fasstt
The Forum of Australian Services for Survivors of Torture and Trauma

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SUBMISSION TO THE SENATE SELECT COMMITTEE ON MENTAL HEALTH

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INTRODUCTION

The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) welcomes the opportunity to make this submission to the Select Committee on Mental Health.

We have examined the Committee's Terms of Reference and this submission selectively addresses items directly relating to the work of FASSTT agencies with survivors of torture and trauma. Recommendations are made in relation to these items.

BACKGROUND

FASSTT is a network of eight not-for-profit agencies – one in each state and territory - that respond to the needs of survivors of torture and trauma who have come to Australia from overseas (the majority through the Federal Government's Refugee and Humanitarian Program). Member agencies seek to address the impact of torture on the individual, the family and the community through health assessment and referral, information provision, counselling and advocacy, training of other service providers, research and service innovation. The agencies have been delivering these services for between nine and 17 years and their work is considered to be expert nationally and internationally.

FASSTT agencies are currently the principal contractors to the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) to provide

Early Health Assessment and Intervention (EHAI) services to refugees in the initial period of their settlement. We are the only agencies funded by DIMIA to provide mental health care to people released from immigration detention on health grounds. FASSTT agencies also receive a small amount of funding through the Department of Health and Ageing's (DHA) Program of Assistance to Survivors of Torture and Trauma (PASTT) to provide services to survivors over the medium to long-term period of their settlement. PASTT funding is also used to build the capacity of other service providers to respond to the needs of survivors of torture

During the last decade, Australia has resettled over 110,000 people through its Humanitarian Program. The Government has recently increased this program to 13,000 people per year. As such, refugee and humanitarian entrants represent a growing population sector.

It is estimated that world-wide up to 35%of refugees have been physically tortured or psychologically violated[1]. In Australia, the Victorian Foundation for Survivors of Torture found that 80% of refugees they assessed in 2003/4 had experienced psychological or physical violence of some kind[2] while a study of refugees who settled in NSW found that 25% had been subjected to severe trauma and torture[3].

Research suggests that this is a particularly vulnerable group for health disorders of different kinds[4]. A majority of these entrants have physical and mental health problems related directly to torture experiences or trauma associated with their refugee experience. For example, clinical studies have found that between 39% and 100% of refugees suffer from post traumatic stress disorder (compared to 1% of the general population)[5] while 47-72% of refugees suffer from depression[6].

Thousands of these entrants have been clients of FASSTT agencies.

RESPONSE TO COMMITTEE TERMS OF REFERENCE

Principles

FASSTT members believe the following key principles should underpin the delivery of mental health services to survivors of torture and trauma:

- Early health intervention for refugee and humanitarian entrants is crucial in ensuring positive outcomes for medium and long-term settlement in Australia.
- Case management and referral services for newly arrived refugee and humanitarian entrants with complex and multiple health needs should become the primary focus of the Commonwealth's investment in humanitarian settlement.
- The Commonwealth should continue to place emphasis on recognising and responding to the particular health needs of refugee and humanitarian entrants who have experienced torture and trauma.
- Specialist torture and trauma services should continue to augment the capacity of mainstream service providers to respond to health needs of humanitarian arrivals, with emphasis by FASSTT services on complex case management, capacity building and sector development focused within the health, community and education sectors.
- Specialist torture and trauma services should continue to develop and implement culturally appropriate support strategies (including community development) for newly arrived refugee and humanitarian entrants.

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[1] R Baker, 'Psychosocial consequences of tortured refugees seeking asylum and refugee status in Europe', in M Basaglu (ed), *Torture and its consequences: current treatment approaches*, Cambridge University Press, Glasgow, 1992, p85.
[2] Victorian Foundation for Survivors of Torture, *Annual Report 2003/4*, Melbourne, 2004, p11.
[3] R Iredale, C Mitchell, P Rogelia and E Pittaway, *Ambivalent welcome: The resettlement experiences of humanitarian entrant families in Australia*, Centre for Multicultural Studies, University of Wollongong, NSW, 1996, p40.
[4] UNHCR, *Refugee resettlement: an international handbook to guide reception and integration*, UNHCR and VFST, Melbourne, 2002, p233.
[5] K Allden, Paper presented to the International Conference for the Reception and Integration of Resettled Refugees, Sweden, 2001.
[6] C Gorst-Unsworth and E Goldenberg, 'Psychological sequelae of torture and organised violence suffered by refugees from Iraq: trauma related factors compared with social factors in exile', *British Journal of Psychiatry*, vol. 172, 1998, pp90-94; MA Simpson, 'Traumatic stress and the bruising of the soul' in J P Wilson and B Raphael (eds), *International Handbook of Traumatic Stress Syndromes*, Plenum Press, New York, 1993, pp667-684.

- Service agreements should reflect the responsibilities of funded agencies to develop methods for successful collaboration and communication, including establishing effective referral mechanisms.
- Each FASSTT agency operates within a state/territory-specific context that requires flexibility across the country in service delivery models and strategies for integration with mainstream health providers.
- Services in rural and regional areas require a higher level of resourcing than those in metropolitan centres
- Torture and trauma related service delivery requires a professional, flexible and rigorous approach based on demonstrated expertise that is commensurate with the complexity of the nature of the work in this field.

Discussion

For ease of reading, the remainder of this submission is organised in response to specific items from the Committee's Terms of Reference.

a. the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress.

Our comments in regard to this term of reference are limited to PASTT, which comes under the National Mental Health Strategy. This program was initially created in 1995 in response to needs identified by FASSTT agencies. PASTT is designed to improve access to mainstream services for survivors of torture and trauma with high needs (case studies of such survivors can be found at Attachment One). It delivers direct service to survivors in the form of medium to long term counselling and case management. PASTT supports survivors at any time after their entry into Australia and regardless of the visa class under which they enter (although the majority have entered under the Refugee and Humanitarian Program).

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

While considerable achievements have been made by FASSTT agencies using PASTT funding, the Program is under-resourced to meet the increasing demand for services. This demand is generated by a number of factors including:

- the success of EHAI services;
- the recent increase in numbers in the humanitarian program and shift in proportion of refugee entrants (who tend to have higher service needs);
- changes in caseload type (for example, there has been a significant increase in the number of African clients and Temporary Protection Visa holders); and
- the particularly complex nature of trauma experienced by recent arrivals.

PASTT funding has been "frozen" (with only CPI increases) since the establishment of the program ten years ago. In 2003/4 this program received approximately $1.6 million nationally.

Since the inception of the PASTT contracts, not only has demand for the service increased, but costs have also increased significantly above CPI, particularly in terms of award salary rates and insurance costs.

The level of funding forces FASSTT agencies into a reactive rather than proactive position. For example, we recognise the need to develop, in addition to conventional one-to-one interventions, a range of community based interventions in response to the needs of certain client groups (for example African clients). However some FASSTT agencies are struggling to maintain existing services levels, making it difficult to work in a developmental way. Instead, resources that ideally would be spent on training and sector development particularly in regional and rural areas get diverted into acute responses – particularly, in some states, with respect to the needs of clients holding Temporary Protection and Bridging visas.

Recommendation:

- That funding available under PASTT be increased to at least $3 million nationally.

b. the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

The adequacy of various modes of care for people with a mental illness varies across States and Territories, with significant deficiencies in certain areas in certain states. For example, in Queensland community mental health services are overwhelmed and can only provide ongoing care to those with a diagnosable mental illness and in some regions only to those with specific illnesses such as bipolar disorder. In South Australia the mental health system is grossly under resourced and struggles to meet the needs of 'mainstream' clients, let alone those with special or complex needs. In most States and Territories mental health services are not appropriately resourced to provide continuity of care and culturally sensitive assessment and interventions.

In all States and Territories there is now a significant proportion of the population who have particular needs as a result of trauma impacts from their refugee or refugee-like experience. All mental health service providers whether in the acute or community sector need to be more aware of the needs of refugee survivors of torture and trauma (see response to item f below for more discussion of these needs). For example, practices such as the use of restraints, placing distressed individuals in isolation and forcibly administering medication replicate torture and other experiences that have led to trauma. This greatly increases the level of an individual's distress and potential retraumatisation. Working with such survivors requires specialist skills to recognise their specific needs. Failure to recognise these needs compounds the failures of the mainstream mental health system to deliver coordinated continuity of care.

Recommendations:

- That resources are made available to ensure better responsiveness to patients with different cultural backgrounds especially where diagnosis is complicated by cross-cultural factors and co-morbid conditions of chronic PTSD, and communication barriers to a comprehensive assessment.
- That torture and trauma services continue to play a significant role in the treatment and rehabilitation of survivors of torture and trauma and in building the capacity of other service providers to provide appropriate care to this group.

c. opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;

In some States, mainstream mental health services rely heavily on the specialist torture and trauma service to meet all the mental health needs of people from refugee backgrounds. Rather than working cooperatively to provide different aspects of care and to develop expertise in working transculturally, some mainstream services see the involvement of a torture and trauma service provider as an opportunity to move a client from mainstream caseloads.

In addition to providing direct services FASSTT agencies have a major role in developing expertise in the delivery of treatment and rehabilitation services to refugees and torture and trauma survivors. We also have a role in promulgating this expertise to the rest of the mental health sector. The major barrier to our ability to implement this role has been limited Commonwealth funding.

Recommendation:

- That resources be made available to ensure proper support for coordinated care involving more than one agency

e. the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;

Unmet needs in each of these areas are a significant barrier to mental health outcomes. For example, a particular problem for our client group is supported accommodation. Many of our recently arrived clients, as a result of their refugee status, do not have family and community support structures. If such a client requires treatment in a mental health facility, supported accommodation after their release from the facility is vital if lasting improvement in their mental health status is to be achieved. Accessing such supported accommodation is difficult, if not impossible.

We are also witnessing increasingly stringent eligibility criteria for welfare and social support services and the loss of a range of services with “open doors” or drop in facilities. This means that only extremely ill and dysfunctional (ie suicidal or violent) clients can receive any assistance. People whose mental health is deteriorating but who are still relatively functional have nowhere to go. In addition, because of the high demand for services, regulations about continuing eligibility for service are narrowly and harshly applied. This results in all marginalised groups effectively being excluded from service or receiving disrupted and inconsistent service because agencies can no longer afford to provide service to people with poor coping skills. This particularly affects torture and trauma survivors who often don't understand what is required of them and have difficulties with a range of circumstances such as dealing with bureaucracies, going out in public, or opening official looking letters.

Recommendation:

- That support be made available for ongoing case management of clients with multiple needs so that there is adequate access to related services and the capacity to monitor and respond to often changing needs.

f. the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;

Refugee and humanitarian entrants, particularly survivors of torture and trauma, have particular needs and should be considered as a special needs group. These needs arise from the fact that their circumstances are characterised by the following:

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

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

The profile of the refugee and humanitarian population is constantly changing and will continue to change in the future because the make up of this group is reactive to conflict situations around the world. It is essential therefore to maintain specialist torture and trauma services so that we can continue to develop new service approaches based on an understanding of the broad impacts of torture and trauma.

Recommendation:

- That refugee and humanitarian entrants, particularly survivors of torture and trauma, should be included as a special needs group. Within this group there a number of subgroups with particular needs. These include:
  - holders of Temporary Protection Visas
  - asylum seekers (including those on bridging visas and those in immigration detention)
  - children
  - unaccompanied minors
  - women
  - sole parents with large families

j. the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;

Through our work we have particular experience of Immigration Detention facilities. These facilities have a custodial rather than a therapeutic focus which often results in security being emphasised at the cost of care. This makes it an extremely stressful environment which serves to aggravate existing mental disorders arising from pre-existing trauma. In particular the isolation and the indefinite nature of detention under the constant threat of forced deportation is highly corrosive of mental health. The fear and anxiety combine to negate and overwhelm normal coping capacities creating a spiral into mental disorder.

Detention centre staff have little experience of, or training in, recognising or working with mental disorders and can be unsympathetic and unskilled in their management strategies. When disorders manifest the custodial response is to manage the behaviour by placing the individual in isolation under surveillance which in turn exacerbates the problem.

Individuals who are suffering from a mental disorder and held in detention are not able to secure the benefit of early interventions because their presenting behaviours tend to be viewed as adjustment disorders arising from their incarceration rather than trauma related. The longer symptoms persist without appropriate intervention, the less potential there is for remission.

Requests to provide an independent psychiatric examination have frequently been met with the assertion that internal services are adequate and there is no need for independent assessment or intervention. Visiting professionals are treated with suspicion instead of as a valuable resource integral to the overall care and support of the detainees. Policies and procedures that are security focused militate against the development of the trusting relationship in a safe environment that is essential to the therapeutic relationship.

Recommendations:

- That community based mechanisms of surveillance are always preferable to detention.
- That independent psychological assessment of those in detention is critical.
- That while acknowledging the difficulties of creating a therapeutic environment within a custodial setting it is nonetheless important to minimise harm. The therapeutic environment must be appropriate, for example it should have minimal surveillance to allow privacy.
- That counselling services should be independent of (ie not provided by) the custodial organisation.
- That counselling should be readily available.
- That geographic and social isolation also aggravates symptoms. Access to friends, family and external professional supports should be encouraged.

o. the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards;

Data collection, outcome measures and quality control are essential for monitoring and evaluating mental health services. The development and maintenance of such systems is resource intensive and this should be recognised in funding agreements. While FASSTT agencies all collect data about their clients this information is not nationally consistent.

We have sought funding from the Department of Health and Ageing to establish a national database to report on the health status and outcomes of torture and trauma survivors however funding has not been forthcoming.

While it is important to ensure that accountability requirements support compliance to national standards, it is also important to ensure that these requirements are not so rigid that they stifle innovative responses and the ability to tailor services to the needs of the clients. Such innovation and tailoring are essential to provide effective services to client populations with diverse needs such as refugees.

Recommendations:

- That the cost of developing information systems is taken into account and factored in to reporting requirements.
- That funding be provided for the establishment of a comprehensive national database for FASSTT agencies to allow national reporting about the mental health needs and outcomes of survivors of torture and trauma.

p. the potential for new modes of delivery of mental health care, including e-technology.

There is significant potential to address the needs of people in rural and regional areas through the use of new technology. Given DIMIA's policy of increasing regional settlement of refugee and humanitarian entrants this is likely to be an important area in the future in relation to torture and trauma services. Video linking is already quite advanced in some states and has been used effectively. However resources are needed to make it more accessible and train practitioners in its use. It also needs to be matched with in-person support – the technology is useful for assessment, but does not meet the requirements of ongoing therapeutic support.

Recommendations:

- That appropriate resources are devoted to the establishment of new modes of delivery of health care
- That e-technology approaches are not used exclusively but are combined with in-person support

ATTACHMENT 1

Case Studies of FASSTT Clients

Case Study One

Malika is a 23 year old woman from the Horn of Africa, who arrived in Australia 5 years ago with her husband and baby who is now 6 years old. She has had two more children, now aged three years and two years. She was referred to a FASSTT agency by an African community worker and she became a client of the PASTT program. Her presenting problems were severe panic attacks, marked sleep disturbance, inability to eat, prolonged periods (up to hours) of being unaware of her surroundings, and suicidal thoughts which she feared. There were several causes for her marked symptoms. Her flashbacks and nightmares were of the horrors she had witnessed during her flight out of her country- the rape and torture of her mother by bandits and witnessing several mass murders. She was also extremely worried about her mother and brother who were still in the refugee camp and subjected to discrimination because of their minority status. She felt responsible for their well-being and guilty about her own comparatively safe circumstances.

Case plan priorities were her dissociative states during which time her children were unsafe and her suicidal ideation. Through intensive counselling she learnt ways to control the triggers for her anxiety and to distinguish past danger from current fears. As her symptoms improved, advocacy became the focus. She was referred to a legal service who provided her with advice about sponsoring her family and how to assist her family in the meantime. Her symptoms have improved markedly, her confidence has grown and she is active in advocating on her own behalf.

Case Study Two

A teacher noticed a 15 year old girl in the classroom who was withdrawn and had scarring on her hand which she was trying to hide. The teacher contacted the FASSTT service in her state who arranged through the school to seek permission to speak with her parents. Her parents had in fact been killed and she was living with her relatives who had recently arrived. The young girl was assessed as depressed and suffering severe post traumatic stress disorder symptoms. She had witnessed her mother's face blown off in a sniper attack and suffered burn injuries. She formed a close relationship with the Early Intervention counsellor-advocate, with whom she was able to share her grief. He was able to find a suitable school work-experience placement for her, something she had been dreading and he facilitated a referral to a plastic surgeon. These interventions led to an immediate improvement in active participation at school. Her guardians were offered support which they felt they did not need but they supported the assistance being provided to their niece.

Case Study Three

A 30 year old woman from the Srebrenica region in Bosnia-Herzegovina was referred for longer term counselling under the PASTT program.

She had been imprisoned for ten days by Serbian soldiers and subjected to mock executions, rape, and other physical and psychological abuse. She escaped with the help of a Serb neighbour. Prior to her capture, the client spent two years in the Srebenica region under siege. Over 40,000 people were crowded into the enclave where most had little food or water, no fuel and were exposed to constant shelling. The client witnessed the death of her boyfriend by shell fragments. The client also lost a number of relatives, and her youngest brother who is still "missing" is presumed to have been killed in the Srebenica exodus and subsequent massacre.

She was seen in the EHAI program and multiple problems were identified. Her physical problems included amenorrhea and migraine headaches. Medical examination revealed high blood pressure and blood cell changes suggestive of cancer. Psychologically, she felt extremely socially isolated, wanting no contact with her own community and having no friends or relatives in Australia. She suffered intrusive symptoms, hyperarousal, nightmares, generalised anxiety and depressed affect.

Initial interventions included housing advocacy, counselling so that she could see a gynaecologist, and referral to a Bosnian speaking GP and psychiatrist who prescribed anti-depressants. Once her fear of social contact was reduced, she was provided with information about the Bosnian Women's choir and attended group sessions. Other volunteer support was also accepted. A Bosnian speaking PASTT counsellor-advocate was immediately able to take up the case from EHAI. The handover was a smooth one, the EHAI counsellor having prepared the client for the program transition.