WITNESS STATEMENT OF KYLIE SCOULLAR

I, Kylie Scoullar, General Manager Direct Services at Foundation House, of 4 Gardiner Street, Brunswick in the State of Victoria, say as follows:

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

2 On 5 July 2019, Foundation House made a submission to the Royal Commission into Victoria's Mental Health System. I refer to and adopt that submission. Attached to this statement and marked **KS-1** is a copy of that submission.

What is your background and experience?

3 I have a Bachelor of Arts (Psychology) and Master of Business Administration (Senior Executive MBA) from Melbourne University. I also have a Graduate Diploma in Applied Child Psychology and Master of Applied Science (Psychology) from RMIT University and a Diploma of Frontline Management from Swinburne University of Technology.

4 I am currently employed by Foundation House as General Manager, Direct Services. I have been in that role since October 2018. This position is a key member of the Agency Management Team (the Executive) of Foundation House and oversees the delivery of quality services across Victoria to clients of a refugee background who are survivors of torture or other traumatic events. I was also employed by Foundation House from January 2014 to April 2015 as the Child, Adolescent and Family Program Leader.

5 Other than in respect of Foundation House, other roles I have held previously have included:

(a) Director Strategic Development and Planning, Mackillop Family Services (May 2017 to October 2018)

(b) Manger, Child and Youth Mental Health Service, Eastern Health (May 2015 to April 2017).

(c) Invited Expert, Child and Adolescent Mental Health Information Development Expert Advisory Panel (2010 to 2015).

(d) An authorised member of the Quality Assurance Committee with the Victorian Office of the Chief Psychiatrist to conduct two clinical mental health reviews (2010 and 2011).

(e) Various roles at The Royal Children's Hospital Mental Health Service from 1995 to 2013. These roles have included a mental health clinician/psychologist within a community team based in multicultural St. Albans); team leader roles; the Program Manager Hospital Consultation & Liaison Mental Health Service; and Community Mental Health Manager. Given the cultural diversity of the catchment across Western and some of Northern Metropolitan Melbourne, clients and families of refugee background were part of our cohort.

6 Attached to this statement and marked '**KS-2**' is a copy of my CV.

What is Foundation House and what does your role involve?

7 Foundation House is a not for profit organisation established in Melbourne in 1987. It provides services to advance the health, wellbeing and human rights of people of refugee backgrounds in Victoria who have experienced torture or other traumatic events in their country of origin or while fleeing those countries.

8 Specifically, Foundation House provides the following services:

(a) Client services – for example, counselling (for individuals, groups and families), advocacy on behalf of clients and community-based psychoeducation. The psychoeducation sessions are deigned to help new arrivals understand the impact of trauma. Foundation House also offers a Mental Health Clinic where bulkbilling psychiatrists, not employed by Foundation House, offer clinical services including prescribing medication if necessary.

(b) Work with communities to build their capacity to identify vulnerable persons of refugee background, interpret their needs, help people access appropriate services and support the recovery of community members – we refer to this as 'community capacity building'.

(c) Professional and organisational development, consultancy and resources to assist health, education, employment and other community service providers to 'capacity build' (ie, to enhance the responsiveness of their services to the needs of people of refugee backgrounds). We focus on those areas given that they have high contact with refugee populations.

(d) Work with the Victorian and Commonwealth Governments to help them develop and implement policies and programs that properly regard the needs of people with refugee backgrounds.

(e) Research regarding the needs of people with refugee backgrounds and the best possible way of meeting those needs.

9 Foundation House is a state-wide agency with over 200 staff across five main locations in Victoria. Our Head Office is located in Brunswick. Our Metropolitan Offices are located in Dallas (Northern), Dandenong (South Eastern), Ringwood (Eastern) and Sunshine (Western). We also provide services in partnership with other agencies in Ballarat, Bendigo, Geelong, Mildura, Shepparton, Swan Hill and the Latrobe Valley.

10 Foundation House is a member of the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) and the International Rehabilitation Council for Torture Victims (IRCT).

11 Foundation House is funded by the Victorian and Commonwealth Governments, charitable organisations and donations from private individuals. Most of the funding comes from the Commonwealth Government. Philanthropic funding allows Foundation House to conduct research and other activities that are not funded by government.

12 My primary role at Foundation House in my current position as General Manager Direct Services is to oversee the delivery of quality services to clients of a refugee background who are survivors of torture or other traumatic events. Those services consist of trauma counselling (individual, family and group), advocacy (individual and community), complementary therapies, community capacity building and the Mental Health Clinic. I also contribute to the strategic direction of Foundation House and lead the governance of Direct Services. Direct Services is the largest area of activity at Foundation House.

13 I also contribute to the development of publications and training programs (both internal and external). For example, in my previous Foundation House role (as Child, Adolescent and Family Program Leader) I developed training programs on (a) refugee mental health, (b) impacts of trauma and (c) context specific responses and interventions for primary and secondary schools and primary health (including general practitioners, community health, refugee and maternal and child health nurses). I am also part of our Executive Practice, Innovation and Knowledge Committee which oversees research, evaluation and practice innovation for Foundation House.

How prevalent are mental health issues among persons with a refugee background?

14 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 – eg, they may vary in terms of the level of exposure to trauma and what protective factors (eg social support and family) are evident; and (b) the methodologies used in those studies.

15 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) 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.[1] 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.

(b) 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.[2]

(c) 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.[3] That is nearly three times greater than the incidence rate among the native born Swedish population.

(d) In a recent 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).

Broadly, what is their level of engagement with the mental health system as compared with the general population?

16 In terms of utilisation rates in Victoria, there isn't data available about this specifically with respect to refugees. Previous reports by the Victorian Transcultural Psychiatry Unit (now known as the Victorian Transcultural Mental Health) have found that immigrant

[1] 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.
[2] Tinghög, P., Malm, A., Arwidson, C., et al. (2017). Prevalence of mental ill health, traumas and postmigration stress among refugees from Syria resettled in Sweden after 2011: a population-based survey, *BMJ Open*, *7*:e018899. doi: 10.1136/bmjopen-2017-018899.
[3] 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.

and refugee communities have lower rates of access to public community and inpatient mental health services than the general population.[4]

17 Although not refugee specific, international studies of immigrant populations in settlement countries show lower utilisation rates of mental health services than the general population.[5]

18 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.'*[6]

19 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*.'[7] In my view, those 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.

20 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.[8]

21 Based on my experience, I would expect that the utilisation rates of persons with a refugee background would be even lower than CALD (culturally and linguistically diverse) or NESB (non-English speaking background) persons generally.

What are some of the barriers for persons of refugee backgrounds to access and seek treatment within the mental health system?

22 Stigma is a significant barrier reported in research by us[9] and others and in consultations with community members. For example, if the words 'mental health' are

[4] Klimidis, S., Lewis, J., Miletic, T., McKenzie, S., Stolk, Y., & Minas, I. H. (1999). *Mental health service use by ethnic communities in Victoria: Part II, statistical tables*. Melbourne: Victorian Transcultural Psychiatry Unit.
[5] 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.
[6] Victorian Auditor-General's Report. (2019, June). *Child and Youth Mental Health*, p. 80.
[7] Victorian Auditor-General's Report. (2019, June). *Child and Youth Mental Health*, p. 80.
[8] 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.

in the name of a service provider, a person of a refugee background will often be reluctant to use that service.

23 With respect to young children, often their families will not want them to access mental health services. This is an issue of stigma but also shame as the parents blame themselves for their child's problems.

24 Another barrier is that in some cases persons with refugee backgrounds are afraid of doctors and authority figures and do not trust them. In some cases, doctors have been a part of the trauma perpetrated upon the person in their country of origin.

25 Other barriers include the inability to travel to mental health services and previous negative experiences with health care professionals.

26 Humanitarian entrants arrive in Australia with permanent residency and, in some cases, they do not want to disclose mental health issues as they fear it will be accessible to the immigration authorities and interfere with their ability to sponsor family members to join them in Australia or become citizens.

27 Likewise, asylum seekers are often reluctant to disclose any mental health issues because of concern that it may be accessed by the immigration authorities and put at risk their visa status and applications for protection as refugees.

In what ways can these barriers be addressed?

28 There are a number of ways in which these barriers can be addressed. The following are some examples.

29 With training and support, people drawn from refugee and CALD communities can effectively bridge the gap between the communities and the service providers – this would help to increase access by increasing knowledge of services, lessen stigma and build trust.

30 Foundation House holds psychoeducation classes for new arrivals in community health centres, TAFEs or adult education centres – this helps to destigmatise mental health. These activities also have the ancillary benefit of helping to 'capacity build' the TAFE or adult education centres. For example, in some cases, TAFEs/adult education centres have developed their own programs to support refugee students.

31 More outreach services (in the person's community or in their home) are needed. Foundation House does this, for example, with clients who are newly arrived – this is

[9] Valibhoy, M., Kaplan, I., & Szwarc, J. (2017). "It comes down to just how human someone can be": A qualitative study with young people from refugee backgrounds about their experiences of Australian mental health services. *Transcultural Psychiatry*, *47*.

part of our early intervention work and to ensure access for women who may not be able to travel to receive care/treatment.

32 Collaboration between Foundation House and mental health providers (such as the Child and Adolescent Mental Health Service in Victoria (CAMHS)) has helped some of our clients to overcome stigma and receive treatment. That has been achieved by, for example, arranging for the client to attend CAMHS sessions at Foundation House (along with their trusted Foundation House counsellor), which is an environment they are comfortable with.

What are the specific needs of persons with a refugee background when engaging with the mental health system?

33 Specific needs arise from the:

(a) nature of the mental health problem (including its potential basis in the experience of trauma) and associated stressors; and

(b) interactions with the mental health system.

Nature of mental health problem and associated stressors

34 The key need in this respect is that the diagnostic process, assessment of the person and the subsequent care must be trauma informed – ie, they must inquire into and consider whether trauma has caused the mental health issues or is affecting recovery.

35 By way of example:

(a) I am aware of a trauma survivor who 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 forced to eat terrible things 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. In a pressured mental health system, there is not always capacity to take on other considerations and this can lead to a misdiagnosis.

(b) I am also aware of a student in a school who was referred onto a mental health service by the school because he showed depressive symptoms. His history was not initially taken and he was treated for depression. However, it was only later discovered that this student had lost both parents, had witnessed his mother be killed by a bomb, and as a result had developed PTSD among other problems. Without active work to identify these issues, and without assessment through a trauma informed lens, these issues would have been missed.

(c) I am also aware of a woman who presented with severe postnatal depression who was being treated in the mental health system but without significant progress. When she became a client of Foundation House, it was uncovered that the woman had experienced a child dying as an infant, cradled in her arms, during a bomb blast. Because of our involvement and trauma focussed treatment, the woman was well supported through her next pregnancy and birth. In addition to effective support for her, attention was given to the issues arising around attachment and her fears of being close to her babies - the attention to these issues helped to strengthen the family system and potentially prevent the development of mental health difficulties for her children.

(d) Based on Foundation House's study into young people of refugee backgrounds using mental health services,[10] we found that some of those people found it difficult to implement the advice provided by practitioners (eg to focus on 'relaxation') when they were worried about the safety of their family who remained in the country of origin (eg worried about a sister who had nothing to eat and was in hiding). Unless practitioners are aware of the issues in that country of origin (which is not always the case) or of the family separation, the treatment proposed may not be effective. This is why it is crucial to inquire into history of trauma.

36 The asylum seeker process also poses distinctive stressors in terms of the effects of protracted detention and the very long processing times. Also, the language of mental health disorders is insufficient to describe the complete powerlessness, loss of hope, the degradation and utter shattering of assumptions about human decency experienced by people who were transferred to Manus Island and Nauru for extended periods and subsequently transferred back to Australia to receive health care that could not be provided at the Regional Processing Centres. In order to provide effective care, mental health professionals need to be able to identify whether the person they are treating has a history of detention or has experienced traumatic events while in detention.

37 Temporary protection visas also cause other specific stressors which include that persons subject to them have no right to family reunification.

38 Persons of refugee backgrounds (like other people too) also need protective factors to help with their mental well-being and recovery from mental illness – this includes support from family and the community, but those things may be lacking because of their experiences.

[10] Valibhoy, M., Kaplan, I., & Szwarc, J. (2017). "It comes down to just how human someone can be": A qualitative study with young people from refugee backgrounds about their experiences of Australian mental health services. *Transcultural Psychiatry*, *47*.

39 With respect to children and adolescents, it is important for mental health providers to understand that schooling for this group may have been affected in their country of origin where there has been protracted conflict and displacement and that they may have been traumatised by events such as violent death of family members and actual or feared kidnappings. There are also barriers to participating in school in Australia, for example, parents' lack of knowledge about the school system.

40 There is a growing body of literature recognising complex trauma – in the sense that many domains of functioning are affected (eg attachment issues, relationships, modulation, social skills, cognitive skills and identity formation) – and that the effects of complex trauma are cumulative without protective factors in play (eg family and community supports, and tailored interventions).

41 It is also relevant that the refugee experience can affect the capacity of families to help children develop and to protect them from the adverse effects of life events. This is particularly the case when parents or care-givers experience trauma symptoms themselves.

42 As additional language learners, children and young people of refugee backgrounds may take up to 7-10 years to achieve academic English.[11] If language issues are not addressed, they may become more 'at risk' in terms of social inclusion and mental health.

43 Both children and adults of refugee background also commonly experience racism and discrimination, which has a particularly high impact in adolescence.

44 People of refugee background also often experience family conflicts and strains – for example, in relation to the change in family roles after settlement, reduced capacity of parents to offer emotional support, financial difficulties and other general day to day cultural transitions.

Interaction with the mental health system

45 Trauma survivors are especially sensitive to how they are treated. Treatments need to be respectful and culturally responsive. This includes understanding the conflict involved in juggling two different cultures and considering culturally based explanations about mental health and views about treatment.

[11] Cummins, J. (2008). BICS and CALP: Empirical and theoretical status of the distinction. In B. Street & N. H. Hornberger (Eds.), *Encyclopedia of language and education* (2nd ed., Vol. 2: Literacy, pp. 71-83). New York: Springer Science+Business Media LLC.

46 They also need to be believed about their stories, if they do open up. If a mental health clinician doesn't believe what the client tells them, minimises it or avoids it, that can cause real harm.

47 There needs to be effective communication between mental health professionals and persons with refugee backgrounds – this means that health services must engage qualified interpreters when required and translate health information / documentation. That does not always occur and there is no data on the frequency with which services and practitioners do not engage qualified interpreters.

(a) For example, as set out in the Foundation House submission to the Royal Commission,[12] a community member whom Foundation House consulted for the purposes of informing the Royal Commission, commented *'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*'.

(b) I am also aware of a woman who presented at an Emergency Department as highly distressed with psychotic symptoms and a likely deteriorating mental state. Her pre-arrival history included being raped and her husband and son being captured. When she was finally assessed at the Emergency Department after waiting several hours, no appropriate interpreter was provided and at the last moment a male security guard was pulled into the session to act as interpreter.

(c) I am also aware of a torture survivor who was unwell, highly distressed and traumatised and required ambulance transport to a hospital for a mental health admission. In the absence of an appropriate interpreter, ambulance officers tried to explain the process to him by shouting. Being shouted at, in a language one does not understand, at a time of high distress and vulnerability would have been significantly re-traumatising for this man who had a history of torture and detention.

48 Family centred approaches are key. Families play a big part in decisions that need to be made about treatment – eg whether to take medication or continue sessions with a mental health professional.

[12] See page 26.

How can the mental health system change or improve its approach towards people with refugee backgrounds?

49 These recommendations, which align with the Foundation House submission to the Royal Commission, are based on my knowledge and understanding of the needs and experiences of people with refugee backgrounds, their interactions with the mental health system, and my 20 years' experience in clinical and management roles within the Victorian mainstream clinical mental health system.

50 As recognised in Victoria's 10 year Mental Health Plan, trauma informed care and practice should be incorporated across the mental health system, with an independent process for assessing compliance which includes feedback from service users and their families.

More research and policy guidance is necessary to ensure that trauma-informed principles and practice are effectively embedded in mental health and other human services

Attached to this statement and marked '**KS-3'** is a copy of the Foundation House 'Integrated Trauma Recovery Service Model' dated 2016.

51 Specific training should be provided to health care providers about how to identify someone with a refugee background and consider whether they may have suffered from torture. A checklist of what to look for and ask about should be incorporated into mainstream mental health services. That knowledge can have a big impact on whether effective treatment is provided.

52 Mental health services should be culturally responsive and should provide holistic care for people with refugee backgrounds, including taking a more family-centred approach.

53 There needs to be coordination between mental health services and other services – eg schools, maternal health services, legal services, settlement services and employment services. The capacity of those mainstream services needs to be built to work with trauma affected individuals and families.

54 Victorian Government funding and design of the mental health service system should explicitly support the roles of specialist services (eg Foundation House) in complementing the work of mainstream services, and require greater collaboration between those specialist and mainstream services.

55 The Victorian Government should provide funds to build and extend the capacity of community-based (psychiatry oriented) mental health clinics. With respect to the Mental Health Clinic at Foundation House, that was established because our clients were often

unable to obtain appointments at other more mainstream mental health services to which they had been referred and experienced challenges accessing private bulk-billed psychiatry given lack of availability.

56 In order to reduce stigma and build mental health literacy, the State should provide recurrent funding for community-based involvement – for example, advisory groups, community liaison workers and programs co-designed with community using bicultural workers to engage in mental health promotion and increase awareness of services. It is also important to ensure that programs are designed to be sustainable, in that they continue to have effect after funding ceases.

57 Appropriate use of interpreting and translation services across all mental health services needs to be assured, with strengthened data, monitoring and governance systems to effectively and transparently track this.

58 I also recommend that research be conducted into the mental health outcomes of persons from refugee populations and how this compares to the general population. Whilst there is some data on mental health outcomes for persons of a refugee background (for example, there is considerable evidence for trauma informed treatments being effective in terms of symptom reduction), there is no data available which compares that to the general population.

sign here ▶ 

print name Kylie Scoullar

date 16 July 2019