens when a person living with mental health issues does not have family or carers to support them?

A. This is a real complexity, because many people find themselves without the supports because, as we've seen and with the advent of the NDIS, if someone doesn't qualify for NDIS supports, they basically don't have the community supports that were once there because of the decommission

that's occurred in Victoria, and I'm speaking specifically to the Victorian situation, so often they can fall into homelessness; they may end up being incarcerated for very minor offences as a result of their mental health issues, and in fact may end up unfortunately taking their own lives.

Q. How will changes to Victoria's changing population, particularly age, impact on this?
A. It has a massive impact because some of the carers that we've spoken to have been carers since they were children, but are now in their senior years and are looking to retirement.

I've spoken to many parents who have had to sell property, cash in their superannuation to try to buy a property so that their child does not become homeless. They've been fortunate to be able to do that, many people can't do that.

So we have a situation where people are - you have intergenerational caring going on, so it just follows people throughout their lives, and without any supports, and if the person doesn't access NDIS in particular - and we're still watching that all evolve - but particularly for those that don't access NDIS, it's really unclear where that support's going to be able come from.

Q. From your experiences at Tandem, what are the impacts on family members and carers caring for someone who experiences mental health issues?
A. There's a myriad of experiences of emotion that occur. There's the distress and the guilt, there's the fear, there's that sense of being abandoned, there's the fear that if they speak up no-one will listen, but there's also the stigma around talking about mental health issues.

There are a myriad of issues that impact on people, but I think that the emotions are very mixed, because they want to be able to do their best, but they don't feel that they are identified in the mental health system and supported, so they're not given the tools to be able to assist, and inadvertently sometimes they may do something that may not actually be helpful, but there's no way of knowing that at the time. So they're sort of thrust into this situation that no-one's prepared for, without any tools, and they just muddle along as best they can, so I

think that's something that really needs addressing.

Q. What do families and carers of people living with mental health issues report that they need - what they need to support their loved ones, what do they report that they need?
A. I think first of all they need to be identified at point of first contact. Well, first of all they need to be able to access services. If we take a step right back, the number of calls we get at Tandem of people who are desperately trying to find a door that will open. The other day I described it as a game of snakes and ladders. A carer said to me that's so accurate, because you think you've gone in the right door, and then all of a sudden you find it's slammed shut.

And when you do get in the door you're often excluded from information. So, you may have a family member, and sometimes services use privacy and confidentiality as a reason not to communicate with family members, and it seems counter-intuitive that what ends up happening is that someone may be discharged from hospital without anybody being contacted. And I hear this in the country particularly. You're hundreds of kilometres away from anywhere, someone's been discharged, the family haven't been notified, so they can't go and pick up the person, the person is discharged to homelessness and in danger to themselves, so this is something that families really struggle with.

So I think that identification of families at first point of contact, and then provision of support and information on what might be helpful with their family member, and also some support for the person to continue in their caring role.

Because the reality is that, when you love someone who has a mental health issue, you are there whether - it's by default: I mean, you want to help, so what you're looking for is some tools, you're looking for some guidance and some support, and that seems to be very inconsistent and based on the individual person or clinician they might come across rather than a systematic provision.

Q. What about a lack of investment in carers?
A. I think that the investment in carers particularly at the moment is really uncertain. There's been announcements

of investment, but from what we're hearing there are less and less carer support services available, support groups are closing. We've had calls this week that there are going to be services all closing by the end of the year due to changes in funding.

So it seems that less and less there are services that people can turn to, so that's something that we hear about all the time. We've been told, no, I'm sorry but we can't support you any more because the NDIS has come in, the NDIS is based on the individual and the individual's needs. So that, we're spending a lot of time in our team assisting people to have conversations around plans because there are no supports put in place holistically; it's all very much based on the individual, and that doesn't take into account all of these informal supports that actually need to be in place for the person to actually be able to live a fulfilling life.

Q. In what ways, and you've touched on some, but in what ways are current services and arrangements meeting, or not, those needs and what could be done to better meet carers' needs?

A. Again, we need a consistent approach, we need a compassionate approach. One of the things that people talk to us about is a lack of kindness and compassion, and when they talk about that what they're talking about is that they feel the staff doesn't have time, doesn't have time to sit with someone in distress, and that could be a consumer or their family member who comes in and is put into an absolutely difficult situation, they can't even anticipate where that's going to go, but they don't have the time to sit with them in that distress, and so therefore there's no opportunity to engage and to form a relationship, and those are the things that people really comment on a lot. And that's about the system being so stretched that people are not able to do that work.

So, you hear amazing examples of individual clinicians who do this work, there are pockets of services that do this work, but there's no consistency across the system.

People talk about a postcode lottery, perhaps that's the case, but I do think that it's more than that, I think we need to really address it as a system.

Q. One of the things you say in your statement, you refer

to:

> "A new fit for purpose system based on compassion and contemporary thinking."

A. Yes, that's right. And when I talk about contemporary thinking, what I'm talking about there is not just providing the current environment that we have which is seen as very punitive, so people talk very much about feeling as though their family member's been punished for having a mental health issue because the use of seclusion and restraint are really prevalent, and so, families are very distressed to see that that's the first response to someone in distress rather than having the time to sit with someone in distress and unpack that distress.

If you look at contemporary models around the world, we look at things like open dialogue and single session family consultation and other models that we've articulated in our submission, it's time I think that we need to think more broadly and not just have a very pure biomedical approach - and it's not just us saying that, I think that staff are saying that, consumers are saying that, so I think that we're very united in that approach.

Q. You say in your statement:

> "In order to fix Victoria's mental health system, we need to ensure that all services are safe, inclusive, fair and funded."

Can you address those points one-by-one, the first is safe?

A. Sure. By "safe" we talk about that use of seclusion and restraint in particular as not being a first port of call. The other thing is that staff need to work in a safe environment as well, so we need to think about the wellbeing of staff and we need to support staff to be able to do the work that they do. And families need to feel safe to express themselves in the mental health system. They don't currently feel that they can, they're worried about saying things because if they do they feel there will be repercussions perhaps on their family member, so this is a situation that we need to address.

When I talk about inclusive I guess we're talking about identifying and supporting families in the whole

journey, so from the beginning. And when I talk about family I don't talk about just blood relations, I'm talking about family of choice. For people from marginalised communities, for the LGBTI community and so on, it may be community - for Aboriginal community it's much broader and other multi-cultural communities. It's about people that are there that they can identify that can support them and be there on the journey, but those people need to not just be identified but they need to be informed and supported and included in the process.

Then when I talk about "fair": again, it shouldn't matter where you live or how much money you have. So, it shouldn't matter whether I live in Toorak or whether I live in Broadmeadows, and I use those two as polar opposites, we should be able to get the same treatment.

And also public and private. So, we have a situation at the moment where we've got public mental health system, some people are entering private thinking they might get better treatment. That isn't always the case. But the reality is that, one, in this system in the state of Victoria, we should know that if we go to a public hospital for care, it doesn't matter whether we have cancer, mental health or we have diabetes, we're going to get the same standard of care, so that's very important.

I think also that services need to be tailored to cultural needs; they need to be culturally safe. So, Aboriginal people need to feel culturally safe in our system, multi-cultural refugee communities need to know that they're going to be considered in the sociocultural context that they live, and that sort of thing is again not consistent.

Then when I talk about funded, we are so far behind in Victoria, and my heart breaks when I think about the fact that we were leaders in the country a few years ago, and now we really have a long way to go. I've heard examples recently about New South Wales being better than us in a number of places - that really breaks my heart.

But in all seriousness, we need to be at least at a par with the rest of the country, and I don't know how we ended up in this position, and I'm sure that we have the political will now and we have this Commission, so this gives us hope that somebody's listening and understanding

that, without adequate investment, we can't provide a safe and inclusive and fair mental health system, we just can't do it, it needs money, it needs investment.

Q. You've already mentioned compassion generally, and compassion in care, but one of the other factors that you raise in your statement is the idea of compassionate leadership. So, can you just address that, please?
A. Sure. I guess that when I talk about compassionate leadership, it's really about the leadership of - well, it's government, it's service leadership that are actually leading by example, and they're actually providing an environment that supports staff to take the time with those in distress.

It actually values that. So we hear stories that staff are being told, "You need to get back to your real work" when they're sitting with someone. We've actually had people say they've been told that, they've got to go back to their paperwork. That is something that needs to be supported by leadership. Leadership needs to say, no, primarily we're here to sit with people in distress and to assist them on their recovery journey and that's about taking the time. It's not about watching our clocks, and saying, five minutes, we've got to get on.

So I think, if that leadership doesn't come from both government - and I believe it is here in government at the moment or we wouldn't be sitting in a Royal Commission - down to the leaders of all of the services. And that goes with clinical and community services, because I think community mental health services that have existed for a long time and that have been founded by family members in the main have been forced to go into this economic rationalist world and the NDIS world which has changed the way they deliver services and families are feeling that.

So I think we need to think about that and we need to think about what the repercussions of this is, and we need to think, what is it at the core of what we're trying to deliver that's important.

Q. Can I move on to ask you some specific questions about culturally and linguistically diverse communities?
A. Sure.

Q. Firstly, what impact do language and cultural barriers

have on family members and carers looking after someone living with a mental illness?
A. They have major impacts, and I think we heard Kali speak beautifully about it and also the pastor earlier, and Foundation House and so on. I think one of the things we need to remember, it's not just about the words, it's not just about language and having an interpreter.

Though, one of the reasons I was really keen to talk about this issue is that I hear that they're still not routinely provided and I think that's a major transgression. But language is not just about words, it's about the meaning and it's about how we understand mental health and wellbeing.

Explanatory models of illness around the world are very different: some people believe that somebody's unwell because of spirit possession; somebody might believe it's the evil eye. It's about staff understanding that, you don't have to agree with that, but you do need to acknowledge that that belief is there and you need to work with that, you need to engage with people who come from very different world views. And be respectful of those, but I think our system needs to be more flexible so it can use a number of different platforms in order to engage with those families and actually assist them to seek help.

I think there is a lot of stigma, but I don't think it's unique to multi-cultural families, but I think that where there's a fear that perhaps someone in the family won't be marriageable as a result of admitting that there's mental illness in the family, that can be a huge barrier.

We've heard of people sending children particularly or siblings overseas to be married, with a hope that perhaps by getting married overseas that the illness will go away. Or that they'll have someone to come back and actually look after them when they're unwell because parents are ageing and they're really concerned about that. So, there are a whole lot of things that come with that.

But there's also role definition, and sometimes services or service staff don't understand that there's a particular person in the family that they should be engaging with because that's the appropriate person to use as a conduit. And it doesn't mean that it's a patriarchal context, it just might mean that it's the best way forward

with putting a treatment plan together.

So there's a lot of complexity, but it's just about engaging as human beings and unpacking the cultural formulation that, you know, Arthur Kleinman originally wrote, and that's in the DSM 5, it's very powerful. I don't believe, I hear, it isn't routinely used. But if that was used all the time, we would be able to understand what people think is happening, why they think it started, what they think might help, and I think that would be very, very useful.

Q. How do mental health services provide culturally appropriate services at the moment, in your experience?
A. So, my experience and from what we hear, it's hit and miss. So, there are some very good programs, there are cultural portfolio holders that VTMH manages, there used to be a lot more bilingual case managers working in the system; a lot of those are not funded any more.

So, I think that it depends on the service and on the individual clinician. My understanding is that interpreters are not generally and regularly necessarily booked. There's a concern about funding. Translated materials are not necessarily readily available and something that we're looking at, to look at whether we can assist with that process of looking at information for families that is translated.

So, my understanding is that there are pockets of good practice, but it's very - again, I don't know if it's postcode lottery or service lottery, but we can't hand on heart say that, if you walk into any mental health service from a particular background, you're actually going to be able to access culturally safe and inclusive and appropriate services.

Q. Can I just move to a different topic now, and that's in relation to additional challenges that might be faced by young carers, and what your recommendations are for how their needs could be better met?
A. So, I think particularly where there are children or young people involved - and we know there are programs such as FaPMI who have presented here - but what we're talking about is that, routinely working with the person and their family means that those children and young people can be supported.

Those children, particularly in the multi-cultural context, we may have a situation where a child is used as an interpreter which can be very damaging and very inappropriate. Those sorts of things aren't perhaps thought about very clearly but those are the kinds of things we need to be mindful of.

I have heard of young people where their parents are separated or divorced, and the young people don't live with the parent with the mental health issue and are being totally excluded from processes. So, staff not actually being aware that there are children that are living with the other parent, but they're still living with all the anxieties and the fears and the hypervigilance that comes from having a parent with a mental health issue, and really being worried about what's going on and what the trajectory is going to be and being scared of the phone ringing.

So, those are particular things that have been brought to our attention that I think are really important, so I think it's about identifying and working with the whole and with the whole family, and thinking about the fact that some of these children can be at school and be unlikely to either - they might struggle to concentrate, they might go to school - and unless they're identified in the school environment, there may not be an explanation as to why they're not completing their tasks, why they're not concentrating. But a lot of that is to do with the fact that they haven't been able to focus as a result of what's happening around them, and they can't articulate it, or they feel they don't have permission to articulate it, and so they're very alone and they're very hidden.

So I think that working across education, but I think from child maternal health, picking up families at a very early stage in kindergarten and school going through right, and work across with mental health services and also primary health services, so GPs, is really critical because otherwise we're going to continue to miss these young people who are vulnerable and are less likely to complete their education or gain ongoing employment.

Q. One of the things you talk about in your statement is other jurisdictions, for example in the United Kingdom, where the young carers are acknowledged and supported?
A. Absolutely, there's legislation around it, there's

lots of programs, there are hundreds of programs that are available. I think that it's something that we really need to look at here, because we're talking about the future, we're talking about people who - as I said, some of the carers we talk to now are getting elderly, but they've been carers their whole lives, they've given up careers.

We've got lots of examples of people who have got to a point and thought, I can't do this any more, I don't have enough hours in the day to be able to do the caring because there's nobody else to support me and also maintain my career, so they've let their careers go. And that impacts on their future security and their ability to be able to function in the community. And they sometimes feel embarrassed about that too because they feel like they're failing, they're failing as professionals because they can't continue in their roles, but then they also fear that they're failing the person that they're supporting and they're failing the community because they're not able to keep working.

I think if we provide that support with people as young as possible and we identify them as young as possible, we can give them the chance to have a positive outlook on life, and to maintain hope. Hope's been mentioned here today before. One of the first things that goes is a sense of hope.

MS COGHLAN: Thank you. Chair, the next part of these hearings will be the subject of a non-publication order.

CHAIR: But perhaps before we go to that, could we just ask one question about that general evidence?

MS COGHLAN: Yes.

CHAIR: Q. We heard early, Ms Piu, from other witnesses in the course of these hearings about the responsibilities of young carers, and in particular on one of our other days we heard about a young carer taking on that role for a very long time before they were even advised they might be eligible for some financial support.

From your reflections and the experience of Tandem, how good are we at identifying those carers, and particularly young carers, who might be eligible for support and care that they just simply don't receive?

A. I think that we're getting better at it. We administer the carer support fund and some of that fund, and we assisted 3,400 people last year in Victoria, some of those people that are assisted are young carers, so they're children who may not otherwise be able to go to camp or attend an after-school activity that might assist them in their caring role. It might also be with practical things that assist the family and allow them to continue to be kids.

Because one of the things that I'm fearful of is that they can't be kids, they've got this responsibility that they've taken on, because they've got no option, there's nobody to help them do that job, so they become the parent. And so, the carer support fund that we've been running has been running for 10 years but we haven't had an increase in that fund for 10 years, so we're only able to help people to a certain point.

And again, I think that it's about the service and identifying those children and young carers and ensuring that they actually identify that they can be assisted through programs like the carer support fund. But certainly, I don't remember us ever knocking back a provision or an application for a young person, and they do come through, but again, it's about whether the staff even are aware. So, if you have a split family, they may not know that the consumer they're working with has kids living with another parent who are perhaps missing out.

So, I think joining those dots is something we need to get a little bit better at.

THE CHAIR: Thank you for that. I will now make the order.

The Royal Commission has made an order that prohibits the publication of part of Marie Piu's evidence to the Royal Commission. A copy of this order has been placed next to the door of the hearing room.

It is ordered that publication of the hearing of Marie Piu's oral evidence to the Royal Commission from this point on until she is excused is prohibited.

I would like to remind all persons present, including the media, that any information or evidence that Ms Piu now provides to the Commission in her oral evidence cannot be

published.

The hearing of the remainder of her evidence today will be limited to the people attending the hearing. For those watching on the live stream, this portion of the hearing today will not be streamed.

I now ask that the live stream be cut.

(Live stream cut.)

(CONFIDENTIAL SESSION FOLLOWS)

MS COGHLAN: That concludes the evidence for today.

AT 3.20PM THE COMMISSION WAS ADJOURNED TO FRIDAY, 19 JULY 2019 AT 10.00AM

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