

**NSW Service for the Treatment and
Rehabilitation of Torture and Trauma
Survivors (STARTTS)**

**Submission to the Australian Senate
Community Affairs Committee Inquiry into
Mental Health Services in Australia**



August 2007

Background to STARTTS

The NSW Service for the Treatment and Rehabilitation of Torture & Trauma Survivors (STARTTS) is a state-wide NSW Health service, established in 1988, that responds to the needs of torture and trauma survivors who have migrated to Australia, most under the Australian Government's Refugee & Humanitarian Program. STARTTS seeks to address the impact of torture and trauma on the individual, family and community through health assessment and referral, information provision, counselling, community development, advocacy and training of other service providers. Funding is provided primarily by the NSW Department of Health, the Federal Department of Health & Ageing and the Department of Immigration & Citizenship, the latter for assessment and short to medium term counselling intervention under the Integrated Humanitarian Settlement Strategy (IHSS). Under the latter, the agency provides assessment and intervention services to newly arrived people arriving under Australian Refugee and Humanitarian Program. STARTTS also provides mental health care to people released from immigration detention on health grounds.

During the last decade, Australia has resettled over 110,000 people through its Humanitarian Program. At present, the Offshore Program has 13,000 places per year, 6,000 for people classed as refugees and 7,000 for the Special Humanitarian Program (SHP), including onshore protection grants. Currently around 3,500 applications for Protection Visas are lodged per annum, most from people living in the community. The vast majority of these (80%) are approved by Department of Immigration and Citizenship (DIAC) at initial application, which means that the majority of on shore applications are judged to be refugees (DIAC: 2007).

It is estimated that world-wide, up to 35% of refugees have been physically or psychologically tortured (Baker R: 1992). STARTTS has found at the stage of initial health needs identification, 29% of those assessed had post traumatic stress disorder as a consequence of their torture and trauma experiences. Over the last 10 years the number of clients assisted by STARTTS has continued to rise, with approximately 6,000 clients assisted in 2006.

As a consequence of these experiences, STARTTS' clients typically experience a range of health problems. Physical health difficulties occur due to factors such as physical torture, malnutrition, lack of capacity to maintain oral health, while mental health symptoms associated with torture and the refugee experience are also common. These include depression, anxiety, sleep disorders (particularly nightmares), intrusive thoughts and flashbacks, memory and concentration problems, feelings of guilt (survivor's guilt), loss of self esteem, social isolation, suicidal attempts, difficulties in social functioning and marital and family disruption (Allodi, et al., 1985; RCT, 1985; Bendfeldt & Zachrisson, 1985; Goldfeld, et al., 1988; Codepu, 1989; Lira, & Weinstein 1984; Gonsalves, 1990; Fischman, 1990; Barudy, 1989, cited in Jorge A & Coello M: 1994).

There is significant ongoing demand for our services, reflected in our waiting list of approximately 148 and a wait time of 3-6 months for adults. Children aged under 18 years are seen in 3-4 weeks.

Inquiry Terms of Reference (TOR)

STARTTS understands that the Australian Senate Community Affairs Committee is to inquire and report with reference to the following TOR:

1. “Ongoing efforts towards improving mental health services in Australia, with reference to the National Action Plan on Mental Health agreed upon at the July 2006 meeting of the Council of Australian Governments (COAG), particularly examining the commitments and contributions of the different levels of government with regard to their respective roles and responsibilities.
2. That the committee, in considering this matter, give consideration to:
 - a. the extent to which the action plan assists in achieving the aims and objectives of the National Mental Health Strategy;
 - b. the overall contribution of the action plan to the development of a coordinated infrastructure to support community-based care;
 - c. progress towards implementing the recommendations of the Select Committee on Mental Health, as outlined in its report *A national approach to mental health – from crisis to community*; and
 - d. identifying any possible remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness.
3. That the committee have access to, and have power to make use of, the evidence and records of the Select Committee on Mental Health.”

Our comments are primarily confined to matters with regard to these TOR that are relevant to our clients, who are refugees who are torture and trauma survivors. As this group are in most cases from culturally and linguistically diverse (CALD) communities, some of our comments are also relevant to CALD communities more broadly, particularly newly arrived communities. Broader matters, such as funding for mainstream mental health services, are also touched on briefly due to impacts on our clients.

Comment on TOR 1

STARTTS acknowledges the increased commitment of the Australian Government and the State & Territory Governments to address mental health issues, apparent in COAG’s July 2007 agreement to the *2006-2011 National Action Plan on Mental Health*. New funding and an emphasis on improved coordination and community care that comes with this initiative, goes some way to addressing the historic underfunding of mental health within Australia. In their 2004 report, Hickie et al discuss the underfunding of mental health in Australia in comparison with other Organisation of Economic Cooperation and Development (OECD) countries, and cite Australian Institute of Health and Welfare (AIHW) data indicating that funding of mental health in Australia increased by only .2% in the nearly 10 years between 92-93 and 01-02. They also note that underspending on mental health occurs in terms of the total health burden that it represents, with relation to other diseases. As The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) noted in its submission to the 2005 Select Committee Inquiry on mental health, “in most States and Territories mental health services are not appropriately resourced to provide continuity of care

and culturally sensitive assessment and interventions” (FASSTT submission to Senate Select Committee: 4).

Promotion, Prevention & Early Intervention

- While supporting the overall directions of the Plan, we note that under Promotion, Prevention & Early Intervention, there is no mention of work in any jurisdiction with culturally and linguistically diverse (CALD) communities, including refugees, although work with a number of other population groups is mentioned.
- Under this heading there is a need to do more with regard to public information and education for CALD communities, including refugees, on mental health risk factors, how to prevent mental illness and promote mental health, and how to seek assistance. This education should include a focus on overcoming the stigma associated with mental illness, which can prevent refugees who are torture and trauma survivors from accessing mental health specific services. Working in collaboration with refugee communities to dispel myths is one solution.

The provision of information and education on mental health issues is particularly important for refugees as additional factors come into play including cultural distance from the mainstream for a large proportion of recent arrivals, high rate of exposure to torture and trauma, potentially resulting in a higher rate of mental health problems, lack of knowledge of Australian systems and processes and lack of trust in Government and health professionals.

- The treatment of CALD communities, including refugees, should be culturally sensitive and appropriate. A scope of therapeutical approaches would be determined by the culture, religion and clients’ habits and has to be perceived within the cross-cultural counselling framework in order to achieve greater therapeutical outcomes. In addition, the treatment has to take into account the impact of torture and trauma on mental health and the socio-political context including settlement difficulties and racism.
- Strategies need to be developed including further translation of information in all relevant language groups and innovative ways of educating communities, especially new and emerging communities and newly arrived refugees. The translated information needs to take into account the different understandings of mental health in different cultures. Strategies also need to be developed to reach new arrivals who are not literate in their first language.
- STARTTS staff have indicated that the provision of information about gender based services, such as the Immigrant Women’s Health Service, is important for refugees. This information should be developed, translated into relevant community languages and disseminated to communities.
- There is a need for early intervention and prevention programs that target newly arrived young refugees, who are at risk of developing mental health and behavioural problems, and contact with the juvenile justice system.

Integrating and improving the care system

- There is a need for improved referral from mainstream health services, including mental health services, to a specialist agency such as STARTTS, to better respond to the mental health needs of refugees who are torture & trauma survivors. Improved training of mainstream health workers is needed to assist them to recognise & respond appropriately to this client group.

Participation in the community & employment, including accommodation

- The social disadvantage and economic marginalisation experienced by people with a mental illness identified in the Plan, is greatly exacerbated for refugees who are torture & trauma survivors, due to a range of factors. Refugees may not have completed basic education in their country of origin, may lack English language skills, and may also suffer from a range of physical and mental health problems that make it difficult for them to find and maintain employment. Like other CALD migrants, they may also face difficulties having their qualifications recognised in Australia. For these reasons effective community support for our client group and their carers is particularly important, particularly assistance in finding employment, undertaking further education and training and obtaining suitable accommodation. STARTTS staff emphasise that the lack of suitable, affordable accommodation for our client group, particularly through the social housing system, is particularly severe, and exacerbates mental health difficulties.
- As FASSTT pointed out in their submission to the 2005 Inquiry, unmet needs in the areas of supported accommodation, employment, family and social support services are significant barriers to mental health outcomes. Despite some improvements in the accommodation area through the Housing Accommodation and Support Initiative (HASI), these issues remain current.

Coordinating Care

- The Government has announced two new initiatives for people with severe mental illness and complex needs who are most at risk of falling through gaps in the system. They will be offered a clinical provider and a community coordinator from Commonwealth and/ or State funded services. We support these new initiatives, however believe that it is important that refugees who are torture and trauma survivors be one of the target groups to have access to this service. Clinical and community coordinators for this group would ideally be bi-lingual, have an understanding of the issues affecting torture and trauma survivors, and should be prepared to work cooperatively with multicultural service providers.

Governments Working Together

- The Plan announces the establishment of Mental Health Groups in each jurisdiction. It is our view that these Groups should include representatives from relevant organisations, such as Multicultural Mental Health Australia at a Commonwealth level, and Transcultural Mental Health Centres at the state and territory level, plus carers, consumer groups and other relevant NGOs. This type of representation is important in order that the needs of CALD communities,

including refugees, are adequately represented. One role for these Groups is to consider how effectively the *National Mental Health Plan 2003-2008 in Multicultural Australia* is being implemented in each jurisdiction.

Increasing Workforce Capacity

- There is a need for improved training for General Practitioners (GPs), dentists, specialists, nurses & mainstream mental health workers in working with refugees who are torture and trauma survivors, including training & improved strategies to encourage the use of accredited interpreters. This need is not recognised in the Plan.
- It has been suggested by our staff that while community mental health teams generally have a good level of cultural awareness, pressure of a large workload and understaffing may mean that all the needs of the client are not taken into account. Staff have also noted that in areas where there is a high turnover of mental health staff, cultural awareness training should be given high priority, particularly in Local Government Areas (LGAs) with high CALD populations.
- To reiterate the point made by FASSTT in its submission to the previous mental health inquiry by the Select Committee, “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” (FASSTT submission to Senate Select Committee on Mental Health: 2).

Commonwealth Implementation Plan

- We are pleased to note the announcement of community based programmes to help families cope with mental illness, and that these projects will include a particular focus on CALD communities. In order that these programs are expertly delivered, they should be delivered by Non Government Organisations (NGOs) with experience working with CALD communities, including refugees, in the mental health area.

NSW Implementation Plan

Our comments are confined to the NSW Implementation Plan only.

General

Although the increased expenditure on mental health by the NSW Government announced in this Plan is to be welcomed, gaps in the funding of mental health promotion, prevention and service provision, as discussed by Hickie et al, still exist.

Notwithstanding the merit of the initiatives announced by the NSW Government, we note that there are no specific initiatives that relate to CALD communities, including

refugees, nor are issues of relevance to these groups included in any of these announcements. The suggestions below attempt to address this absence.

Promotion, Prevention & Early Intervention

24 hour Mental Health Access Phone line

- We note that the NSW Government will provide funding for a mental health telephone advice, triage and referral service. It is important that this phone line provide access for CALD clients, including refugees, by making arrangements for the provision of appropriately trained bi-lingual counselling staff and interpreter services. Centrelink Multilingual Call Centre is a good model.

Integrating & Improving the Care System

- **Specialist Mental Health Services for Older People**

Consideration should be given to how these facilities will be made accessible to older CALD clients, including refugees, for example through the appropriate training of staff and use of interpreters.

- **Establishing Psychiatric Emergency Care Centres**

The establishment of these care centres at major metropolitan hospitals should be accompanied by the training and capacity building of staff in appropriate ways of responding to refugees who are torture and trauma survivors during periods of acute mental illness. As FASSTT indicated in the submission referred to above “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” (FASSTT submission to Senate Select Committee: 4)

Specifically practices such as use of restraints, placing distressed individuals in isolation & forcibly administering medication may replicate torture and lead to re-traumatisation. Specialist torture & trauma services need to play a role in building capacity of mainstream services to provide appropriate care, in addition to playing a significant role in their own right in the treatment and rehabilitation of torture and trauma survivors.

These comments apply not just to new psychiatric emergency care centres but to all psychiatric facilities.

Participation in the Community & Employment, including Accommodation

- **Housing Accommodation & Support Initiative (HASI)**

HASI is a positive initiative, however consideration should be given to targeting a number of support packages available under HASI to CALD people with mental health problems, including refugees.

We support the Multicultural Mental Health Australia recommendation to the Senate Select Inquiry, that supported housing needs to cater to the specific needs of CALD communities in areas such as language, (provision of bi-lingual staff and translated material), diet and be sensitive to the needs of clients for gender specific services and staff, for example.

Increasing Workforce Capacity

- **Mental Health Workforce Programme**

The Mental Health Workforce Programme should incorporate training for health professionals in working with CALD communities, including refugees who are torture and trauma survivors. In regard to the latter, training can be provided by specialist services such as STARTTS. Training should also include familiarisation with the use of interpreters, and NSW Health policy in this regard. In addition STARTTS has the potential to provide clinical supervision to mental health staff dealing with torture and trauma survivors to decrease effects of secondary traumatisation and prevent burn out. Unfortunately the capacity to do so within existing resources is limited.

As Multicultural Mental Health Australia has argued, an increase in cultural competency training is needed to increase the recognition of the impacts of culture on mental health and improve the capacity of mainstream mental health and general health services to respond appropriately and provide culturally appropriate services for CALD mental health consumers including refugees.

Cultural competency training should also be incorporated into Mental Health in the Tertiary Curricula, which targets registered nurses.

TOR (2) (a) Extent to which Plan addresses aims & objectives of Mental Health Strategy

Overall Aims- Consumer rights

The aims of the Strategy include “to assure the rights of people with mental disorders”. Although this issue is not the focus of our comment, a consideration of the Plan in relation to the Strategy leads to the conclusion that development of strategies to address and ensure consumer rights and civil liberties are notably absent from the Plan, at least from the overview provided on pages 1-6, and the individual implementation plans of the Commonwealth and NSW. Given the emphasis on the issue of protecting consumer rights in the Strategy, this absence is puzzling and warrants investigation.

Because of the added disadvantage experienced by clients of our service in dealing with the mental health system for reasons such as torture and trauma experiences, being newly arrived and lacking knowledge of the health system, potential English language difficulties, and cultural barriers, respect for consumer rights is particularly important for this group.

Linking mental health services with other sectors

The Strategy identifies the importance of cooperation between mental health services and the various programs and services needed to enable people with severe mental problems and disorders to participate more fully in community life (e.g. access to housing, accommodation support, community and domiciliary care, income security and employment and training opportunities).

- While some improvements have occurred in this area, for example through the HASI program, there are still a range of gaps for clients of our service with ongoing mental health problems. Access to affordable accommodation with support, through programs such as HASI that involve the allocation of public housing, remains inadequate. This is within the overall context of inadequate commonwealth support for the public housing system, to the extent that it can not meet legitimate demand, prompting the narrowing of eligibility criteria in jurisdictions such as NSW so that housing is effectively restricted to people in extreme poverty with multiple problems.
- In addition, changes to Commonwealth income support eligibility through 'Welfare to Work' have placed added pressure on clients with mental health problems, due to changes in eligibility for the Disability Support Pension as well as eligibility for Parenting Payment. Difficulties some of our clients face when trying to fulfil their work obligation have the potential to lead to loss of payments through breaching, with severe impacts such as destitution.
- We also understand that there is limited support for our clients through Job Network providers due to the lack of services specific to refugees and humanitarian entrants as well as lack of training on refugee and more general CALD issues among those providers. It is acknowledged that the Department of Employment and Workplace Relations (DEWR) conducted a successful refugee project trial with two job network providers in Sydney. It is likely that STARTTS clients would benefit from the availability of similarly structured approaches by DEWR.
- Lack of access to English language courses for new arrivals due to restrictions on hours available, a 5 year limit on accessing these courses under settlement programs and high demand for TAFE places, plus difficulty having overseas qualifications recognised and lack of Australian work experience, compounds difficulties for our client group.

Service Mix

CALD/ NESB as special needs group

Under this heading the Strategy places some emphasis on the importance of adequate resources being made available within the mental health system at a state and area basis, and more broadly, to meet the needs of special 'at risk' groups, one of which was identified as people from Non-English Speaking Background (NESB), referred to in this submission as Culturally and Linguistically Diverse (CALD) communities. We feel that the recognition of the importance of meeting the needs of this group is not carried through as strongly within the Plan, both at a Commonwealth or NSW level, but seems to have been lost. There remain considerable gaps in meeting the needs of this group at a State level, identified in this submission and submissions to this and the previous Senate mental health inquiry, from Multicultural Mental Health Australia and the Forum of Australian Services for Survivors of Torture & Trauma (FASSTT) (latter attached).

For example a gap identified by STARTTS staff in response to this Inquiry is the availability of diagnostic instruments in relevant languages and access to pre-trauma mental health history, for example when making differential diagnosis (co-morbidity/ existing pathology or pre-trauma). This creates a barrier when clients could potentially be referred to specialists for neuro-psychiatric assessment within the health system, however the fact that language and cultural experience is absent is a barrier to referral. To address this, staff have suggested that a national register/ resource of translated and proven instruments be developed and promoted. However the importance of training and mentoring in the use of these tools has also been identified, with the suggestion that a module could be provided by the appropriate professional body.

Planning for special needs groups

An objective identified under this heading is that each jurisdiction and area/ region have a plan that takes account of the needs of special needs groups. In 1999, NSW Health published *Strategic Directions in Refugee Health Care in NSW*. This Plan should now be reviewed, evaluated and updated, in consultation with relevant agencies. Also, all Area Health Services should develop their own Refugee Health Strategies based on the State Directions.

In addition, as identified by Multicultural Mental Health Australia, we understand that implementation of the *Framework for the Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia* has not been ideal in all jurisdictions. In order for appropriate planning to occur for CALD communities including refugees, it is important that this Framework is rolled out in all jurisdictions. Any review and reworking of *Strategic Directions in Refugee Health Care in NSW* should take this Framework into account.

Provision of adequate accommodation & community based services

In the context of de-institutionalisation, the Strategy establishes as an objective the provision of adequate alternative arrangements such as adequate accommodation and community based services. While improvements have occurred through programs such as HASI, there remains a lack of options in this regard for clients, particularly clients who require culturally appropriate support and services such as refugees. These issues are discussed above.

Promotion and Prevention

The Strategy recognises ‘immigrant populations’ and socially disadvantaged families as particularly at risk of developing mental health problems, and identifies the need for primary, secondary and tertiary preventive programs for at risk groups. There remains a lack of preventive programs that specifically target CALD communities, including refugees, and are specifically designed to meet the needs of refugees who are torture and trauma survivors. These issues are not addressed in the Plan.

Primary Care Services and Mental Health Workforce

Objectives of the Strategy include ensuring education for primary health care professionals, including within curriculum and continuing education, that incorporates adequate coverage of mental health issues.

While the Plan does recognise the importance of such training, there is a lack of recognition of the need that such training include the development of basic cultural competency in responding to the needs of CALD clients, and include a basic understanding of the mental and physical health issues of refugees who are torture and trauma survivors, including appropriate responses and referral options. Education on the use of interpreters and the importance of doing so, including duty of care, is also lacking.

The same specific training is needed within the mainstream mental health workforce, but this is also not identified in the Plan.

TOR 2 (b) The overall contribution of the action plan to the development of a coordinated infrastructure to support community-based care.

We are not able to comment on this matter.

2 (c) Progress towards implementing the recommendations of the Select Committee on Mental Health, as outlined in its report *A national approach to mental health – from crisis to community*.

We confine our comments to recommendations 76- 81 of this report, under the heading CALD communities and refugees.

Recommendation 76 3.67

That state and territory mental health services provide CALD consumers, their carers and families with information on their rights under state and territory legislation in an understandable manner appropriate to their language and culture.

- As far as we are aware there has been a lack of significant progress in regard to implementation of this important recommendation.

Recommendation 77 3.68

That the Australian Government review funding levels to providers of mental health services to refugee communities, to ensure those levels reflect the high levels of need amongst this population.

- This recommendation has been addressed to the extent that additional funding has recently been provided for the Commonwealth Program of Assistance for Torture & Trauma Survivors, and increased recurrent funding of \$3 million promised by the Department of Health and Ageing under this Program. STARTTS will need to monitor if this additional funding enables us to meet the demand for our services outlined in this submission.

Recommendation 78 3.69

That appropriate assessment protocols for CALD consumers be developed and disseminated to increase the capacity of primary care providers to detect and manage the early signs and symptoms of mental health problems and mental illness.

- As discussed above under CALD as a special needs group, there is a lack of appropriately translated diagnostic instruments and staff in mainstream mental health services with the competence to use these.

Recommendation 79 3.70

That culturally specific mental health services be developed in partnership between all levels of government, migrant resource centres and other organisations, including the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT).

- As far as we are aware this recommendation has not been implemented. This was not a recommendation put forward by FASSTT in their submission to the 2005 Inquiry.
- In NSW a culturally specific mental health service already exists in the form of the NSW Transcultural Mental Health Centre. While it is important for services such as this to exist, it remains vital that mainstream mental health services regard it as their responsibility to pick up and provide services to CALD clients, including refugees. Mainstream mental health services should work cooperatively with specialist services such as STARTTS and the NSW Transcultural Mental Health Centre to provide different aspects of care, and develop expertise in working cross-culturally.
- We also understand that specific Transcultural Mental Health positions have been created within district health services in Queensland, but not in other jurisdictions.

We support Multicultural Mental Health Australia's call for this model to be rolled out in other states and territories.

Recommendation 80 3.71

That funding be provided to develop and disseminate throughout CALD communities translated information delivered in a variety of media about early signs and symptoms of mental health problems and mental disorders, where to get help and how to provide support.

- As far as we are aware, and as discussed above, there has not been significant progress in regard to implementation of this important recommendation.

Recommendation 81 3.72

That there be a review of health care policies for the delivery of health care for refugee and asylum seekers in both the Australian community and Australian run detention centres, with a view to developing more culturally sensitive and comprehensive policies and standards that recognise the complex needs of asylum seekers; and there be consideration of providing access to Medicare rebates during refugee determination processes.

- There has been some progress made in developing health policies for asylum seekers in detention, in the context of the recently established Detention Health Advisory Group (DeHAG), which comprises representatives from key professional associations and from specialized services with relevant expertise. DeHAG was recently involved in the development of a set of Health Standards for use in detention centres that will act as a guide to providers of health services to people in detention, including psychological services. These standards have been co-badged with the Royal Australian College of General Practitioners (RACGP) (RACGP: 2007). We understand that other policies on health, including mental health, that will influence the way health services are provided to people in detention are currently in draft form, but will later be made publicly available. It is imperative that DIAC continues to have a constructive relationship with DeHAG that results in the implementation of changes to policies and procedures recommended by DeHAG. It is also imperative that such changes are widely publicised.
- In addition, some progress has also been made in developing health policies for people from refugee backgrounds in the community, but more needs to be done. For example, the Multi-Jurisdictional Refugee & Humanitarian Working Group has developed a working paper on 'Rural and Regional Settlement of Refugees-Health Related Issues' and on the 'Education Needs of General Practitioners and other health workers providing services to refugees and asylum seekers', both with a series of recommendations. We understand that these papers have not yet been endorsed by the Australian Government. In addition, the Refugee Health Service, has recommended that the *NSW Health Strategic Directions in Refugee Health Care in NSW*, developed in 1999, should be reviewed, however this proposal has also not yet been approved by the NSW Department of Health.

- Our most up to date information indicates that there are still significant problems in regard to access to Medicare for asylum seekers during processes of refugee determination. People on bridging visas without work rights and those who do not have a spouse, child or parent who is an Australian citizen or permanent resident, do not have access to Medicare. Our staff emphasise that there remains a need for additional financial support for clients, and better access to medical, including dental services.
- People on Temporary Protection Visas (who are unauthorised arrivals who have been successful in their application for refugee status) have access to Medicare, but are ineligible for a range of other government services and benefits (i.e. not eligible for most DIAC funded services such as those provided by Migrant Resource Centres; only have access to special benefit in terms of income support, not eligible for federally funded English language programs, and have no family reunion rights; full tertiary fees imposed effectively excluding access). We believe that all of these exclusions are also significant, and have been documented to have an adverse impact on mental health and social well-being, (Momartin et al: 2006). The fact that people from refugee backgrounds must apply for another Temporary Protection Visa (TPV) after 3 years leaves them in a limbo situation, and the ban on family reunion is particularly detrimental to mental health.
- As a consequence, we strongly recommend that asylum seekers on Bridging Visas have access to Medicare and that the category of Temporary Protection Visa be abolished in the interests of the mental health of people from refugee backgrounds. People who have been judged to be refugees by the Australian Government should be granted permanent residency, and later if they wish, have ready access to Australian Citizenship. We understand that DIAC is in the process of undertaking a review of bridging visas, but that this has not been concluded in a timely fashion

(2) (d) identifying any possible remaining gaps or shortfalls in funding and in the range of services available for people with mental illness

A range of gaps and shortfalls in funding and services for refugees who are torture and trauma survivors, are identified above throughout this submission. Other specific issues and further elaboration of points touched on above is provided below:

1. There is a need to build the capacity of mainstream mental health and general health services, in part through the employment of bi-cultural staff, to address and respond appropriately to the mental health needs of people from refugee backgrounds. However we are aware that the mental health system is overstretched to extent that it is able to respond mainly to acute care needs, and that makes it more difficult for the mental health system to address the needs of our client group. Adequate funding of mainstream mental health services is required.

Our staff indicate that mental health services in rural areas are limited in their expertise in working with people from CALD and refugee backgrounds and that services are not adequately accessible. A range of strategies are needed to address this, including cultural competency training, providing regular clinical supervision

and support and upskilling of staff. However the limited time staff can be released for training, and the lack of rural mental health workers are barriers. Strategies need to be put in place to recruit and retain rural mental health staff.

2. There is also a need for training/ capacity building with general practitioners to work with refugees on mental health and other health issues (pg 14 FASSTT supplementary submission).
3. Unmet needs in supported accommodation, employment, family and social support services remain important barriers to improved mental health outcomes for our client group and were not listed in CALD/ refugee recommendations of the Select Committee. There is a lack of supported accommodation for our client group following release from a mental health facility. To address this we reiterate the FASSTT 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 changing needs” (FASST submission to Senate Select Committee Inquiry: 5).
4. There is a need for additional funding for mental health promotion and education for small and emerging communities particularly where issues of literacy in their own language are significant.
5. Better networking between agencies would lead to improved referral pathways and coordination of care. STARTTS staff have indicated that improved relationships with agencies such as domestic violence counselling services and drug and alcohol services would enable clients to be referred to these services before they commence torture and trauma counselling.
6. There is a need for improved support for older clients with torture and trauma issues who may have been in Australia many years but still require ongoing support and treatment. There is also a need to adequately resource the capacity and knowledge base of specialised Torture and Trauma services in working with this client group.
7. There is a need for improved and better coordinated support for children and young people, who may have been traumatised themselves or who are suffering from secondary traumatisation. This should occur through interagency partnerships that involve both specialised mental health services, the school system and youth services.
8. Although a number of changes have been made and are in the process of being made to the health care of people in detention, as discussed above, we would reiterate the following recommendations made in the FASSTT submission to the Senate Select Committee Inquiry on this issue:
 - “That community based mechanisms of surveillance are always preferable to detention”.
 - That independent psychological [and psychiatric] 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 (i.e. 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”
- (FASSTT submission to Senate Select Committee Inquiry: 7).

(3) That the committee have access to, and have power to make use of, the evidence and records of the Select Committee on Mental Health

Given the relevance of the evidence and records of the Select Committee on Mental Health to the current Inquiry, particularly material related to the report *A national approach to mental health- from crisis to community* (April 2006), it is only reasonable that the Community Affairs Committee should have access to them. This would enable the Committee access to information likely to result in improved consideration of relevant issues and thus enable it to produce a better report and recommendations than would otherwise be the case. We attach submissions made to the Select Committee wide-ranging 2005 Inquiry into mental health by The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT), of which STARTTS is a member, for the information of the Committee. Many of the issues raised in this submission remain relevant, and we would ask you to give them your consideration.

We also note that a Government Response to the 2005 Inquiry is not yet available and believe that it would be timely for a response to its recommendations to be released, particularly in the light of the current Inquiry that is being undertaken by the Community Affairs Committee.

References

Australian Health Ministers (1995) *National Mental Health Policy/ Strategy*, Commonwealth of Australia,
[http://www.health.gov.au/internet/wcms/publishing.nsf/Content/BF4CF02AE1033BF1CA25722200119A23/\\$File/policy.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/BF4CF02AE1033BF1CA25722200119A23/$File/policy.pdf).

Baker R, 1992, ‘Psychosocial consequences of tortured refugees seeking asylum and refugee status in Europe’, in M Basaglu, (ed), *Torture and its consequences: current treatment approaches*, Cambridge Uni Press, Glasgow: 85.

Council of Australian Governments (COAG), (2006), *National Action Plan on Mental Health 2006-2011*,
<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-pubs-n-plan03>

Department of Health and Ageing (2004), *Framework for the Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia*, National Mental Health Strategy, Commonwealth of Australia,
<http://www.mmha.org.au/mmha-products/books-and-resources/framework-for-the-implementation-of-the-national-mental-health-plan-2003-2008-in-multicultural-australia>.

Department of Immigration and Citizenship (2007), *Presentation at Practitioner Information Forum*, July 2007, Sydney.
Forum of Australian Services for Survivors of Torture and Trauma, (FASSTT), (2005), *Submission to the Senate Select Committee on Mental Health*.

Hickie I, Groom G, Davenport T (2004), *Investing in Australia's Future: the personal, social and economic benefits of good mental health*,
http://www.mhca.org.au/Publications/documents/1.Introduction_IIAF.pdf.

Jorge A & Coello M, (1994) *Towards a systematic approach for the treatment rehabilitation of torture and trauma survivors in exile*, <http://www.startts.org/>.

Momartin S, Steel Z, Coello M, Aroche J, Silove D, Brooks R, (2006), 'A comparison of the mental health of refugees with temporary versus permanent protection visas', *Medical Journal of Australia*, Vol 185, No 7, 2 Oct 2006: 357- 361.

Multicultural Mental Health Australia, (MMHA), (2005), *Submission to the Senate Select Committee of Inquiry into Mental Health Services*.

NSW Health Department, (1999), *Strategic Directions in Refugee Health Care in NSW*, <http://www.health.nsw.gov.au>.

Royal Australian College of General Practitioners, (RACGP), (2007), *Standards for health services in Australian immigration detention centres*, RACGP, Melbourne.

Senate Select Committee on Mental Health, (2006), *A national approach to mental health- from crisis to community, Final Report*
http://www.aph.gov.au/Senate/committee/mentalhealth_ctte/report02/report.pdf