Foundation House

The Victorian Foundation for Survivors of Torture Inc.

Submission to the Royal Commission into Victoria's Mental Health System

The Victorian Foundation for Survivors of Torture Inc.

HEAD OFFICE

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Summary

People of refugee backgrounds are likely to have higher prevalence of mental health issues than the general population owing to experiences in countries of origin such as torture and other traumatic events, in flight and countries of temporary sanctuary and in Australia, such as stressors of settlement. They are also less likely to utilise mental health services.

Significant barriers to and facilitators of the access of people of refugee backgrounds to mental health services, and the responsiveness of those services to this population, include lack of familiarity with Australian mental health services; stigma; trust; how clinicians and health services communicate with people who are not proficient in English; clinicians' and services' awareness the significance of the diverse cultural backgrounds of their consumers; clinicians' and services' awareness or lack of awareness of the impact of traumatic events; and the availability or lack of good data and its use for monitoring, evaluation planning and research.

Foundation House requests the Royal Commission into Victoria's Mental Health System to consider the following recommendations:

1 –that the Victorian Government provide recurrent funding to train, employ and build the capacity of people from refugee communities to develop and deliver programs within their communities to reduce mental health stigma and improve mental health literacy.

2 – that the Victorian Government encourage the Commonwealth Government to provide access to fee-free interpreting for all Commonwealth funded mental health programs and improve national general practice education and accreditation standards on the use of credentialed interpreters.

3 – that the Victorian Government adopt funding models that ensure that all state-funded health and mental health services are able to engage professional interpreters and translators when required.

4 – that the Victorian Government require state funded health services to collect, analyse and publicly report data on the number of clients requiring an interpreter, their preferred languages, and the provision of interpreters to those clients.

5 –that the Victorian Government commission the co-design of translated mental health literature and documents with new and emerging communities.

6 – that the Victorian Government promote service development and innovations in language services delivery for mental health.

7 – that the Victorian Government prepare an overarching intersectional framework for mental health services.

8 – that the Victorian Government commission the development of a standard for mental health services on trauma-informed care and practice and guidelines for their implementation and an independent process for assessing compliance.

9 – that Victorian Government funding for Victoria's mental health services system should explicitly support the roles of specialist services in complementing the work of mainstream services.

10 - the Royal Commission should recommend which specific data the Victorian Government and state funded health services should collect and publish that indicates the accessibility and responsiveness of services to people of refugee backgrounds.

11 - the funding of mental health projects and programs by the Victorian Government should include funding for evaluation and the Victorian Government should establish a research fund for issues critical to assessing continuity of care and the impact of reforms. The purposes of the funding should include assessing the accessibility and responsiveness of the mental health service system for people of refugee backgrounds.

Contents

Introduction

The Victorian Foundation for Survivors of Torture Inc. (Foundation House) welcomes the opportunity to provide this submission to the Royal Commission into Victoria's Mental Health System.

The submission is informed by:

- our work for more than 30 years with thousands of survivors of torture and other traumatic events;
- interaction with mental health and other services - they include services assisting the population in general and services specifically for people who have been formally recognised as refugees and people seeking asylum;
- research that we and others have conducted – a number of these projects are cited in the body of the submission and several reports have been provided to the Commission;
- information provided by community members – Foundation House held two focus groups with people from the Syrian and Iraqi and Karen and Chin refugee background communities to seek their views about issues raised by the Royal Commission into Victoria's mental health services - notes from both fora are included as attachments to this submission to ensure that community voices are directly included (see Appendix 1);
- information from similar agencies in others states and territories, who are members of the Forum of Australian Services for Survivors of Torture and Trauma, a network of Australia's eight specialist rehabilitation agencies that work with survivors of torture and trauma who have come to Australia from overseas[i] and
- Victorian and Australian government policies on health services.

Foundation House is a member agency of the Victorian Refugee Health Network and has been involved in the preparation of its submission to the Royal Commission, which we endorse.

About Foundation House

Foundation House was established in 1987 to assist survivors of torture and other traumatic events[ii], of refugee backgrounds[iii], who had settled in Victoria.

Our work is guided by an understanding that recovery and wellbeing are affected by a complex interplay of pre-arrival experiences and the risk and protective factors encountered by people from refugee backgrounds in Australia.

For that reason, we have adopted an integrated model of work[iv] that involves:

- providing services to clients in the form of counselling, advocacy, family support, group work, psycho-education, and complementary therapies;

- working with client communities to improve their capacity to access the services they need and to enable them to support recovery;
- offering professional and organisational development, consultancy and resources to assist health, education, employment and other community service providers, to enhance the responsiveness of their services to the needs of people of refugee backgrounds;
- working with the Victorian and Commonwealth Governments to ensure that policies and programs have proper regard to the needs of people of refugee backgrounds; and
- conducting and contributing to research about the needs of people of refugee backgrounds and the best possible ways of meeting those needs.

The client services of Foundation House are directed at achieving and promoting recovery through a range of interventions that are both "trauma-focused" and "trauma-informed". Trauma-focused interventions focus on symptoms characteristic of post-traumatic stress disorder and behaviours characteristic of complex trauma such as emotional dysregulation, interpersonal difficulties and problems of self and identity.

Trauma-informed interventions recognise the impact of trauma in the past and present on mental health and wellbeing. Trauma recovery goals are generally aimed at developing skills such as problem solving, communication and social skills, creating and facilitating social connections and participation and implement interventions that target the goals of safety, justice and dignity using the strengths of the individual family and community.[v] To recognise the breadth of their work, our counsellors are titled "Counsellor Advocates".

In 2018-19, Foundation House provided counselling and other direct services to more than 4000 people from over 30 countries of origin. There were slightly more female than male clients. There was wide range of ages – 361 were under 10; 906 aged 11-20 and 61 were older than 70.

During that year, we also conducted 111 sessions of professional learning with 2264 participants from health and community services.

Foundation House receives funding from:

- the Victorian Government for work including counselling;
- the Australian Government under the Programme of Assistance for Survivors of Torture and Trauma (PASST), which funds agencies in each state and territory to provide not only services directly to clients and refugee communities but also education and training to mainstream health and related service providers and additional support (such as secondary consultation) to services outside metropolitan areas;[vi] and
- philanthropic bodies.

The scope of the submission

The submission covers a number of issues affecting the mental health of people of refugee backgrounds and their access to health services that are particularly pertinent to clients of Foundation House as well as the communities of which they are members.

It does not cover all the issues. The people who we assist directly and for whom we work more generally are also affected by issues affecting the population in general and which will undoubtedly be the subject of substantial evidence to the Commission from other sources. For example:

- as cited in the background to the Commission's Terms of Reference, there is "significant pressure" on mental health services from factors such as population growth and access to services is restricted by "structural issues" such as funding arrangements – Counsellor Advocates report that it is particularly difficult to secure timely access to mental health services for children and young people ;
- the "disruption" in the community mental health sector caused by the implementation of the National Disability Insurance Scheme[vii]. An aspect of the National Disability Insurance Scheme that does affect a significant number of people of refugee backgrounds and some others who have migrated to Australia is that eligibility is restricted to people who are permanent residents. This excludes, for example, people granted refugee status on Temporary Protection Visas and Safe Haven Enterprise Visas. The denial of general access is a policy of the Commonwealth Government and we are aware of advocacy by others on the matter, such as the Refugee Council of Australia, the Federation of Ethnic Communities Councils of Australia, the National Ethnic Disability Alliance and the Settlement Council of Australia.[viii]
- people from refugee backgrounds may face additional barriers to accessing and fully participating in the NDIS. These include the prohibitive cost of assessments required to access the NDIS[ix] and a lack of familiarity with the Australian disability service system and available supports required to create an appropriate NDIS plan[x].

Foundation House is mindful that the Commission's Terms of Reference require it to focus on services that are funded by the Victorian Government. However, the capacity of the Victorian mental health system is significantly impacted by policies of the Commonwealth Government. We believe it would be appropriate for the Commission to note key issues for the Victorian Government to raise with the Commonwealth, in conjunction with other states and territories, to improve access to mental health services generally. An example cited to us by a psychiatrist with whom we consulted for the submission is the impact of a lack of access to private psychiatric care because few psychiatrists bulk bill:

> There is a gap between the range of services available to privately insured patients and those without private insurance that particularly affects patients with high prevalence mental disorders. Because public community mental health services generally provide ongoing treatment only to patients with serious mental illness, patients with high prevalence mental disorders may have limited support from primary care providers. On the other hand, privately insured patients are able to access a significantly broader range of services, including specialist inpatient and day programs that have no real equivalent in the public sector. This gap particularly affects those in the community who are marginalised, or who may have difficulty in accessing services, including patients of CALD backgrounds and individuals who face other socioeconomic disadvantage.

Another instance of Commonwealth policy impacting adversely on people who are not proficient in English is restrictions in Commonwealth funding for interpreters to be engaged by certain mental health professionals (this is the subject of recommendation 2).

The submission does examine some issues that affect not only people of refugee backgrounds but others with whom they share characteristics, such as lack of proficiency in English and a need for culturally responsive, trauma-informed care, which may constitute significant barriers for their access to health services unless the services take action to facilitate people's ability to access them.

Factors affecting the mental health of people of refugee backgrounds

> People from refugee backgrounds, including asylum seekers, often come from countries where they have had limited, interrupted, or no access to mental healthcare where health infrastructure is poorly developed. People from refugee backgrounds almost universally have a history of exposure to highly traumatic events that impact mental health. These factors increase the risk of poor mental health for refugees and asylum seekers.
> Victoria's 10-year mental health plan, page 22.

Australian and international studies show that the prevalence of mental health issues is far higher than the general population.[xi] A variety of individual, family and community/system factors summarised below affect the mental health of people of refugee backgrounds in countries of origin, in flight and countries of temporary sanctuary and in Australia.

In countries of origin

The pre-arrival experiences of our clients are characterised by

- being tortured and the torture of family and other people with whom they are close;

- other acts of persecution, such as the discriminatory denial of access to employment, education, health and other services and denial of the right to practice one's faith;
- communal or generalised violence, for example in the context of civil war, that inflicts death and injury on family, friends and communities and destroys places of personal, cultural and religious significance.

In flight and countries of temporary sanctuary

Forced displacement is an inherent element of being a refugee. It typically features extreme hardship, insecurity and prolonged uncertainty and can include protracted periods spent in so-called transit countries.[xii]

In Australia

There are a number of significant "protective" (promoting and supporting) factors for trauma recovery for people recognised as refugees and on other humanitarian grounds overseas, and accepted for settlement here. The community at large and the Commonwealth, State and Territory Governments offer a generally very supportive and welcoming environment for this group.[xiii] For example, they are entitled and assisted to find employment and to receive welfare benefits if unable to work; they can attend government-funded English language classes. The Commonwealth and State Governments fund free interpreting for people receiving various health services e.g. general practitioners in private practice; hospitals; community health services and counselling for survivors of torture and other traumatic events.

Risk factors (impeding recovery from traumatic experiences) for refugees accepted for settlement in Australia include:

- poor physical and mental health on arrival;
- lack of familiarity with health and other systems (discussed in more detail below), English language and the dominant culture;
- hostility on racial and religious grounds;[xiv]
- difficulties finding employment for reasons such as lack of English proficiency, a lack of formal recognition of skills and qualifications acquired in country of origin and discrimination; [xv]
- loss of social and economic status;
- family separation compounded by anxiety about family members abroad living in dangerous and difficult circumstances, with prolonged delays and uncertainty to secure reunification in Australia.

There are additional very profound and well-documented risk factors for those who come seeking asylum in Australia and in particular if they have come by sea without valid visas. These include:

- immigration detention: the harmful consequences of immigration detention on people seeking asylum is extensively documented through our work and a substantial body of other research conducted in Australia and elsewhere;[xvi]
- prolonged delays in processing claims for refugee status;
- very limited assistance for those who are unable to work or find work, resulting in homelessness and destitution;[xvii]
- the granting of only temporary protection to people found to be refugees, so they continue to live with uncertainty and family separation as they are not entitled to apply for the settlement of family members in Australia;
- systemic barriers to accessing services due to temporary visa status (e.g. people seeking asylum are ineligible for a Health Care Card, despite the generally low incomes of this population) and for some, ineligibility for Medicare.

People of refugee backgrounds and mental health services

There is not comprehensive, current data about the level of engagement of people of refugee backgrounds with the mental health system in Victoria as compared with the general population. We believe that the paucity of data is an area for improvement that should be the subject of a recommendation by the Commission under its Term of Reference 2.5 - see our proposed recommendation 10.

Although not refugee specific, international studies of immigrant populations in settlement countries show lower utilisation rates of mental health services than the general population.[xviii]

A recent report by the Victorian Auditor-General's Office on Child and Youth Mental Health concluded that data analysis 'shows that young people born in Sub-Saharan Africa who are frequently refugees who have experienced trauma, are accessing Child and Youth Mental Health Services at a higher rate than their population share, but there is no evidence to show whether this rate is commensurate with the mental health needs of the population given its experience of trauma.'[xix] More generally the Auditor-General reported that 'people who were born in Southern Europe, Asia and the Indian Subcontinent are underrepresented as [Child and Youth Mental Health Services] clients' and that 'young people from these regions are at risk of not accessing the mental health services they need.'[xx] Those young people are likely to include children and young people of refugee backgrounds but this group is not separately reported on, probably because both adult services, and children and young people's services, do not routinely collect or publish data that would allow refugee backgrounds to be determined.

Another recent study of Australian children with mental disorders showed (based on parent surveys) that children with non-English speaking backgrounds are the least likely to access mental health services.[xxi]

This section describes significant barriers to and facilitators of the access of people of refugee background to mental health services and the responsiveness of services to the needs of this population. They are apparent to us through our work with clients and communities and research conducted on our initiative and with partners and that of other researchers. [xxii] They include factors relating to knowledge and understanding of mental health issues and services, and issues relating to services, that may also affect other groups of people.

The barriers and facilitators discussed below are:

- familiarity with Australian mental health services;
- stigma;
- trust;
- how clinicians and health services communicate with people who are not proficient in English;
- clinicians' and services' awareness the significance of the diverse cultural backgrounds of their consumers;

- clinicians' and services' awareness or lack of awareness of the impact of traumatic events;
- whether services provide holistic approaches;
- the integration of the work of generalist and specialist agencies; and
- the availability or lack of good data and its use for monitoring, evaluation planning and research.

Lack of familiarity with Australian mental health services

Case example: "In our country we don't know about mental health. Parents don't understand mental health. Parents need to learn about mental health especially if they are to help their children. There is a tendency for parents to tell their children (adolescents/young adults) to 'forget about worries' rather than recognising that they are struggling with mental health issues. This is because parents don't understand mental health – concept of or symptoms - and what services might be available to assist and so tell their adolescents to "get over it". So parents are key – they need to increase their understanding of mental health."

Chin youth leader in consultation for the submission – see Appendix 1.

As is the case with people who have migrated generally, people of refugee backgrounds will be unfamiliar with the Australian health care system.

During the early period of settlement in Australia, certain groups of people who arrive under Australia's Refugee and Humanitarian Program[xxiii] are entitled to a range of assistance, including information about physical and mental health and well-being services.[xxiv] The assistance is provided for a limited period and so may not be available later in settlement when the information and support is required by individuals and families for mental health concerns. People seeking asylum are not eligible for assistance under the program even if they are subsequently recognised as refugees and granted Australian legal protection.

The community members with whom we consulted about the Royal Commission's inquiry affirmed the necessity of increasing the knowledge and understanding of mental health issues and services within their communities (Appendix 1). It is likely that these perspectives are relevant to other refugee background communities. Because refugee-background communities have not, commonly, had access to mental health services prior to arrival there is very limited understanding of the availability of services in Victoria, what they offer and how to access and use them e.g. appointments systems.

People of refugee backgrounds may have perceptions of the nature of mental health problems and expectations about the role of health services in responding to them that are very different to the dominant culture and understandings in Australia e.g. they may be reluctant to seek help because in some of their countries of origin "mental health services are associated only with custodial or hospital treatment of the most severely ill and psychotic patients."[xxv]

The key response that is required is described as improving "health literacy" which has been defined as "the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care and take appropriate action."[xxvi] This applies to mental as well as physical health.

Health literacy, information and communication is one of five domains identified in Safer Care Victoria's development and consultation process for the Partnering in Healthcare Framework (2018).[xxvii] In 2014, the Australian, State and Territory Health Ministers endorsed the Australian Commission on Safety and Quality in Health Care "National Statement on Health Literacy" as Australia's national approach to addressing health literacy.[xxviii] According to the statement,

> (o)nly about 40% of adults have the level of individual health literacy needed to meet the complex demands of everyday life….. However, the likelihood of a person experiencing barriers to health literacy may be increased where disadvantage and vulnerabilities connect, for example there may be greater barriers for people with lower educational attainment, *who speak a language other than English* (emphasis added) or who have a disability.

The Commission has published a package of proposals to increase health literacy in Australia.[xxix] Central to the package is the perspective that "everyone can play a part in addressing health literacy." One of the parties mentioned by the Commission on Safety and Quality in Health Care is community organisations.

Members of the community groups with whom Foundation House consulted identified the importance of working in partnership with community leaders – both informal and formal - to deliver community education sessions and to co-design the messages conveyed and language used in these sessions. Young people of refugee backgrounds who participated in Foundation House research about mental health issues and services also identified the potential contribution of people drawn from communities being involved in the development and delivery of health literacy initiatives.[xxx]

In recognition of the potential role of community members to promote health literacy, in 2017, the Department of Health and Human Services funded a small grants program titled *Improving the mental health and well-being of immigrant and refugee background communities by building capacity*, providing grants of $5,000-$80,000 per year for community organisations. The program was funded for only two years. According to fund-holders, Tandem and VMIAC, 13 organisations received total funding of $800,000 in 2017. However, they received a total of 57 applications from ethnic communities all over Victoria.[xxxi].

Example of a project involving community members: The Al-Rafahiya Al-Sehiya (Healthy Wellbeing) mental health literacy project delivered by Foundation House is embedded in community. Two community Advisory Groups with membership drawn from the Syrian and Iraqi communities in the North and West regions of Melbourne were established and healthy wellbeing sessions delivered to community members and facilitated by bicultural workers. The project team worked closely with Advisory Group members to develop community engagement strategies and the co-design of community based sessions in relation to mental health and wellbeing. Primary and tertiary mental health service providers are included in the group program to increase reciprocal understanding and improve the communities' access to and the responsiveness of mainstream mental health services. Inherent in the model is the enhancement of knowledge and skills of Bicultural Workers who then become a resource to their communities and to other services. The project also works in collaboration with a mental health triage, assessment and referral project (Orygen Youth Health) and the development of a Community of Practice in child and youth mental health (Foundation House). All three projects have been funded by the Victorian Government for three years (2017-2020).

Examples of other projects in Australia and elsewhere are in Appendix 2.

Based on our experience, consultation and research, the subjects of mental health literacy work with communities of refugee backgrounds in particular must focus not only on services but also to enhance the capacity of community members to recognise when individuals are struggling psychologically and to increase the acceptance of the need for professional support for individuals and reduce the tendency to view them as "mad" or "crazy" (see discussion of "stigma" below).

It is evident that community members and community organisations have direct and influential contact with many members of refugee communities, and their guidance and intervention are often sought when mental health concerns are being experienced. They can also play an important role in challenging stigma within their communities. They need support to play these roles and the response to the grants program described above indicates significant unmet demand for community capacity building relating to mental health. Foundation House therefore asks the Royal Commission to consider making a recommendation to that effect – recommendation 1.

Stigma

If you talk about mental health concerns you are labelled as 'crazy'. Some of the comments made were: "*People in the community tease and mock someone who has had to have treatment*". If someone has had mental health treatment "*they are treated as second class citizens within community*" "*Community don't know how to treat and be kind*" "*Community discourages the use of medication because of the stigma/shame of needing medication*" Comments from participants in the Chin/Karen community consultation – Appendix 1.

Young participants in a study conducted by Foundation House used the terms "shame", "embarrassment", "guilt", "judgment", "pity", "mockery", and "taboo" when discussing attitudes of peers, families and community towards mental-ill health and accessing services. One noted: If you tell your family that you're depressed, then that's wrong to them, you can't…It's like, "rubbish, be quiet"…"nobody needs to know what's happening in our family."

The background section to the Terms of Reference of the Royal Commission states: "(f)or many, the stigma that continues to surround mental health remains a barrier to seeking help." It is valuable that the Terms of Reference specifically suggest that the Royal Commission has regard to "the need to address stigma associated with mental illness." In the recent State Budget, the Victorian Government allocated additional funds for a campaign to reduce the stigma around mental health. We are not aware that details have been published about how the funds will be allocated.

The significance of stigma and shame about mental issues is as profound for many people of refugee backgrounds, from diverse ethnic and religious origins, as it is among the general population.

As indicated in the preceding section, both young people and older adults who have participated in research and consultations have identified the potential contribution of people drawn from communities being involved in the development, design and delivery of initiatives on mental health issues.

We believe the engagement of community members in various roles should be considered for adoption as an integral component of the mental health (and broader health) system – see proposed recommendation 1.

Trust

The need for trust as a prerequisite for meeting the mental health needs of populations disadvantaged by lack of access to services has been recognised for some time. In the case of refugees, mistrust may be a legacy of torture and other traumatic events, as it is for other populations that have experienced trauma. People of refugee backgrounds may also have encountered systemic exclusion from

public health care, in some cases by government, on account of their race and religion, and the absence of protection of sensitive personal information.

People of refugee backgrounds who have encountered such circumstances will approach health services and health professionals in the settlement country reluctantly, with mistrust and even fear. Mental health services need to anticipate reticence and appreciate the necessity and additional time it may take to build trust and the resource implications of that.

We propose that the Royal Commission into Victoria's Mental Health Services consider several actions to build the trust of people in affected communities to seek assistance from mental health services:

- as a component of community engaged mental health literacy promotion (recommendation 1);
- by improving the responsiveness of health services staff and agencies to the diversity of the Victorian population, many of whom have been affected by traumatic experiences (recommendation 7).

Cultural difference and diversity

> Even in the big cities, villages more, people used to go sometimes to older people with their problems. If I have a problem my parents would take me to the religious people and they would say "oh I think his name is not good, you have to change his name." They would write something like this paper, and put it and keep it in something and say "OK, hang this in your neck or close it in your arm and you would be fine. And people believe. (A young participant in Foundation House research on barriers to accessing Australian mental health services stated about his country of origin [xxxii])
>
> We are communities of faith and suicide is not allowed. People need to strengthen their faith in mental health. Teachers at school are not aware about children's culture and open up the trauma which transfers to the kids. So it is important to employ bicultural workers to strengthen school community in responding to the children. Australia community deal with Iraqi and refugees of other countries individually and we are community based and we very much work together. For example if someone is unwell people go and ask a community member. (A participant in the consultation with members of the Syrian and Iraqi communities – see Appendix 1)

The cultures of many people of refugee backgrounds are very different to the dominant culture of Australia. There may be culturally-based differences in areas such as:

- understanding of mental health problems
- beliefs about appropriate responses and
- the role of family.

The Victorian Government provides several policy frameworks that promote responsiveness of state funded services to the cultural and linguistic diversity of the population. For example, Victoria's Cultural Responsiveness Framework which was adopted in 2009 requires that staff at all levels of state-run and funded health services are provided with professional development to enhance their cultural responsiveness. The workforce development component of the 10 Year Mental Health Plan also recognises the importance of cultural responsiveness for staff.

There is, however, an absence of data to monitor how effectively policies have been implemented to improve cultural responsiveness or identification of what gaps in professional development and education still need to be addressed – recommendation 10 responds to this issue.

There is an additional mechanism the Royal Commission into Victoria's Mental Health Services may wish to consider to encourage mental health services to improve their responsiveness to not only "cultural diversity" but other aspects of diversity pertinent to people of CALD backgrounds and other groups of Victorians. In response to the recent Royal Commission into Family Violence, the Victorian Government published *Everybody Matters: Inclusion and Equity Statement* (2019) to set out a ten-year vision and strategic priorities for the creation of a family violence system that is more inclusive, safe, responsive and accountable to all Victorians. This framework, developed in consultation with a Diverse Communities and Intersectionality[xxxiii] Working Group, will be complemented by an *Equity and Inclusion Blueprint* that identifies actions for 2019-22.

With respect to mental health services, such a framework would help the Victorian Government to realise its commitment to "understand, respect and respond to diversity" as set out in Victoria's 10 Year Mental Health Plan, which states that "the Victorian Government will design and deliver services and support in a way that promotes equitable access and safe and inclusive services for people with diverse cultural, religious, racial, linguistic, sexuality and gender identities" (page 21).

Foundation House believes that the development of an overarching intersectional framework for the mental health services system, as has been done with respect to the family violence system, merits consideration – see recommendation 7.

Awareness of the impacts of traumatic experiences

Case example: A young woman of refugee background was admitted to a public mental health facility and treated for an eating disorder. She refused to eat and was close to dying. However, it became evident that she did not have an eating disorder – she was a torture survivor and had been force-fed body parts as part of her torture in her country of origin. Despite the fact that it was widely known that torture was prevalent in her country of origin, no consideration was given to this in her assessment or initial treatment.

The psychological and social effects of torture and other traumatic events vary in their nature and severity but characteristically have a debilitating impact not only on the individuals who have experienced them but also the functioning of their families. The effects may be intergenerational. Comprehensive frameworks, such as the integrated service model of Foundation House, have been developed to respond to the way traumatic events associated with persecution can adversely affect a sense of agency and control, attachment and relationships, fundamental values about life itself and human dignity, as well as produce specific symptom syndromes.

An understanding of the link between mental health problems and the traumatic events underlying them facilitates effective mental health assessment, diagnosis and treatment. The treatment of people who experience mental health problems associated with deliberately inflicted violence in the refugee context has parallels with the treatment approach for people who have had other types of traumatic experiences, such as survivors of family violence and/or sexual abuse.

Foundation House welcomes the commitment of the Victorian Government that "mental health services should adopt trauma-informed care practices to aid the recovery of people in care, reduce the potential for re-traumatisation, and promote a more collaborative and empowering care environment." [xxxiv] "Trauma informed" care is also identified as one of the service delivery principles for the purposes of the workforce development strategy of Victoria's 10-Year Mental Health Plan. It states:

> The impact of traumatic experience on people who access health and human services can be profound and can vary considerably from person to person. Service delivery will be provided in a way that is informed by the impact of trauma on the lives of people requiring mental health treatment and care.

The commitment also recognises that for services to be "trauma informed" has implications for a range of organisational capabilities and not simply that of clinicians. [xxxv] This is consistent with literature on the subject, exemplified in a paper prepared by the Mental Health Coordinating Council which states:

> Responding appropriately to trauma and its effects requires knowledge and understanding of trauma, workforce education and training, and collaboration between consumers and carers, policy makers, and service providers and crosses service systems. It involves not only changing

> assumptions about how we organise and provide services, build workforce capacity and supervise workers, but creates organisational cultures that are personal, holistic, creative, open, safe and therapeutic."[xxxvi]

In our experience as the state's specialised torture and trauma counselling provider for people from refugee backgrounds living in Victoria, there is much to be done for the principle of trauma informed care and practice to be firmly embedded into the operating policies and practices of Victoria's mental health service system. For example, Foundation House staff report that people of refugee backgrounds who present to mainstream mental health services may be referred to Foundation House without a formal assessment of other significant issues. As reported by one Counsellor Advocate:

> There is a need to integrate trauma assessment with other presenting issues. Clients with dual diagnosis are pushed onto Foundation House because there is a history of trauma but the client might present with other significant issues. This means people are not given diagnosis in other areas (speech delays, cognitive issues, ADHD, BPD) which means they cannot get access to mainstream services for support around these issues and cannot get NDIS assistance or Centrelink allowance for carers, etc.

The Victorian Government commitment to trauma-informed care in mental health services is important - we believe further action is required to ensure this principle is realised.

"Principles" of care have been published[xxxvii] but to our knowledge not detailed guidance about how they are to be implemented and their implementation monitored. The 10-Year Mental Health Plan does not specify any indicators to assess the progress of mental health services to becoming trauma-informed and we are not aware of any requirements on mental health services to undertake specific steps to become trauma-informed.

The Centre for Mental Health Workforce Learning and Development, established under the 10-Year Mental Health Plan, has key responsibility for the realisation of the principle of ensuring that mental health services are trauma-informed and recognises that this involves more than training staff:

> Training alone does not guarantee change. Organisations need to be able to review their readiness for particular interventions and often need support to do this. Without tailored, strategic advice on workforce development interventions, many organisations will continue to provide training with the hope that change will occur.[xxxviii]

Foundation House considers that a stronger mandate for implementation is necessary for the principle of trauma-informed care for mental health services to be thoroughly implemented in practice. Foundation House, therefore, proposes that the Royal Commission into Victoria's Mental Health Services recommend that the Government commission the development of guidelines or a "standard" for mental

health services to adopt in order to deliver trauma-informed care and requires Victorian-funded services to comply with them – see recommendation 8.

There are various precedents for this approach to be used by the Victorian Government to promote service compliance with Victorian and national policies, for example:

- the policy frameworks that promote responsiveness of state-funded services to cultural and linguistic diverse communities, described in the preceding section;
- the National Standards for Mental Health Services, which include a specific standard on "diversity responsiveness"[xxxix] and are designed to be assessed;
- the Family Violence Royal Commission recommended a review and update of standards for family violence service providers, to specify providers' obligation to develop suitable services for diverse communities, consistent with their obligation to provide non-discriminatory services under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) and the *Equal Opportunity Act 2010* (Vic) (Recommendation 140).

If such action is implemented by Victoria, it could provide the catalyst for national action to develop a standard to be adopted by mental health services.

A significant implication of the principle of trauma-informed care is that services adopt a holistic approach to assessing and responding to the diverse and sometimes complex needs of people who seek assistance. This is described in the following section.

Responding to the wider determinants of mental health

Taking a holistic view of health is essential in the planning process as mental illness is often associated with wider physical, social, cultural and economic determinants of health.
Primary Health Network Advisory Panel on Mental Health[xl]
From a community perspective:
"Employment or being engaged in something that creates a sense of worth like volunteering is crucial. There will be less focusing on negatives in their life. There is a need to recognise the skills and resources someone brings and build on these."
"Job Network makes us feel that we are helpless and it is a hard feeling. It is important to find a way to let them change their behaviour – like kind of training maybe."
These comments were made by community members during our focus group with the Syrian and Iraqi communities. They were made in the context of discussion about the intersection between housing, employment, education, income support and income security, and mental health. There are particular challenges for community members in relation to seeking employment and dealing with the Job Network system. See Appendix 1.

As described above, the mental health and wellbeing of people from refugee backgrounds is affected not only by experiences of torture and other traumatic events prior to their arrival to Australia, but also potentially stressful settlement factors such as finding stable housing and employment, learning English, anxiety about the safety of family in other countries and encountering racial and religious prejudice – comments by community members are particularly pertinent in this regard (Appendix 1).

The integrated service model of Foundation House is based on an understanding that recovery from traumatic experiences requires a comprehensive awareness of and response to clients' psycho social circumstances and accordingly the agency operates in a manner that is both complementary to and collaborative with a wide range of other services. The training, professional development and secondary consultation that we provide to other service providers is based on our integrated service model and informs the need to adopt an holistic approach that is alert to settlement stressors and that service providers are aware of how, when and where to refer clients for services.

Case example - the Ucan2 program: The program aims to facilitate and support the social inclusion of newly arrived young people of refugee backgrounds between the ages of 16 and 25 years. It combines psychosocial support, development of social connections and networks and work experience placements, to support learning and employment pathways that connect young people of refugee backgrounds into the Australian community. Ucan2 is conducted by Foundation House in partnership with the Centre for Multicultural Youth and various education and employment service settings in which it is delivered. An independent evaluation found that the combined elements of the Ucan2 program effectively support young people of refugee backgrounds by providing a holistic response to the challenges they face.[xli]

This approach is consistent with the Terms of Reference of the Royal Commission, which require the Commission to inquire into and deliver the best mental health outcomes by means including "strengthened pathways and interfaces between Victoria's mental health system and other services." (2.3) Those other services are broadly defined as "services that seek to address the wider determinants of mental health, such as housing, homelessness, disability, education, alcohol and other drug, family violence, health justice and employment services."

The importance of holistic approaches is recognised with respect to other populations that have experienced traumatic events. For example, the Royal Commission into Institutional Responses to Child Sexual Abuse (2017) concluded that "a system-wide response is needed to address all aspects of victims' and survivors' wellbeing, which may include financial, legal, medical, psychological, spiritual and other forms of assistance."[xlii] Similarly, with respect to young people, Orygen (The National Centre of Excellence for Youth Mental Health) and Phoenix Australia (Centre for Posttraumatic Mental Health) have called for the development of trauma-informed services and systems for young people with a "systems approach" involving "integrated and coordinated delivery of care

and supports across human services, justice, education providers and mental health services, to enable multiple issues to be addressed simultaneously."[xliii]

As indicated in the preceding section, the essential starting point for services to address the wider determinants of mental health is that they undertake comprehensive assessments to determine what if any significant issues are affecting the health and well-being of people seeking assistance, as a matter of course. This approach would be promoted by the development and adoption of a standard on trauma-informed care and practice for mental health services.

Having identified those needs, services must have the knowledge and capacity to link clients with other services. Based on our experience, taking care to link clients of refugee backgrounds to other services with which they may completely unfamiliar is very important to ensure they effectively access the assistance they require. There is a variety of ways in which to promote more effective referrals and links between services, including through, for example, collaboration between specialist and generalist services (see below), service partnerships and co-location of services. The submission of the Victorian Refugee Health Network describes some relevant models.

Communication

Case example: In November 2018, a young woman came to me for support around experiencing panic attacks. After consulting a Counsellor Advocate, she was deemed to not be a VFST client, and the Counsellor Advocate suggested I refer her to a youth mental health service. I spoke with a person at the service who informed me that under the Better Access scheme there is no provision for interpreters. The person suggested I refer the client to another service but this is a phone or online counselling service, which would have been too challenging for the client. The youth service psychologist suggested that I find a psychologist who speaks the language of the young woman as an alternative.

Foundation House Ucan2 youth program staff member

Good communication between health practitioners and their patients of all cultural and linguistic backgrounds is essential to ensure that the care that is provided is both effective and safe. The Australian Charter of Healthcare Rights stipulates that "communication", or "the right to be informed about services, treatment, options and costs in a clear and open way" as one of the seven charter rights (Australian Commission on Safety and Quality in Healthcare, 2008). With respect to people who are not proficient in English this involves a number of elements.

Two are discussed below: the engagement of accredited, professional interpreters by health practitioners when they are not proficient in the language of their patient; the provision of translated information about mental health matters, services and care for specific individuals (e.g. their medication).

The engagement of accredited interpreters

A number of Victorian and national policies provide that health service providers should engage accredited interpreters (when available) when people seeking assistance are not proficient in English. The Victorian policies[xliv] include:

- Victoria's Department of Health and Human Services' Language Services Policy (2017) stipulates that Departmental and funded organisations are responsible for providing appropriate language services when: a) the client requests an interpreter or expresses a need to communicate in their preferred language and/or b) staff are unable to effectively communicate with a client;[xlv]
- the Victorian Government's Policy and Procedures: 'Using Interpreting Services' and 'Effective Translations' set out the obligations of government departments and funded agencies to provide language services and give advice on the practical aspects of planning, arranging and working with interpreters and translators;[xlvi] and
- Victoria's Department of Health and Human Services' Cultural Responsiveness Framework: guidelines for Victorian health services, Standard 3 states that accredited interpreters should be provided to patients who require one.[xlvii]

Evidence indicates that there are significant deficiencies with respect to both the engagement of accredited interpreters and the provision of translated material. Anecdotal evidence from our clients and through our engagement with other services through the Victorian Refugee Health Network and other sector partnerships indicates that mental health services do not engage accredited interpreters as a matter of course when they engage with people who are not proficient in English. This creates difficulties not only for clients directly but may also be stressful and burdensome for family members, including children, who are often asked to assist with interpreting and translating correspondence that is in English.

> *"I was rung one night by the hospital to interpret for a community member who had been admitted for mental health treatment because the hospital had been unable to get an interpreter."* This comment was made by a Karen female community member during our focus group in the context of describing how people in the Karen community are in and out of hospital mainly because of the language barrier as often there is no interpreter.

We refer to anecdotal evidence because none of the numerous service providers we are aware of compiles, analyses and publishes data on the number of clients they assisted who required an interpreter and whether or not an interpreter was provided on the occasions the client attended for assistance.

While Victorian Government departments are required through the *Multicultural Victoria Act 2011* to report annually on use of interpreting and translation services, existing reports are limited to listing agency funding for interpreters across programs, without analysing interpreter demand or provision trends across Victoria over time. Public reporting through the Mental Health Annual Report, the 10 Year Mental Health Plan Outcomes Framework and VAHI Hospital Performance website also excludes any reporting on interpreter use. (See the discussion about data below)

Further, apprehension that an accredited interpreter will be not be engaged constitutes a barrier to people approaching services. Further, failure to use an accredited interpreter adversely affects the quality of assistance services can provide. For example, a retrospective audit of 20,563 admissions at the Mater hospital in Brisbane during 2013-14 found that the provision of professional interpreting services in the hospital setting decreased communication errors of clinical significance and improved clinical outcomes.[xlviii] Results showed that only 19.7% of Low English Proficiency patients were provided professional interpreting services at emergency department and 26.1% were provided on the ward. A related study at the Mater hospital also revealed that the provision of professional interpreting services in the hospital setting decreased clinically significant communication errors and improve clinical outcomes.[xlix]

In Victoria, Northern Health reported in 2013 that since the Transcultural and Language Services Department was created in 2007, there had been a reduction in the average length of stay for low English proficiency clients from 9.14 days in 2007 to 5.9 days in 2012, which resulted in significant cost-efficiencies for the hospital.[l]

There appear to be multiple reasons for service providers not engaging accredited interpreters as a matter of course, a number of which are described below.

Inadequate funding and reporting on compliance with language service obligations

Commonwealth

The Commonwealth Government funds access to interpreting services for certain health care providers, such as medical practitioners and psychiatrists, working in private practice providing Medicare-funded services. Psychologists and other mental health practitioners are a particularly significant exclusion with respect to mental health services.

The Medicare Benefits Schedule is currently subject to review to ensure Medicare-funded services align with contemporary clinical evidence and practice, and improve health outcomes for patients[li]. We provided a submission to that review in which we recommend that the Commonwealth government should expand access to fee-free interpreting to all health care providers providing services under Medicare. [lii]

We propose that the Royal Commission into Victoria's Mental Health Services recommend that Victorian Government advocate to the Commonwealth Government to provide access to fee-free interpreting for Commonwealth mental health programs (Recommendation 2).

Victoria

The two main mechanisms used by the Victorian Government for the provision of language services in state-funded health services are access to a language services credit line and direct funding allocations to agencies. According to the DHHS Language Services Policy (2017): "departmental programs and services should seek to incorporate funding for language services within core ongoing operating budgets. Whether this funding is best provided through an integrated unit price, specific block funding, program specific arrangements or contribution to a credit line, is a decision to be made by the department on a case-by-case basis."

In 2013, Foundation House conducted a major study on the engagement of accredited interpreters in Victorian health services and concluded that "the amount of funding in each (of the mechanisms) is less than required to meet the level of need for interpreting services." [liii]

As indicated above, health services do not publish data on the number of occasions the services did not engage an interpreter for a person who required one. Therefore, critical information necessary to assess the adequacy of current funding to meet demand is not available.

The 2019 VAGO Audit on Access to Mental Health Services found that "to understand and respond to demand and access issues, DHHS needs data to reflect current service capacity and to calculate unmet demand….. DHHS is missing available information to understand unmet demand" (page 12). In language services, this represents a missed opportunity for both the Victorian Government and mental health service providers to better understand and plan for interpreter demand pressures and address underutilisation trends in critical services.

In relation to language services, Victoria's 10 Year Mental Health Plan only states that "Culturally and linguistically diverse communities often have poorer mental health outcomes and typically present to services when their illness is more severe. Services must address language and cultural barriers, as these can hinder effective treatment and support."

We request the Royal Commission into Victoria's Mental Health System to consider two recommendations to ensure that health and mental health services funded by the Victorian Government do engage accredited interpreters when required, and available. One is that the Victorian Government adequately funds them to do so (recommendation 3); the second is that health services are required to report publicly in greater detail on their engagement of accredited interpreters (recommendation 4).

Staff awareness and service protocols

As described above, the Cultural Responsiveness Framework requires that staff at all levels of state funded health services are provided with professional development to enhance their cultural responsiveness[liv]. A key outcome of such training should be that staff understand how, and when, a credentialed interpreter must be engaged. This includes the administrative staff who often book interpreter appointments. However health services do not routinely report sufficient information about the implementation of their culturally responsive plans to provide information about the extent to which this occurs and what gaps there are. This information is, in turn, not publicly reported on through annual Cultural Diversity Plan reporting required by each Victorian Government department under the *Victorian Multicultural Act 2011*. Hence it is the subject of a proposed recommendation for the Royal Commission into Victoria's Mental Health Services to consider (recommendation 10).

Translated information

The Victorian Department of Health and Human Services Language Services Policy stipulates two reasons for translating material: for distribution to a broader population for information and educational purposes; and translating documents to understand a client's history can be crucial to providing services[lv].

The provision of translated materials is also crucial to communicating information about upcoming appointments and about diagnoses or treatment plans. Some Foundation House clients have reported being exited from services without understanding why, after having been sent multiple letters about appointments in English that they have not understood. Clients and a participant in a community consultation (Appendix 1) also report receiving discharge summaries in English which they do not understand. The lack of translated information clearly poses a significant barrier to these clients' ability to access and meaningfully engage with health services and thereby compromises the principle of equitable access to those services.

> *"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 10-15 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 and there was enormous pressure and stress for all the family."*
> This comment was made by a Karen community member during the focus group with his and the Chin communities. It highlights the very real challenges for both the person who had been unwell and the family who want to support him given their lack of understanding of mental illness. See Appendix 1.

In addition to strengthening requirements about the provision of translated information, there may be innovative responses that will assist. For example, we have been advised that some specialist service providers have trialled technologies to record phone or video messages to organise appointments in preferred languages, rather than written text, particularly for people with low literacy.

Foundation House requests the Royal Commission to consider a recommendation to improve the availability of appropriate translated information and documents by commissioning the co-design of translated mental health literature and documents with new and emerging communities (proposed recommendation 5). This has previously occurred with respect to the translation of material on other health issues and was not targeted at refugee background communities.

More generally to tackle the barrier of language, Foundation House proposes that the Royal Commission extends to the area of mental health the current program of funding technological and other innovations to improve interpreted and translated communication between clinicians and services and people seeking assistance (proposed recommendation 6).

Peer support groups

> Program for children with parents affected by mental health problems are good but there is no access for language specific communities. Kids end up being cultural brokers and interpreters for sick parents but don't have access to carer support.
>
> Foundation House Counsellor Advocate

A number of Foundation House Counsellor Advocates who provided information for this submission said that they had sought to link clients and family members with groups that provide peer support for people experiencing or caring for people experiencing mental health problems. This was generally not possible because the groups usually provide services and information only in English, and many of our clients and their families are not proficient at all or sufficiently proficient to engage.

It was beyond the scope of our resources to undertake a detailed examination of the funding and support of such programs with a view to proposing a specific recommendation so that they become more accessible for people of refugee and CALD backgrounds. That might be through either:

- general grants programs for peer support groups, such as the Health Condition Support Grants program; or
- funding specifically for CALD communities, such as the Capacity Building and Participation Program (this has a broad remit and does not focus on mental health. An instance of a targeted mental health related program are the LGBTIQ+ HEY Grants to raise awareness, promote diversity, eliminate stigma and discrimination, and improve the mental health of LGBTIQ+ young people.

One example of a project funded through a Primary Health Network (PHN) is the *Bedaya Sehaya* Program which included Healthy Wellbeing (mental health) Peer Support groups delivered by Foundation House. While the evaluation of the program identified the benefits of the peer support groups, the reality of short-term funding impacts the continuity of such programs (refer to Appendix 2 for a more comprehensive explanation of the Healthy Wellbeing Peer Support Groups).

Foundation House requests the Royal Commission to examine the funding options as the basis for a recommendation.

The complementary roles of mainstream and specialist services

Case study of collaborative work between Foundation House and Royal Children's Hospital Mental Health program

An 11 year old Iranian boy was referred to Foundation House by his primary school student welfare officer for behavioural problems including challenging aggressive behaviour believed to be associated with his trauma background. The assessment by a Foundation House Counsellor Advocate identified the family as asylum seeking from Iran with a history of persecution; a traumatic boat journey to Australia; immigration detention experiences in Australia, where the child witnessed violence and self-harming behaviours. There were attachment issues, uncertainty about the visa outcome and issues of conflict in the parents' relationship.

Other symptoms and signs were affect dysregulation, agitation, inability to focus, anxiety and bed-wetting. With individual counselling and sessions with his parents, there was considerable improvement in regard to many anxiety symptoms and bed-wetting but his concentration remained poor and aggressive behaviours persisted. After consultation with the [redacted] clinician, a further developmental assessment was recommended to assess cognitive functioning and developmental lags. It was also recommended that counselling for trauma based symptoms continue with family therapy work for relational attachment issues. The developmental assessment identified ADHD as the cause of the persisting problems. Medication led to marked improvements in emotional and behavioural regulation, benefiting all family relationships and enabling much improved self-esteem at school.

[redacted]

Victoria's 10-year Mental Health Plan recognises specialist community-controlled services may be necessary in order to "promote equitable access and safe and inclusive services for people with diverse cultural, religious, racial, linguistic, sexuality and gender identities."[lvi] The Plan refers specifically to the provision of services to people who need assistance but as this section relates, specialist agencies can play critical other roles to support and complement the work of mainstream agencies.

It has been recognised in Australia and a number of other countries of settlement that mainstream services alone cannot ensure equitable, responsive and effective access to mental health assistance by people of refugee backgrounds who have been tortured or had other traumatic experiences. lvii In Australia, this is manifest in the establishment of the national PASST program and the support provided by the Victorian and other State and Territory governments for PASSTT funded agencies in their jurisdictions.

Foundation House (and other specialist agencies) work in two ways – providing a range of services directly to people who need assistance and supporting generalist health and mental health services. Particular examples of the second role are briefly described below, with details in Appendix 3:

- The collaboration between Foundation House and Royal Children's Hospital Mental Health, which is referred to in the case study at the beginning of this section;
- The Community of Practice in Child and Youth Refugee Mental Health Project, which aims to build the capacity of health professionals and services to respond effectively to the mental health and wellbeing needs of children and young people and their families, from refugee backgrounds;
- Supporting the provision of services for people of refugee backgrounds settling in rural and regional areas e.g. by providing training and advice - experience with this cohort. The need for this role is anticipated to grow in particular as the Commonwealth Government is seeking to encourage more people from refugee backgrounds to settle in rural and regional areas.

These programs demonstrate how flexible funding to design and deliver new models can strengthen service partnerships and address gaps in capacity across Victoria. In the case of Foundation House, the Victorian Government has for years recognised and supported the complementary roles of providing both direct services and undertaking other work such as professional and organisational development to assist health, education, employment and other community service providers, to enhance the responsiveness of their services to the needs of people of refugee backgrounds. Foundation House proposes that the Royal Commission recognises the importance of the collaboration between specialist and mainstream services and recommends that these be supported as an integral element of Victoria's mental health service system (recommendation 9)

Data and research

This part of our submission relates specifically to the Commission's Terms of Reference to inquire into and report on "improved data collection and research strategies to advance continuity of care and monitor the impact of any reforms." (2.5)

The collection and analysis of a variety of data is essential for services and government to assess accessibility and effectiveness, to plan for unmet and future needs and the publication of such data is necessary for accountability.

Foundation House anticipates that in response to its Terms of Reference the Royal Commission will provide a recommendation/s about:

- the general data that the Victorian Government and mental health services should be required to collect, analyse and publish;
- the evaluations that should be undertaken using that data and
- the complementary research required to assess matters that may not necessarily be assessed by routinely collected data e.g. outcomes of interventions.

Within or in addition to the recommendation/s that the Royal Commission makes about data and research generally, Foundation House requests that there be specific reference to the collection, analysis and publication of data and research relating to the accessibility and responsiveness of services to people from refugee backgrounds including people seeking asylum, and more broadly, people of CALD backgrounds. This action would complement the proposed recommendation relating to the engagement of professional interpreters.

Victorian law and policy guidelines impose various requirements on departments to collect and report data about the population they are serving including people of culturally and linguistically diverse backgrounds. They include the *Multicultural Victoria Act 2011;* the "Cultural responsiveness framework"; the 10 Year Mental Health Plan; "Victorian Government Standards for Data Collection on Interpreting and Translating Services".

Previous sections of this submission have mentioned areas where data about certain aspects of services is not collected and published, such as the engagement of accredited interpreters when required, and the progress of services to ensure they are culturally responsive and trauma-informed.

As illustrated in recent reports of the Victorian Auditor-General's Office cited below, deficiencies in data collection have been identified as a general problem with respect to mental health and other services, not just in relation to people of refugee backgrounds or the larger group of people who are not proficient in English.[lviii] For example:

> DHHS does not have a clear method for monitoring the performance of the (Child and Youth Mental Health System) within broader health service and mental health system performance monitoring and oversight. Without this, DHHS cannot fulfil its role to advise government on the system's performance, its resourcing needs, or the challenges patients and health services face in engaging other necessary social services.[lix]

Deficiencies in data collection have been specifically noted with respect to people of refugee backgrounds, migrants and people seeking asylum. For example, in 2014 the Victorian Auditor- General reported:

> All departments are required to report annually to the Office of Multicultural Affairs and Citizenship (OMAC) on their diversity planning, use of interpreters and translators, and multilingual publications. However this reporting is limited to outputs rather than outcomes, and departments cannot give assurance that their services are meeting client needs.[lx]
>
> Poor data collection and analysis of service delivery means that departments and service providers do not always know if their services are being effectively accessed by migrants, refugees and asylum seekers. Current reporting requirements do not hold service delivery departments sufficiently accountable for their performance with culturally and linguistically diverse (CALD) communities.[lxi]

The Auditor-General recommended that the Department of Health, the Department of Human Services and the Department of Education and Early Childhood Development develop and report annually on aspects of their cultural diversity plans such as the incorporation of culturally appropriate training for staff, how information/data has been used to increase service accessibility for culturally and linguistically diverse communities and the effectiveness of service delivery to culturally and linguistically diverse communities.[lxii] These recommendations were accepted by departments but we do not know whether the information is in fact collected because it is not publicly reported.

Several factors appear to contribute to gaps in the collection and reporting of data.

One is that data that is apparently required to be collected and reported such as data on access to interpreters, is either not collected or is not reported.

Another is that there are not specified data requirements or they are not an adequate source of evidence to assess how well services are performing. An example of the former is that there are no specific indicators to determine whether mental health services are or are making progress towards the principle being trauma-informed. An example of the latter is the evidence cited for progress to achieve Outcome 2 of the 10-year Mental Health Plan, that "the gap in mental health and wellbeing for at-risk groups is reduced." People from refugee backgrounds are one of the mentioned groups. However the only "outcome and related indicator" is "the proportion of Victorian population who speak a language other than English at home with high or very high psychological distress (adults)." [lxiii] The data source is not cited and we assume it is the Victorian Population Health Survey.[lxiv] If that is the case then it is important to note that interviews are conducted in nine community languages – Italian, Greek, Mandarin, Cantonese, Vietnamese, Arabic, Turkish, Serbian and Croatian. These languages include some languages spoken by people of refugee backgrounds but languages spoken by significant numbers of other people of

refugee backgrounds are omitted. In the 2016 survey (the most recent published), only 266 of the total of 7,352 telephone interviews were in a language other than English.[lxv] Clearly this data cannot provide proper evidence of the mental health of people of refugee backgrounds currently or be used as a basis for assessing progress.

The absence of key data significantly constrains evaluation of services and research about significant subjects such as the effectiveness of interventions. Funding for evaluation in state funded programs and/or collaborative research partnerships is often provided in an ad-hoc, short-term manner. Work undertaken by research collaborations such Bridging the Gap: Partnerships for change in refugee child and family health (led by Murdoch Children's Research Institute with Foundation House and other partners)[lxvi] demonstrates the value of research partnerships between service providers, researchers, policy makers and refugee communities to fill gaps in the evidence base for effective interventions, strengthen community participation in service planning and promote best practice in state-funded mental health services.

Research and evaluation projects like these need dedicated resourcing to support continued quality improvement of mental health services. In 2012 the Victorian Government established the "Mental Illness Research Fund" which awarded $10 million to five projects for the period 2013-2017. We believe the Royal Commission should examine the desirability of further funding for subjects that are critical to achieving the objectives of the reforms that will be implemented. Improving data collection, evaluation and research are the subject of recommendation 10 and 11.

Recommendations for the consideration of the Royal Commission into Victoria's Mental Health System

This section provides recommendations for the Royal Commission into Victoria's Mental Health System to consider. There are two types.

Firstly, Foundation House puts forward recommendations for the Royal Commission to consider making to the Victorian Government, with respect to issues where we believe there is sufficient evidence that a particular approach will respond effectively to a barrier or be an effective facilitator.

Secondly, Foundation House proposes recommendations in areas where we believe the evidence indicates a significant issue that warrants attention by the Royal Commission, but requires further investigation by the Commission to formulate a specific recommendation for action by the Victorian Government. This process could be supported through the specific issues papers that the Royal Commission has indicated it will publish.

Proposed recommendation 1 – Supporting the engagement of people from refugee backgrounds to undertake mental health literacy work

Foundation House requests the Royal Commission to consider recommending that the Victorian Government provide recurrent funding to train, employ and build the capacity of people from refugee communities to develop and deliver programs within their communities to reduce mental health stigma and improve mental health literacy.

Rationale

The funding of projects and programs should include funds for evaluation – see recommendation 11.

In Australia and other countries there are multiple examples of projects and programs involving members of particular communities undertaking tasks such as promoting health literacy to members of their communities – see Appendix 2. There are parallels in other areas e.g. the Royal Commission into Family Violence recognised that there was an important role for community members to contribute to preventing family violence and it recommended the development of training packages on family violence and sexual assault for faith leaders and communities (Recommendation 163). The implementation of that recommendation is based on a consultation and co-design process with (the Multifaith Advisory Group) members, other relevant stakeholders and expert family violence practitioners.

This consultative approach is consistent with the advice of the Australian Commission on Safety and Quality in Health Care, that a characteristic of a "health literate organisation" is that it "includes populations served by the organisation in the design, implementation and evaluation of health information and services" e.g.

by collaborating "with members of the target community in the design and testing of interventions, including design of facilities, redesign projects and evaluation."[lxvii]

Proposed recommendation 2 – Advocacy to the Commonwealth regarding access to fee-free interpreting

Foundation House requests the Royal Commission to consider recommending that the Victorian Government encourage the Commonwealth Government to provide access to fee-free interpreting for all Commonwealth funded mental health programs and improve national general practice education and accreditation standards on the use of credentialed interpreters.

Rationale

This proposed recommendation builds on years of advocacy on this issue by the Victorian Government and the service sector (for example, the Foundation House submission to the current review by the Productivity Commission).

The Family Violence Royal Commission provides precedence for this approach on subjects not within the jurisdiction of the Victorian Government, making a number of recommendations for the Victorian Government to advocate for legal and policy changes to the responsible bodies e.g. pursuing amendments to the Family Law Act 1975 (Recommendation 131); establishing mandatory training for general practitioners in family violence (Recommendation 103); ensuring that accreditation and testing processes of translator and interpreter courses require an understanding of the nature and dynamics of family violence (Recommendation 160).

Proposed recommendation 3 – Ensuring adequate funding for interpreting services

Foundation House requests the Royal Commission to consider recommending that the Victorian Government adopt funding models that ensure that all state-funded health and mental health services are able to engage professional interpreters and translators when required.

Rationale

This recommendation is designed to ensure that Victorian health services are encouraged and able to comply with the long-standing policy commitment that services and clinicians should engage professional services when required. No service or clinician should be deterred from engaging a professional interpreter because they are concerned, correctly or not, that there is not funding available for that purpose. The reference to "models" is to ensure necessary flexibility in how this obligation is met, for example, by employment of interpreters, of qualified bilingual staff, use of contracted occasional interpreters or new technologies.

Proposed recommendation 4 – Monitoring the engagement of accredited interpreters

Foundation House requests that the Royal Commission considers recommending that the Victorian Government require state funded health services to collect, analyse and publicly report data on the number of clients requiring an interpreter, their preferred languages, and the provision of interpreters to those clients.

Rationale

This recommendation is related to the Royal Commission's Terms of Reference to inquire into and report on improved data collection and research strategies to advance continuity of care and monitor the impact of any reforms (2.5).

The gist of this proposed recommendation already appears to be at least implicit in Victorian policies that have been in place for some time. However as described previously, current reporting requirements are inadequate to ensure the collection, analysis and publication of data to permit the monitoring of compliance with legislative and policy requirements which stipulate that services engage accredited interpreters when required, as well as to provide essential information for government and agencies to plan for, monitor and manage issues related to language service demand and utilisation.

It is proposed that the Royal Commission's recommendation relate to health services generally because the policy commitment applies to health services generally and it would be arbitrary to distinguish data about clients seeking assistance for mental health as distinct from other issues. The recommendation involves providing data on all languages because reporting on only the largest language groups (as currently occurs) means that it is not possible to assess whether some of the smaller, newly emerging communities in Victoria are receiving this essential service early in settlement, as is the case with certain refugee populations.

This proposed recommendation will support implementation of actions recommended by the Victorian Auditor-General outlined in the 2019 VAGO Audit on Access to Mental Health Services (2019, page 14) to strengthen the Victorian Government's ability to "set relevant access measures with targets, which reflect the intended outcomes of the investment plan, and routinely report on these internally and to the public" and "re-establish routine internal governance and reporting against mental health system priorities, activities and performance that ensures senior executive level oversight and accountability."[lxviii]

Proposed recommendation 5 – Translation of mental health literature and documents

Foundation House requests the Royal Commission to consider recommending that the Victorian Government commission the co-design of translated mental health literature and documents with new and emerging communities.

Rationale

There is a very evident need for a broader range of translated information about mental health issues and services in general and specific material such as information provided by services to people seeking their assistance (e.g. about making appointments) and who are clients (e.g. their medication, discharge information).

The Victorian Government has previously commissioned the Centre for Culture, Ethnicity and Health to develop culturally responsive, translated resources on family violence for publication on the Health Translations Directory. The proposed recommendation would take a similar approach to engaging new and emerging communities in the development of culturally responsive translated resources (such as written, pictorial and audio-visual resources) to improve mental health service orientation and address community stigma, as well as how to engage with services, e.g. their appointment procedures. We suggest that at least initially new and emerging community languages would be the key focus of this work because translated mental health resources for larger and longer established CALD populations are widely available.

Proposed recommendation 6 – Promoting service development and innovations in language service delivery

Foundation House proposes that the Royal Commission recommend that the Victorian Government promote service development and innovations in language services delivery for mental health.

Rationale

We suggest that technological and other innovations should be explored to promote improvements in interpreted and translated communication between clinicians and services and people seeking assistance.

This proposed recommendation would extend existing Victorian Government approaches that promote innovation in hospital settings into mental health services. The Victorian Government currently funds a hospital innovation grants program for language services (non-ongoing), Better Care Victoria grants through the Improvement and Innovation Program, and a grants program supporting telehealth initiatives. There are no equivalent programs supporting the development and sharing of innovative practices for engaging language services across mental health settings.

Proposed recommendation 7 – Promoting responsiveness to the diversities of the Victorian population

Foundation House proposes that the Royal Commission recommend that the Victorian Government prepare an overarching intersectional framework for mental health services.

Rationale

As indicated in the submission, the precedent for this proposed recommendation is the Victorian Government's development of *Everybody Matters: Inclusion and Equity Statement* (2019) as a response to the Royal Commission into Family Violence, setting out strategic priorities for the creation of a family violence system that is more inclusive, safe, responsive and accountable to all Victorians.

With respect to mental health services, such a framework would help the Victorian Government to realise its commitment to "understand, respect and respond to diversity" as set out in Victoria's 10 Year Mental Health Plan, which states that "the Victorian Government will design and deliver services and support in a way that promotes equitable access and safe and inclusive services for people with diverse cultural, religious, racial, linguistic, sexuality and gender identities" (page 21).

Proposed recommendation 8 – Promoting the adoption of trauma-informed care and practice in mental health services

Foundation House proposes that the Royal Commission recommend that the Victorian Government commission the development of a standard for mental health services on trauma-informed care and practice and guidelines for their implementation and an independent process for assessing compliance.

Rationale

Traumatic events affect the nature of mental health disorders and presenting conditions are critical for clinicians to assess for accurate diagnosis and appropriate treatment purposes.

The model for this recommendation is the "National Standards for Mental Health Services" which are accompanied by implementation guidelines for public mental health services and private hospitals, non-government organisations and private office based mental health services. The Standards have a variety of mechanisms for compliance including accreditation.

Proposed recommendation 9 – Complementary mainstream and specialist roles and relationships

Foundation House proposes that the Royal Commission recommend that Victorian Government funding for Victoria's mental health services system should explicitly support the roles of specialist services in complementing the work of mainstream services.

Rationale

This proposed recommendation is intended to strengthen the complementary roles and relationships of specialist services such as Foundation House and generalist

mental health service providers in areas such as referral and shared assistance to clients; secondary consultation and professional development. Subject to evaluation, funding should be provided to extend promising models such as communities of practice (see Appendix 3). The importance of complementary roles and relationships will grow as increased numbers of people of refugee backgrounds settle in rural and regional locations where generalist services have no or little experience in working with this population.

Proposed recommendation 10 – Specifying the data about mental health services that should be collected, analysed and published

Foundation House proposes that the Royal Commission should recommend which specific data the Victorian Government and state funded health services should collect and publish that indicates the accessibility and responsiveness of services to people of refugee backgrounds.

Rationale

This recommendation is related to the Royal Commission's Terms of Reference to inquire into and report on "improved data collection and research strategies to advance continuity of care and monitor the impact of any reforms" (2.5).

There is long-standing acceptance that health services, including mental health services, should be accessible and responsive to people of refugee backgrounds as well as other groups who might be at heightened risk of experiencing poor mental health and are likely to be under-represented as users of services. Current service data requirements are inadequate to assess these gaps with confidence and whether any changes the Royal Commission may recommend will improve the accessibility and responsiveness of services for people of refugee and CALD backgrounds.

For the purposes of its final report, the Royal Commission may find it necessary to seek or commission advice to determine the particular indicators about which data should be collected and used for service planning purposes, perhaps as the subject of an issues paper.

Proposed recommendation 11 – Supporting evaluation and research

Foundation House requests the Royal Commission to recommend that

- the funding of mental health projects and programs by the Victorian Government include funding for evaluation and

- a research fund is established for the study of issues critical to assessing continuity of care and the impact of reforms.

The purposes of the funding should include assessing the accessibility and responsiveness of the mental health service system for people of refugee backgrounds.

Rationale

This recommendation complements the preceding one. Evaluation and research must be resourced if they are to be undertaken at all or effectively. The Victorian Government provides in-kind support for some research partnerships but this is not adequate to achieve the objective of the Royal Commission's Term of Reference 2.5. Further investment is required. Among other areas, community based agencies undertaking mental health projects commonly require external assistance to design and implement evaluations of their work.

The Sax Institute's Evidence Check of community-based mental health and wellbeing support programs for refugees identified that, while such programs are needed to support refugees, there are relatively few high quality studies undertaken to evaluate these programs. And that the strength of the evidence there is, is low. They strongly recommended that:

> "Future efforts should be focused on undertaking rigorous evaluations of well-designed, multi-sectoral, trauma informed, and culturally competent programs in order to strengthen the evidence base. Well-designed mixed methods studies that capture both quantitative and qualitative data and which will ensure the voice of refugee communities are heard."

Appendix 1: Notes of community consultations

Focus group with members of the Syrian and Iraqi communities

Foundation House ran a focus group with community members, all of whom have a leadership role within their communities, to seek their input to a submission to the Royal Commission into mental health services in Victoria. Nine community members attended a meeting for 2 hours. They are currently members of two Advisory Groups established as partners in *Al Nafsahiya Al Sehiya,* the mental health literacy project being run by Foundation House. Two additional Advisory Group members contributed individually as they were unable to attend the focus group. There were 6 males and 5 females in total and collectively they represent the Syrian and Iraqi communities - both Christian (Assyrian, Chaldean, Syriac) and Muslim – and are engaged with families, young people and the elderly. Some have been in Australia less than 2 years, others for over 20 years.

Participants were provided with information about the Royal Commission and a list of questions to consider about their communities' understanding of and engagement with mental health needs and access to services. The purpose was to gather insights from communities about the issues being considered by the Commission and to include their perspectives as an attachment to the Foundation House submission. In this way community voice could be included in a significant way for consideration by the Royal Commission.

Arising from the discussion three areas for focus in documenting the input from community were identified:

1. What makes people unwell AND what contributes to wellness in Australia?
2. What are the barriers to accessing services?
3. What are the "solutions":
    a. To increase/contribute to wellness?
    b. To make services more accessible / responsive?

The following is based on what the community members raised during our meetings – in the focus group and individually.

1. **What makes people unwell?**

- **Pre-arrival experiences**

"The negative impact of the past on newly arrived people because of the war and the difficulties they have been through." (Comment made by a community member)

People arriving have had to flee their birth countries because of threats to life and safety, systematic persecution and human rights violations. In some situations whole villages were raided by ISIS and villagers had to make the decision within hours to leave. Journey to first country of safety is usually very unsafe, dealing with significant privations including lack of access to shelter, sustenance or safe protection; exposure to ongoing violence and threats to life; and often facing discrimination from locals as they flee through unfamiliar areas. Having to flee, often with little or no time for planning, meant that people have had to leave

everything behind, lose what they have built up over the years such as educational pathways, businesses, comfortable homes, secure employment etc. in order to be safe and most importantly to ensure that children and vulnerable family members are safe.

On arriving in a first country of asylum the uncertainty continued. Very meagre income support, often difficulty finding work, insecure accommodation, children often unable to attend school, little or no access to physical health services (let alone mental health services) with long waitlists, increasingly facing discrimination and even violence from the "host" community who see the refugees as a threat to their employment and access to housing etc. Family separation is core to the experience. Families can spend years waiting for a decision about resettlement exacerbating uncertainty about safety and the future. They are often reliant on the financial support of family in Australia in order to survive (which becomes an ongoing pressure on families once they do arrive in Australia and then have to support those left behind/still awaiting a resettlement outcome). When accepted for resettlement the relief is accompanied by guilt at having to leave family and friends behind to an uncertain future. This is often compounded by the fragmentation of families – both immediate and extended – when family members end up being resettled in different countries – Canada, USA, Europe and Australia. For older people separated from their children this is doubly difficult.

- **Continuing events in country of origin**

Whether while still in first country of asylum or after arrival in Australia news of ongoing violence/danger/lack of safety/extreme hardships those left behind continue to suffer continues to be felt by those who have had to flee. Fear for family/friends, feelings of guilt and shame at being safe once resettled in Australia, contribute to ongoing stress and un-wellness – both physical and mental. Exposure to news of further attacks on the villages or towns they had to leave behind exacerbates these stressors on all family members. According to one participant this can result in the community wanting to keep things quiet *"People don't want to talk about the past or hear about what's happening now back home because it is so distressing."*

- **Settlement stresses**

The process of settling in a new country, society and culture present profound stressors for many. Community members cited many examples of challenges finding housing, employment, maintaining income support, learning English, negotiating systems and particularly facing tremendous pressure from Job Network providers to find employment with little or no recognition of previous skills and experience or much assistance to negotiate unfamiliar work cultures or processes for seeking and gaining employment.

One participant indicated that family issues are challenging for the newly arrived because of *"swapping roles within the family and parents' difficulties in dealing with children and lack of communication between family members"* and the importance of *"giving attention to and taking care of the teenagers as they need a lot of support because of the difficulties in integrating in the new culture without losing their own culture."*

A participant from the Muslim community commented: *"The Shia Muslim community have been displaced for 30+ years – multiple displacements and never accessed mental health services. There is no shame saying "I'm psychologically tired" as it reaffirms the norm.*

Because of the years of displacement and exposure to violence community members don't believe that their current safety will last – they live with the fear of turmoil again all the time."

It is particularly difficult for older members in the community, many of whom had their own successful businesses back home or were successful and respected professionals but are unable to find a way of utilising their skills, knowledge and experiences now in Australia. Dealing with services/workers who have little or no understanding of the pain they have been through, the losses they have experienced nor their desire to find work, to be able to support their family and contribute back the community.

A strong theme articulated was being treated with a lack of respect or dignity by some service providers which has a tremendous impact for the mental health of community members. The loss of dignity in the way they are treated and the lack of employment here compounds their pre-arrival losses. As one community member stated: *"Job Network makes us feel that we are helpless and it is a hard feeling. It is important to find a way to let them change their behaviour – like kind of training maybe."*

AND what contributes to wellness in Australia?

- The intersection between housing, employment, education, income support and income security, and mental health was highlighted in the discussion. More affordable, safe and secure housing is essential when they have had to flee their home in terror in order to save their lives.
  There needs to be better ways of valuing the skills, knowledge, qualifications and experiences of those who have arrived and are seeking employment in order to maximise the opportunities for being assisted to find appropriate employment. *"Employment or being engaged in something that creates a sense of worth like volunteering is crucial. There will be less focusing on negatives in their life. There is a need to recognise skills and resources someone brings and build on these."*

- Recognising the legacy of pre-arrival experiences would take into account the vulnerability of some (not all) who are seeking employment or trying to study and learn English and that they may need more time – and flexibility of expectations - to settle and engage in employment and educational pathways. *"There is a need for pathways into employment. Job Network is not helping especially if someone has no employable skills. There is also a need for 'on the job' English."* (comment by one community member).

- Being connected to own community as well as the wider community is important to wellness and reducing social isolation – having the opportunity to participate in social groups, excursions, healthy well-being activities and other opportunities for social inclusion. *"Give attention and take care of elderly people and create the opportunity of socialising to make them feel that they are important."*

- Being treated with respect and dignity by service providers is fundamentally important, particularly in order to build trust and safety in services and the assistance that is available. This significantly contributes to mental health and wellbeing and the recovery for survivors of torture and other traumatic events. *"Don't make them feel that they are*

helpless and they are second class residents. Give them the opportunity to be able to integrate in a new life style as most of newly arrived are qualified and skilled."

2. **What are the barriers to accessing mental health services?**

- Stigma and shame within community in relation to mental health issues and especially in accessing mental health services – in the community you are considered "mad" or "crazy" if you do. In the words of one member it is the *"words and social customs"* which are a barrier to community members getting help from mental health services. Another stated *"There is stigma within community about mental health as being 'psycho' or 'crazy'. We need to engage with community to build connections rather than to exclude."*

- *"Mental health is rarely spoken about within community. 'This is how I am' is a common view within community about mental health issues – a normalising reaction – it is a norm to be suffering".*

- Cultural understanding of mental health issues and the need to open up conversations at the community level about acknowledging that community members do struggle with mental health issues and the importance of seeking professional assistance. According to one participant: *"There are a number of suicidal cases in the Christian, Muslim and Yazidi's communities especially young people, as they still not settled. Due to the stigma people are not accessing the mental health services."* He also commented on his experience overseas where online services were offered to young people and recommended to have something similar here. *"It was an online service with a clinical psychologist and available for certain hours with translators available. People first creating an account send their problems and people get suggestions online and through chatting. The only problem people faced was people couldn't access to the Internet."*

- Lack of knowledge within the community about what mental health services are available and how to access – compounded by the "hidden nature" that mental health issues do exist and kept secret within the family

- Language barriers and lack of/being unaware of translated materials/resources

- No confidence that help can be given as well as not being familiar with mental health support services. As one participant commented: *"There is a need to nourish people within the community – the belief is that 'the system has always abused me, why should it be different now?'."*

- Workforce related issues – lack of understanding of the refugee experience and so workforce not trauma-informed or trauma-focused in their interactions with community members who might seek help. In the words of a community member: "*People are linked directly to the job network, so it's good to teach workers at job network how these things impacts on their mental health negatively- training for workers because workers deal with in unprofessional way."*

- Erosion of trust because not treated with dignity with other services such as Job Network, Centrelink, housing services etc. so no trust or confidence in any services and contributing to a wider distrust of society

- For some who are caring for a family member with a mental illness the barrier is inherent in the belief that they are being "tested by God" in having a family member who needs their full time care and so if they accept help from services they are "not succeeding" in this test from God

3. **What are the solutions to (a) increase/contribute to wellness and (b) make services more accessible/responsive?**

(a) Solutions that increase/contribute to wellness:

- By opening up conversations within community about mental health and providing information about what services are available to support and assist individuals and their families we can increase the possibility of earlier interventions to support mental health wellbeing for all family members. One community member added "*It's so important for our community if we can find a venue to meet and be able to have information session about Healthy wellbeing for all ages. That could be done through schools, English language schools and out of schools as well. It's really important to have the sessions in Healthy wellbeing from the specialist service and facilitators as it's a sensitive topic for our community and it's preferable to be the right person for such a topic as this."*

- The importance of normalising mental health issues within community and particularly drawing on community members who have accessed mental health services effectively to share their experiences. This could be done through self-help groups, group work within community, information sessions, psychoeducation groups etc.

- Raising awareness about healthy eating/a good diet was also identified as being important: *"Al-Raha Al-Nafsiya 'psychological comfort' comes from the healthy environment."*

- Trust and the medium of engagement is important. In terms of information about mental health it is important that the information comes from trusted sources and that it is essential they are community led. *"It's not what you say, it is WHO says it."* was a comment made by a participant and he drew a parallel with the ways that are in place of engaging with the Koori community.

- Ideas of developing "ambassadors" or "community champions" within community – people who are known and active within the community – around mental health and give them duties - **'You are part of this'** messaging.

- Provide ongoing funding to deliver programs such as the *Al Rafahiya Al Sehiya Healthy Wellbeing* sessions which models community engagement and employment of bicultural

workers as a way of reaching community members to engage in dialogue about mental health and wellbeing, increasing awareness of services, making supported referrals etc. The suggestion was made that initially, at least, community sessions around mental health literacy should be in groups that share the same background/culture given the conflict between groups pre-arrival but that it is also important to look at opportunities to cross these divides in the long term. Another participant indicated the importance of having separate sessions for men and women.

- Provision of more opportunities for community to participate in social groups building connections, participating in excursions, being provided with strategies for self-care. As stated by a community member: "*Some of the solutions, Holol, is to make groups – like social groups – and make some sessions around mental health and mental and other physical issues– going out for excursions .*" Another participant said *"Encouraging people to join some groups such as the ones offered at my school"* (where she is a Bicultural Worker).

- Another commented on the value of creating opportunities for social connections with other cultures to break down barriers, citing an example of *"a dance group of 15 to 20 Syrian and Iraqi young people who have joined with Greeks and Armenians and together performed at the Greek Festival. The plan is to invite six more cultures to join and build over time. This is a very important opportunity for connection and relationship building both within and across cultures."*

- Strengthening a community/collective approach rather than an individual focus supports more individuals and acknowledges that their communities are collective societies rather than individually focused; that they tend to seek help from within community rather than outside it.

- Recognising the importance of faith in many refugee background communities and the importance and influence of faith leaders who need to be included in strategies to respond to mental health literacy and support

- Another viewpoint expressed was: *"It is important to recognise that churches and mosques are not the only way to access community – it is important to empower the community."*

- **Training for community members:** In order to implement much of the above it is necessary to increase the role of community members who are trained (in group facilitation skills/mental health literacy/how to talk about mental health issues/how to recognise where someone might need mental health services and where to refer) and mentored both as volunteers and in paid roles to engage with their communities. They could then provide culturally appropriate information about mental health and services available, provide peer support to vulnerable community members, support referrals and engagement with mental health services and could be employed within mental health services as bicultural workers to work alongside service providers and be a link with community members accessing service to support their entry into unfamiliar

systems. *"Taking a Train the Trainer approach builds leaders within community and builds trust with community."*

(b) Solutions that make services more accessible/responsive – all strategies need to be trauma informed:

- Given that community members are more likely to go to their GP to talk about their mental as well as physical health the importance of empowering GPs who are either of the same background as the refugee communities or speak the same language, to be the conduit into mental health specific services. As one member commented: *"GPs are the most trusted point of entry – they are respected and can bring communities together. For example if you are a parent you go for your children almost weekly. Arabic speaking GPs would see more than 1000 of our community a week because of the language, they bulk bill, are open 7 days a week and they are close to where people live. We need to engage with them to get them to be involved in input around mental health and the changes needed."*

- Having trained bi-cultural workers as mental health workers employed within GP clinics and mental health services to support GPs and clinicians to engage with a community member and to be a familiar point of contact for the community member within the service. As suggested by a participant: *"Empowering community members with some mental health certifications diploma for 1 or 2 years so people can be advocates in their community and it's going to be a first entry to the community to bring awareness. Community will trust the service when they employ people like mental health therapist from the community."*

- Having more trauma informed early intervention services within schools/school community hub programs; ensuring that teachers are aware about children's and young people's cultures and the trauma many have suffered; to raise awareness about the impact on mental health from bullying within schools (as identified by one participant *"It is more important to bring awareness in the schools as newly arrived children are exposed to bullying because their level of English is not good enough"*); and to employ bicultural workers to be an interface between school and community

- While it can be hard to reach parents it would be important to connect with children through schools and through this engage with parents. As stated by one participant *"If you focus on children you can get parents' consent for their kids to be involved as one way of engaging parents as well as children. The program doesn't have to be named as mental health but more supporting children to be successful such as leadership skills which is what parents want for their children."*

- **Workforce development**: ensuring that workers within mental health settings are **trauma informed** and **culturally responsive** and that more bicultural workers are intentionally employed to be a bridge between services and communities and to be a resource to clinicians about how best to engage with community members who access their services.

- Need to move away from diagnostic language and to use simple clear language when talking with community members who are accessing services – use of clinical terminology is a barrier to being able to assess and assist the individual and to support the family as carers and for them to develop trust in the service. Even when using an interpreter, if the clinician relies on the interpreter to explain terminology there is greater likelihood for misunderstanding or explanations that alienate the individual seeking help because they think they are being described as "crazy" or "mad".

- Services must systematically use interpreters AND/OR employ bicultural workers and have intake systems that recognise the role of family/community in the care of someone who is ill and not respond or treat from an individual (more Western oriented) perspective.

- Need for partnerships between community organisations and mainstream agencies with secure funding in order to deliver programs within community. An example was given of an art therapy group for women that was such a partnership but which ceased due to lack of ongoing funding.

- *"Pathways to opportunities are essential. Sit with communities to understand their perspectives. Establishing Advisory Groups, rather than one-off community consultations, so that government* (and service providers) *can hear the issues directly from community. Consultations without follow-up result in resignation by community that nothing will happen – if asked to consult again they ask "What for?"."* – a clear statement made by a community member about the importance of engaging with communities in a meaningful way to be able to come up with solutions.

Focus group with members of the Karen and Chin communities

Foundation House ran a focus group with community members, all of whom have a leadership role within their communities, to seek their input to a submission to the Royal Commission into mental health services in Victoria. Nine community members attended a meeting for 2 hours:

- five were from the Karen community – 2 who are young people (1 male, 1 female) and 3 (1 male 2 female) who are middle aged; all are very well connected with community although not as formal or elected leaders;
- four were from the Chin community – 3 young people (2 females and 1 male) and one older male community member; all are actively engaged within their communities.

Participants were provided with information about the Royal Commission and a list of questions to consider about their communities' understanding of and engagement with mental health needs and access to services. The purpose was to gather insights from communities about the issues being considered by the Commission and to include their perspectives as an attachment to the Foundation House submission. In this way community voice could be included in a significant way for consideration by the Royal Commission.

1. **What are the barriers to people in your community talking about mental health generally?**

The mental health and wellbeing of parents and their understanding of mental health and wellbeing is crucially important to the wellbeing of family members. The shame associated with recognising that they are struggling psychologically and emotionally is clear from the comments made by those who attended the focus group with Chin and Karen community members. This reflects the shame (stigma) more generally across the communities in relation to having mental health problems and/or seeking mental health services.

Chin youth leader: *"In our country we don't know about mental health. Parents don't understand mental health. Parents need to learn about mental health especially if they are to help their children"* – there is a tendency for parents to tell their children (adolescents/young adults) to "forget about worries" rather than recognising that they are struggling with mental health issues. This is because parents don't understand mental health – concept of or symptoms - and what services might be available to assist and so tell their adolescents to "get over it". *"Back home there are no services so parents learned that there is nothing there to help."* (Chin female youth leader). So parents are key – they need to increase their understanding of mental health.
Karen female leader/elder: lots of mental health problems amongst women – "people don't seek help". Shame associated with needing help – don't want to talk to pastors or others in community because of the shame. Women – both older and younger - are overdosing with medication because they do not know what to do.

Most women are embarrassed about having problems even when they seek help. *"Women run homes. If they are sad, depressed or worried they hide it so that their children don't see that they are sad. They cry on their own because they don't want their children to be affected by their problems as it will affect the children's study and life."* Other participants strongly agreed with this comment – across both Karen and Chin communities.

A Chin male leader referred to the situation where, because of the government system, people are under pressure. He talked about the example in the Chin community where men, and sometimes women, are unable to bring partners through an arranged marriage because they cannot get a visa. This leads to distress and mental problems and use of alcohol to manage their distress which then impacts on employment sometimes leading to unemployment.

Males are more likely to release their worries through sport and other activities while women - young and old – hide feelings inside until it builds up. Culturally men have to show strength and be the head of the household – it's hard for them to show that they are suffering (both Karen and Chin).

"In our culture we don't seek help" "Don't want to talk to others because of shame" (about mental worries*) (Karen female leader/elder)*

"Men and women express their worries differently – women cry, men look tough but may still be suffering" (Chin female youth leader).

If you talk about mental health concerns you are labelled as 'crazy'. Some of the comments made were*: "People in the community tease and mock someone who has had to have treatment".* If someone has had mental health treatment *"they are treated as second class citizens within community" "Community don't know how to treat and be kind" "Community discourages the use of medication because of the stigma/shame of needing medication"*

2. **Why is it difficult for community members to seek support from services? Who would they go to in community?**
3. **What role does/do community/community leaders or elders have to support anyone in the community who is struggling?**

In addition to the issues described above of shame and stigma within community in relation to admitting to experiencing mental health issues or seeking assistance when feeling mentally unwell, the community members talked about the challenges even within community of seeking support.

All leaders from both communities stated that mental health education is critical for community to receive: *"People don't know that they are suffering from mental health problem/s…if you don't know it's a mental health problem you can't/don't seek help."*

Unless there is a referral from a GP to a mental health support service people just suffer in silence…until they get so unwell that they are admitted to hospital.

Both Karen and Chin participants (all Christians) commented that religious leaders judge someone who has mental health problems so that there is the expectation

within community NOT to go to the pastor for help. Christians are often made to feel shamed because mental health is down-played.
"Pastors pray for us but we need more"
If young people have problems they are more likely to go to friends for support before they would go to their parents or the pastor. (Both Chin and Karen youth leaders)
Karen male youth leader described how they visit young people from their youth group in their families - this gives the opportunity to ask questions as they spend time with the family in order to encourage them to share.
Chin focus group members in particular identified trust issues with interpreters when communities are small – as there is fear that the interpreter will talk about the person's mental health issues in the community after they have been used in sessions
A Karen female leader/elder commented that people are in and out of hospital mainly because of the language barrier as often there is no interpreter. *"I was rung one night by the hospital to interpret for a community member who had been admitted for mental health treatment because the hospital had been unable to get an interpreter."*
Problems within community, especially family problems/conflict, contribute to a sense of hopelessness. Particularly hard for sole parents with the challenges of parenting their young people (Karen female leader/elder). *"When they feel there is no hope and not knowing what to do can lead to suicidal thoughts."*
"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 10-15 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 and there was enormous pressure and stress for all the family." This comment was made by a Karen male leader during the focus and highlights the very real challenges for both the person who had been unwell and the family who want to support him given their lack of understanding of mental illness.

4. **What do you/your community think supports mental wellbeing?**
5. **What are your ideas for what a GOOD system of mental health support would look like for your community?**

All leaders from both communities stated that mental health education is critical for community to receive: ***"People don't know that they are suffering from mental health problem/s…if you don't know it's a mental health problem you can't/don't seek help."***
"Mental health is a very important issue. We need much more education about that as it is difficult to talk about within community. It is important to educate because it is prevention." (Karen male leader/elder)
"We need to educate and advocate within the community…this is critical. And not just educating about symptoms, also training in how to respond." (Karen male leader/elder)

"You need to focus on small sections of community first" (Karen male leader/elder, Chin female youth leader affirmed this).
Developing culturally appropriate videos/role plays/visual educational resources: Examples of need to develop resources – not just written…use of pictures, stories, videos etc. and asking the pastor or leader to speak to the issues at church (e.g. Chin church where over 1000 attend each week) as they can pass on information in their language.
Promoting bi-cultural workers: The need for bicultural workers located in mental health services as they will have the knowledge of community and can act as a bridge between community and services (all participants). Bicultural workers would be more acceptable than an interpreter for many in the community.
Home visiting/outreach services were identified as being needed to build relationships and connections and to provide psychosocial support (Karen female leaders/elders).
TRUST is very important to community – outreach and home visits builds trust
Focus groups about mental health in community: the need to have trained community members to have conversations about mental health within community.
"We need to educate and advocate within the community…this is critical. And not just educating about symptoms, also training in how to respond." (Karen male leader/elder)
If professionals come to church they could focus on men, women and children as there are different "departments" within church organisation. Important to come to where community are in order to reach as many as possible.
Addressing the language barrier and making it culturally appropriate AND using simple wording (not diagnostic terminology)

Finally a statement made by a Karen male leader which was affirmed by all participants:
"We know that mental health is a very important issue – but we need much more education about it as this is prevention – to accept that it is normal and someone is not 'crazy' or 'mad'."

Appendix 2: Examples of health literacy projects run by or involving community members

The following are examples of projects that have a strong engagement with community members in the development and delivery of health and mental health literacy projects.

Building Social Capital Through a Peer-Led Community Health Workshop:

A Pilot with the Bhutanese Refugee Community

A program with Bhutanese refugees in the USA used a peer-led intervention involving training Bhutanese community leaders – both formal and informal - on mental health and psychosocial support, health education and group facilitation skills. Those trained in all these areas subsequently delivered community-based health workshops to their peer refugees. These trained leaders were actively involved in cultural adaptation of the curriculum with particular attention to cultural relevance of examples and activities and terminology to be used such as stress, mental health, healthy lifestyle and community, as sessions were delivered in Nepali.

The sessions provided the opportunity for participants to openly discuss health concerns, mental health issues in the community, coping with stress and "to open up to the tabooed topic and acknowledge mental health problems existing within community" and promoting help seeking "in spite of high stigma around mental health in the Bhutanese culture".

The peer based model also improved social capital: expanding social networks and community participation, strengthening a sense of community, building community capacity and leadership, and increasing connectedness and supports.

The study was a community-based participatory research project and incorporated focus group discussions in the health workshops to seek feedback from participants about the workshop content and format. Findings support the cultural sensitivity and relevance of a peer-based model with a refugee community whereby shared cultural values and language contributed to the acceptance and high regard of the interventions delivered though a group process.

This study was considered to be of medium to high quality in the Evidence Check undertaken by the Sax Institute (Slewa-Younan et al 2018) for the NSW Ministry of Health on the effectiveness and appropriateness of community-based mental health and wellbeing support for refugees.

Im, Hyojin & Rosenberg, Rachel. *Building Social Capital Through a Peer-Led Community Health Workshop: A Pilot with the Bhutanese Refugee Community* J Community Health, 2016 Jun;41(3):509-17. doi: 10.1007/s10900-015-0124-z.

Slewa-Younan S, Blignault I, Renzaho A, Doherty M. *Community-based mental health and wellbeing support for refugees: an Evidence Check rapid review* brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Ministry of Health, 2018

Australian Aboriginal and Torres Strait Islander Mental Health First Aid (AMHFA) program

Adaptation of the Mental Health First Aid (MHFA) training content to be culturally relevant and responsive for the Aboriginal and Torres Strait Islander peoples resulted in the development of the Australian Aboriginal and Torres Strait Islander MHFA (AMHFA) course (Kanowski 2009). Cultural adaptation was identified as necessary through a series of consultations with ATSI individuals and groups between 2004 and 2006. An AMHFA Working Group, comprising Aboriginal people with professional experience in the Aboriginal mental health field, was established in 2006 and they guided the process of incorporating specific cultural adaptations of the manual and course materials.

"An important result of the cultural adaptation process was that materials were empowering for Aboriginal people and acknowledged their resilience in surviving historical traumas and losses." Aboriginal artwork was used in the materials and manual "to illustrate important messages and Aboriginal concepts of mental health and well-being, and to give a clear identification of these materials as belonging to Aboriginal and Torres Strait Islander people."

To evaluate the AMHFA program it was delivered to 199 Aboriginal people training them as instructors having completed the 5-day Instructor Training Course. Most instructors subsequently delivered AMHFA courses to members in their communities. The AMHFA Training and Administration team also employed indigenous staff members to provide cultural input and on-going support to Instructors. An outcome of the evaluation was that newly trained instructors wanted ongoing support. The qualitative data affirms "widespread support for the cultural appropriateness of the training approach and the training materials" and identifying the need for more adaptations to the materials particularly to suit participants with lower levels of literacy.

The study recognised that to continue the work beyond this initial stage and further develop course content and delivery of training, Government support through ongoing funding was essential. Evaluation of the impact of the AMHFA program on help provided to Aboriginal people with mental health problems would be incorporated in further delivery.

This example of the process of adaptation of MHFA course materials and format for the Aboriginal community is very relevant for developing similar culturally relevant and appropriate courses and training with refugee-background communities. Central to the process is working with community members to develop content, messaging, and engagement with community.

Kanowski L, Jorm A & Hart L. *A mental health first aid training program for Australian Aboriginal and Torres Strait Islander peoples: description and initial evaluation*, International Journal of Mental Health Systems 2009, **3**:10 Article available from http://www.ijmhs.com/content/3/1/10

The role of community organisations and mental health literacy

A study of Refugee-led Community Organisations (RCOs) in the UK explored their contribution to inclusion, cohesion and social integration (Williams 2018). RCOs were found to have three important assets: the ability to **reach** members of their community, **insight** of cultural and other factors impacting behavior and attitudes within community and finally the ability to find **solutions** to the barriers and challenges facing refugees. There are of course challenges for RCOs: the level of needs and issues within community; increased demand on services; organisational, financial, governance and strategic planning challenges for some RCOs; and insecure funding.

Two RCOs specialised in mental health services while others included mental health support with other activities. "All RCOs emphasised early intervention and prevention and worked closely with mainstream health providers." (p20) The mental health outcomes of those RCOs involved in mental health service delivery were identified as:

- improvements in mental health using various tools to measure same (e.g. the Recovery Star system);
- take up of mental health services including self-referrals,
- lower rates of hospitalisation,
- increased awareness of mental health among community members, and
- solutions to social issues affecting mental health such as income support and housing.

Williams D. *A bridge to life in the UK: Refugee-led community organisations and their role in integration,* Research Report commissioned by Refugee Council, UK. Available for download at www.refugeecouncil.org.uk

Health and Wellbeing (*mental health*) Peer Support Groups

The *Bedaya Sehaya* Program, funded by NWMPHN, provided face-to-face health information in a community setting led by bicultural workers. The program was a partnership between cohealth and Foundation House and involved three aspects: *training and support of bicultural workers* who were upskilled in health topics to be able to deliver *health information sessions* to members of newly arrived refugee communities from Syria and Iraq (both aspects delivered by cohealth); and the delivery of self-sustaining and trauma-informed *health and wellbeing (mental health) peer support groups* co-facilitated by a Counsellor Advocate, mental health bicultural worker (both through Foundation House) and a newly trained cohealth bicultural worker. The peer support groups were delivered by Foundation House.

The health and wellbeing peer support groups provided opportunities to promote self-awareness, knowledge of mental health wellbeing and identification of resilience building strategies, introducing activities such as yoga and Zumba to look after oneself. They also offered a culturally safe and appropriate environment to engage in dialogue around understandings of 'psychological distress' within community, families and individually and how attitudes may influence seeking assistance; to identify mental health needs; and to improve an individual's capacity to recognise when and how they contact relevant mental health supports.

Feedback from participants attending the peer support groups indicated that the program increased social connectedness and had begun to build trust amongst each group's participants and with the facilitators. Participants learnt from each other through the sharing of similar experiences and coping strategies and felt more confident to access support services.

The *Bedaya Sehaya* program was externally evaluated however the report has not yet been released by the PHN. The evaluation recognised that for a peer support group to be self-sustaining it was necessary to run the groups for a longer period of time in order to identify an active leader within the group and develop their skills to lead and facilitate the group in the longer term. Linking group participants to existing community supports was also central to the sustainability of the group.

The Health system engaging with refugee communities: The Group of Eleven "G11"

Queensland's Mater Centre for Integrated Care and Innovation (CICI) engaged a group of eleven refugee-background community leaders to be trained in health literacy and research skills so that they could become a health resource for their own communities. From their training the members would take health information back into their communities. Concurrently, the group contributed to the building of the health system and capacity through providing advice to clinicians, service providers and policy makers particularly in relation to how the clinical encounter may be received by a person from a refugee background and culture.

The initiative undertook a trauma informed model of engagement recognising the impact of trauma and loss on individual members and their communities more broadly and building engagement on a solid framework of trust. The G11 significantly contributed to building health literacy within the communities with reported increased confidence and knowledge and shifts in perceptions and attitudes around health practice and prevention. Clinicians also identified the value of attending professional development sessions incorporating the G11 perspective.

Peterson et al (2019) *Community engagement with refugee-background communities around health; the experience of the Group of 11*, Australian Journal of Primary Health https://doi.org/10.1071/PY18139

Appendix 3: Examples of relationships between Foundation House and mainstream mental health services

Collaboration between Foundation House and Royal Children's Hospital Mental Health

In 2016, Foundation House and Royal Children's Hospital Mental Health (RCHMH) signed a Memorandum of Understanding to enter into a collaborative relationship to improve the mental health and wellbeing of children and their families from refugee backgrounds. The RCHMH staff and Foundation House provide to each other clinical support for primary and secondary consultation for children and families referred by staff of the other service. RCHMH staff also participate in the Foundation House school support program in the area by providing secondary consultation. The arrangement has been extended so that RCHMH locate staff on a part-time basis at the Foundation House office in Dallas. Staff of both agencies provide very positive reports about the value of the collaboration.

Community of Practice in Child and Youth Refugee Mental Health Project

The Community of Practice in Child and Youth Refugee Mental Health Project (CoPCYRMH) aims to build the capacity of health professionals and services to respond effectively to the mental health and wellbeing needs of children and young people and their families, from refugee backgrounds (located primarily in a region of northern and north western Melbourne). The project aims to achieve its objective through actions including the development and exchange of best practice and building relationships between staff and services. It is led by Foundation House and funded by the Victorian Government for 3 years, commencing in 2017. The work of the CoPCYRMH is being monitored and evaluated.

Supporting the provision of services in rural and regional areas

There has been significant settlement of people of refugee background in rural and regional Victoria, including people with permanent protection visas, people with temporary Safe Haven Enterprise Visas (which have incentives for non-metropolitan residence) and people seeking asylum.

Foundation House has undertaken a number of types of work to support agencies and staff to respond to the needs of people of refugee backgrounds, including funding and supporting the placement Counsellor Advocates in several locations, and providing training, advice and secondary consultation. We provide support in both areas with significant refugee-background populations and locations with few, where assistance may be particularly required because health providers have had little if any experience with this cohort.

[i] "What is FASSTT?" Forum of Australian Services for Survivors of Torture and Trauma. Accessed 5 July 2019. https://www.fasstt.org.au/

[ii] Perhaps the most commonly used definition of the term "torture" is that contained in the international Convention against Torture which Australia is committed to respect, which describes it as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity." Torture may include rape and other forms of sexual abuse. The definition of "traumatic events" adopted by Foundation House is that of the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*) criteria for Posttraumatic Stress Disorder viz. events as those where an individual has experienced:
"A. Exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways: 1. Directly experiencing the event(s).2. Witnessing, in person, the event(s) as it occurred to others.3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental. 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

[iii] Foundation House services are for people who have a "**refugee or refugee-like background" defined as including: p**eople who have been found to be refugees by the UNHCR or the Australian Government; people who have suffered persecution in their country of nationality or usual residence; people who have been subjected to substantial discrimination and human rights abuses in their country of nationality or usual residence and immediate family members, such as a child, of the above. http://www.foundationhouse.org.au/making-a-referral/ They include people seeking asylum i.e. they have applied to the Australian Government to be granted protection because they are refugees or otherwise at risk of serious human rights violations in their countries of origin.

[iv] Victorian Foundation for Survivors of Torture. *Integrated Trauma Recovery Service Model*. Melbourne: Victorian Foundation for Survivors of Torture, 2016.
http://www.foundationhouse.org.au/integrated-trauma-recovery-service-model/

[v] Ibid

[vi] Australian Government Department of Health. "Program of Assistance for Survivors of Torture and Trauma." Modified 27 October 2017.
https://www.health.gov.au/internet/main/publishing.nsf/Content/mental-torture

[vii] "Report of the PHN Advisory Panel on Mental Health," September 2018, page 2.

[viii] Refugee Council of Australia, Federation of Ethnic Communities Councils of Australia, National Ethnic Disability Alliance and Settlement Council of Australia, Barriers and Exclusions: the support needs of newly arrived refugees with a disability, 2019.

[ix] Victorian Foundation for Survivors of Torture, Service responses for people with disabilities from refugee backgrounds in northern Melbourne, Melbourne: Victorian Foundation for Survivors of Torture, 2018.

[x] Victorian Foundation for Survivors of Torture, Service responses for people with disabilities from refugee backgrounds in northern Melbourne, Melbourne: Victorian Foundation for Survivors of Torture, 2018.

[xi] Many prevalence studies have been conducted in refugee populations. The rate of prevalence found varies from study to study. That is because: (a) refugee populations are diverse – e.g., they

may vary in terms of the level of exposure to trauma and what protective factors (e.g. social support and family) are evident; and (b) the methodologies used in those studies. However, overall, those studies show that the rate of prevalence among refugees is high and there is unequivocal consensus that those rates are higher than when compared with the general population. By way of example: A study conducted in Australia showed that recently arrived humanitarian migrants had a risk of psychological distress at much higher rates than the general Australian population. (De Maio, J., Gatina-Bhote, L., Rioseco, P., & Edwards, B. (2017). *Risk of psychological distress among recently arrived humanitarian migrants*. (Building a New Life in Australia Research Summary). Melbourne: Australian Institute of Family Studies. Between 31% and 46% were classified as having moderate or high risk of psychological distress in the first three waves of the study. For the Australian population, 7% of men and 11% of women had these levels of difficulties. A recent study of refugees from Syria who had settled in Sweden (which has a comparable refugee population to Australia) showed the following prevalence rates: 30% suffered from PTSD; 40% suffered from depression; and 32% suffered from anxiety. Tinghög, P., Malm, A., Arwidson, C., et al. (2017). Prevalence of mental ill health, traumas and post migration stress among refugees from Syria resettled in Sweden after 2011: a population-based survey, *BMJ Open*, *7*:e018899. doi: 10.1136/bmjopen-2017-018899.) Another recent study showed the incidence rate of non-affective psychotic disorder was 66% higher among refugees (excluding asylum seekers) than among non-refugee migrants from similar regions in the same country of origin. (Hollander, C., Dal, H., Lewis, G., Magnusson, C., Kirkbride, J. B., & Dalman, C. (2016). Refugee migration and risk of schizophrenia and other non-affective psychoses: Cohort study of 1.3 million people in Sweden. *BMJ*, *352*, doi: https://doi.org/10.1136/bmj.i1030.) That is nearly three times greater than the incidence rate among the native born Swedish population. In a recent unpublished Foundation House analysis, counsellors who had assessed our clients found that 80% of those adults had moderate to severe anxiety symptoms, 80% depressive symptoms and 76% traumatic stress symptoms. (This analysis was part of a report to a Commonwealth funding body, The Program for Assistance to Survivors of Torture and Trauma, and is not published).

[xii] United Nations. "Contribution to the fifteenth coordination meeting on international migration." Accessed 2 July, 2019. https://www.un.org/en/development/desa/population/migration/events/coordination/15/documents/papers/14_UNHCR_nd.pdf

[xiii] Scanlon Foundation. *Mapping Social Cohesion: The Scanlon Foundation Surveys 2018.* Melbourne: Monash University, 2018. https://scanlonfoundation.org.au/wp-content/uploads/2018/12/Social-Cohesion-2018-report-26-Nov.pdf

[xiv] Priest, Naomi, Angeline Ferdinand, Ryan Perry, Yin Paradies, and Margaret Kelaher. "Mental health impacts of racism and attitudes to diversity in Victorian schools." (2014).; Vichealth. "Mental health impacts of racial discrimination in Victorian CALD communities." Modified 21 November 2014. https://www.vichealth.vic.gov.au/media-and-resources/publications/mental-health-impacts-of-racial-discrimination-in-culturally-and-linguistically-diverse-communities; Scanlon Foundation. *Mapping Social Cohesion: The Scanlon Foundation Surveys 2018.* Melbourne: Monash University, 2018. https://scanlonfoundation.org.au/wp-content/uploads/2018/12/Social-Cohesion-2018-report-26-Nov.pdf

[xv] See for example Centre for Policy Development, "*Settling Better: Reforming refugee employment and settlement services*", 2017, https://cpd.org.au/2017/02/settlingbetter/

[xvi] von Werthern, Martha, Katy Robjant, Zoe Chui, Rachel Schon, Livia Ottisova, Claire Mason, and Cornelius Katona. "The impact of immigration detention on mental health: a systematic review." *BMC psychiatry* 18, no. 1 (2018): 382.; Coffey, Guy J., Ida Kaplan, Robyn C. Sampson, and Maria Montagna Tucci. "The meaning and mental health consequences of long-term immigration detention for people seeking asylum." *Social science & medicine* 70, no. 12 (2010): 2070-2079.

[xvii] Refugee Council of Australia. "An unnecessary penalty: Economic impacts of changes to the Status Resolution Support Services." Accessed 2 July, 2019. https://www.refugeecouncil.org.au/srss-economic-penalty/

[xviii] Saunders, N. R., Lebenbaum, M., Lu, H., et al. (2018). Trends in mental health service utilisation in immigrant youth in Ontario, Canada, 1996–2012: A population-based longitudinal cohort study. *BMJ Open*, *8*:e022647. doi:10.1136/bmjopen-2018-022647.

[xix] Victorian Auditor-General's Report. (2019, June). *Child and Youth Mental Health*, p. 80.

[xx] Ibid page 80.

[xxi] Hiscock, H., Mulraney, M., Efron, D., Freed, G., Coghill, D., Sciberras, E., Warren, H., & Sawyer, M. (2019). Use and predictors of health services among Australian children with mental health problems: A national prospective study. *Australian Journal of Psychology*, https://doi.org/10.1111/ajpy.12256.

[xxii] Kaplan, Ida, Hardy David Stow, and Josef Szwarc. "Responding to the challenges of providing mental health services to refugees: an Australian case report." *Journal of health care for the poor and underserved* 27, no. 3 (2016): 1159-1170.

[xxiii] Australian Government Department of Home Affairs. "About the program". Accessed 2 July 2019. https://immi.homeaffairs.gov.au/what-we-do/refugee-and-humanitarian-program/about-the-program/about-the-program

[xxiv] Australian Government Department of Social Services. "Humanitarian Settlement Program." Modified 4 April 2019. www.dss.gov.au/settlement-services-programs-policy-settlement-services/humanitarian-settlement-program#top

[xxv] Kirmayer LJ et al. Common mental health problems in immigrants and refugees: general approach in primary care. Can. Med Assoc J. 2011 Sept 6; 183 (12): E59-67. EPub 2010, Jul 5. page 4, cited in Kaplan I, Stow H, Szwarc J. Responding to the challenges of providing mental health services to refugees: An Australian case report. Journal of Health Care for the Poor and Underserved. 27 (2016): 1159-1170, page 1162.

[xxvi] This is the definition of "individual health literacy" as defined by the Australian Commission on Safety and Quality in Health Care, which also describes the related concept of "health literacy environment." Australian Commission on Safety and Quality in Health Care. Health Literacy: Taking action to improve safety and quality. Sydney: ACS page 12.

[xxvii] Engage Victoria. "Partnering in healthcare." Accessed 2 July 2019. https://engage.vic.gov.au/partneringinhealthcare

[xxviii]Australian Commission on Safety and Quality in Health Care. "National Statement on Health Literacy – Taking action to improve safety and quality." Accessed 2 July 2019. https://www.safetyandquality.gov.au/publications/health-literacy-national-statement/

[xxix] Ibid.

[xxx] Valibhoy, Madeleine Claire, Josef Szwarc, and Ida Kaplan. "Young service users from refugee backgrounds: their perspectives on barriers to accessing Australian mental health services." *International Journal of Human Rights in Healthcare*10, no. 1 (2017): 68-80.

[xxxi] Tandem Carers. "*Improving the mental health and well-being of immigrant and refugee background communities by building capacity* Small Grants Program." Accessed 2 July 2019. https://www.tandemcarers.org.au/images/CALD%20Grant%20Release%20from%20Tandem%20and%20VMIAC.pdf

[xxxii] Valibhoy, Madeleine Claire, Josef Szwarc, and Ida Kaplan. "Young service users from refugee backgrounds: their perspectives on barriers to accessing Australian mental health services." *International Journal of Human Rights in Healthcare*10, no. 1 (2017): 68-80.

[xxxiii] The Inclusion and Equity Statement (2019) posits that the term 'intersectionality' describes how systems and structures interact on multiple levels to oppress, create barriers and overlapping forms of discrimination, stigma and power imbalances based on characteristics

[xxxiv] Victorian Government Department of Health and Human Services. "Trauma-informed care." Accessed 2 July 2019. https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/trauma-informed-care

[xxxv] Page 28.

[xxxvi] Bateman, Jenna, C. Henderson, and C. Kezelman. "Trauma-informed care and practice: Towards a cultural shift in policy reform across mental health and human services in Australia. A national strategic direction." *Position paper, Mental Health Coordinating Council* (2013).; see also the paper of the US Substance Abuse and Mental Health Services Administration which advises:
"A program, organisation or system that is trauma-informed realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff and others involved with the system and responds by fully integrating knowledge about trauma into policies, procedures and practices and seeks to actively resist retraumatisation." Cited in Liz Wall et al, Trauma-informed care in child/family welfare services, Australian Institute of Family Studies, CFCA Paper No. 37, February 2016.

[xxxvii]Victorian Department of Health and Human Services. "Trauma – understanding and treating." Accessed 2 July 2019. https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/trauma-informed-care/trauma-understanding-and-treating

[xxxviii] "The Centre for Mental Health Workforce Learning and Development – what will it do?" Victorian Government Department of Health and Human Services. Accessed 5 July 2019. https://www2.health.vic.gov.au/mental-health/workforce-and-training/the-centre-for-mental-health-workforce-learning-and-development

[xxxix] Australian Government Department of Health. "Standard 4. Diversity responsiveness." Accessed 2 July 2019. https://www.health.gov.au/internet/main/publishing.nsf/Content/CFA833CB8C1AA178CA257BF0001E7520/$File/serv4.pdf

[xl] Primary Health Network Advisory Panel on Mental Health. *Reform and System Transformation: A Five Year Horizon for PHNs*. 2018. https://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Tools/$File/Reform-and-System-Transformation-A-Five-Year-Horizon-for-PHNs.pdf

[xli] Block, Karen, Dana Young, and Robyn Molyneaux. *Ucan2: Youth Transition Support – Evaluation Report 2017.* Melbourne: University of Melbourne Centre for Health Equity, 2017.http://www.foundationhouse.org.au/wp-content/uploads/2018/08/UCan2_evaluation_Full_Report_Final_May2018-1.pdf

[xlii] Royal Commission into Institutional Responses to Child Sexual Abuse. *Final Report, Advocacy, support and therapeutic treatment services, Volume 9.* Commonwealth of Australia, 2017. https://www.childabuseroyalcommission.gov.au/sites/default/files/final_report_-_volume_9_advocacy_support_and_therapeutic_treatment_services.pdf

[xliii] Bendall, S., Phelps, A., Browne, V., Metcalf, O., Cooper, J., Rose, B. , Nursey, J. & Fava, N. Trauma and young people. Moving toward trauma-informed services and systems. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health, 2018. https://www.orygen.org.au/Policy-Advocacy/Policy-Reports/Trauma-and-young-people-Moving-toward-trauma-info/Orygen_trauma_and_young_people_policy_report.aspx?ext=

[xliv] Commonwealth policies include: Commonwealth Department of Home Affairs, Multicultural Access and Equity Policy Guide, 2018, https://www.homeaffairs.gov.au/mca/PDFs/multicultural-access-equity-policy-guide.pdf; Commonwealth Department of Social Services, Multicultural Language Services Guidelines, 2013, https://www.dss.gov.au/settlement-services/programs-policy/settle-in-australia/language-services; Australian Commission on Safety and Quality in Healthcare, Australian Charter on Healthcare Rights, 2008. The Commonwealth Department of Immigration and Citizenship,

Multicultural Language Services Guidelines for Australian Government Agencies, 2013 set out a range of situations in which a credentialed interpreter should be engaged, including when a client requests an interpreter, indicates a preference to speak in another language, or nods or says 'yes' to all comments and questions – at page 27; The Australian Charter of Healthcare Rights stipulates that 'communication', or 'the right to be informed about services, treatment, options and costs in a clear and open way' as one of the seven charter rights .

[xlv] Victorian Department of Health and Human Services. *Language services policy*. Victorian Government: Melbourne, 2017. https://dhhs.vic.gov.au/publications/language-services-policy

[xlvi] Victorian Multicultural Commission. "Standards and Guidelines." Accessed 2 July 2019. https://www.multicultural.vic.gov.au/projects-and-initiatives/improving-language-services/standards-and-guidelines

[xlvii] Victorian Department of Health. *Cultural responsiveness framework: Guidelines for Victorian health services*. Rural and Regional Health and Aged Care Services, Victorian Government, Department of Health: Melbourne, 2009.

[xlviii] Ryan, Jennifer, Samantha Abbato, Ristan Greer, Petra Vayne-Bossert, and Phillip Good. "Rates and predictors of professional interpreting provision for patients with limited English proficiency in the emergency department and inpatient ward." *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 54 (2017): 0046958017739981.

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[l] Reported in Foundation House, Promoting the engagement of interpreters in Victorian health services, 2013, page 116.

[li]Australian Government Department of Health. "Medicare Benefits Schedule (MBS) Review." https://www.health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce

[lii] Available on request.

[liii] Victorian Foundation for Survivors of Torture, Promoting the engagement of interpreters in Victorian Health Services, 2013, page 52.

[liv] Victorian Department of Health, Cultural responsiveness framework: Guidelines for Victorian health services, 2009, page25.

[lv] Victorian Department of Health and Human Services, Language services policy, 2017, page 26.

[lvi] Victoria's 10-year mental health plan, page 21.

[lvii] They include Canada, the USA, the UK and Denmark. Many of these are members of the International Rehabilitation Council for Torture Victims, which is a network of more than 160 rehabilitation centres in over 70 countries – see https://irct.org/who-we-are/about-the-irct.

[lviii] Victorian Auditor- General's Report, *Child and Youth Mental Health*, June 2019; Victorian Auditor-General's Report, *Access to Mental Health Services*, March 2019.

[lix] Victorian Auditor- General's Report, *Child and Youth Mental Health*, June 2019, page 43.

[lx] Access to Services for Refugees, Migrants and Asylum Seekers, page 34.

[lxi] Ibid page 20.

[lxii] Ibid.

[lxiii] Victorian Department of Human Services, Victoria's Mental Health Services Annual Report 2017-18, page 59.

[lxiv] Victorian Government Department of Health and Human Services. *Victorian Population Health Survey 2016: selected survey findings.* Melbourne: State of Victoria Department of Health and Human Services, 2018. Accessed 5 July 2019. https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/victorian-population-health-survey/victorian-population-health-survey-2016

[lxv] Ibid.

[lxvi] "Bridging the Gap: partnerships for change in refugee child and family health." Murdoch Children's Research Centre. Accessed 5 July 2019. https://www.mcri.edu.au/bridging-the-gap

[lxvii] Australian Commission on Safety and Quality in Health Care. "National Statement on Health Literacy – Taking action to improve safety and quality." Accessed 2 July 2019. https://www.safetyandquality.gov.au/publications/health-literacy-national-statement/

[lxviii] Victorian Auditor-General's Office. *Audit on Access to Mental Health Services*. Melbourne: 2019, page 14. https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf