Forum of Australian Services for Survivors of Torture and Trauma

Submission to the Productivity Commission: Mental Health and Suicide Prevention Agreement Review

March 2025

Introduction

The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) welcomes the opportunity to contribute a submission to the Productivity Commission's final review of the National Mental Health and Suicide Prevention Agreement ('National Agreement').

Our submission is informed by the specialist expertise, knowledge and experience of our member agencies accumulated through our work with refugee survivors of torture and other trauma. We provide further details about our work and the clients and communities we work with within the opening sections of this submission.

The submission then focusses on selected matters within the Productivity Commission's scope of the inquiry, specifically the following matters as outlined in scope of the inquiry:

a. The impact of mental health and suicide prevention programs and services delivered under the National Agreement to Australia's wellbeing and productivity

b. The effectiveness of reforms to achieve the objectives and outcomes of the National Agreement including across different communities and populations

c. The opportunities under the National Agreement to adopt best practice approaches across Australia, particularly where productivity improvements could be achieved

On (a) and (b) of the scope of the inquiry, we provide our responses in relation to the following matters:

- The inclusion of refugees as a priority population group in the National Agreement
- Addressing the mental health needs of people seeking asylum in Australia
- Considerations of other national strategies of significance and relevance to the National Agreement, with reference to the National Suicide Prevention Strategy and the National Stigma and Discrimination Reduction Strategy
- Partnering with Primary Health Networks (PHNs) to respond to the mental health needs of people from refugee backgrounds.

And in response to (c) of the scope of the inquiry:

- Trauma-informed approaches in mental health services.

We trust our contributions will be duly considered by the Productivity Commission.

We look forward to the interim findings of the Productivity Commission and welcome further enquiries about our work or requests to elaborate on the contents of our submission.

Summary list of recommendations

RECOMMENDATION 1

FASSTT recommends to the Productivity Commission that in the conduct of its final review of the National Agreement that it includes a comparative analysis of the quantity of programs, resources and funds targeting priority population groups. This analysis should include details of programs and activities that are delivered by federal and state government services, non-government services, and those delivered in partnership with priority population community organisations.

RECOMMENDATION 2

FASSTT recommends to the Productivity Commission that future iterations of the National Agreement continue to identify priority population groups, with the continued inclusion of people with refugee backgrounds as a priority population group. This must be done alongside the inclusion of specific programs, services, or actions that address the needs relevant for each priority population group, and specify related indicators, measures, and policy or guidance in the agreement or other instruments of the agreement (eg. bilateral schedule).

RECOMMENDATION 3

FASSTT recommends to the Productivity Commission that future iterations of the National Agreement identify people seeking asylum as a priority population with distinct mental health and suicide prevention support needs. This commitment must be undertaken alongside the inclusion of specific programs, services, or actions that address the needs of this cohort, and specify related indicators, measures, and policy or guidance in the agreement or other instruments of the agreement (eg. bilateral schedule).

RECOMMENDATION 4

FASSTT recommends for the Productivity Commission to request a copy of the draft National Stigma and Discrimination Reduction Strategy from the Department of Health and Aged Care, to examine and review as an important aspect of inquiry in the final review of the National Agreement. Additionally, we ask for the Productivity Commission to give consideration to recommending that the government promptly finalise and publicly release the National Stigma and Discrimination Reduction Strategy, in the interest of maintaining accountability and transparency, as a genuine commitment to addressing mental health stigma and discrimination.

RECOMMENDATION 5

FASSTT recommends to the Productivity Commission that the future iteration of the National Agreement recognise the essential need for mental health and suicide prevention programs and initiatives to be co-designed and delivered with priority population communities to effectively address stigma and discrimination, for it to be guided by the lived-experience and cultural expertise of those communities. This complementary commitment will bolster the impact of a national strategic approach to reducing mental health stigma and discrimination.

RECOMMENDATION 6
FASSTT recommends to the Productivity Commission for the ongoing inclusion of PHNs as part of the National Agreement; retaining the initiative's localised approach to the identification of local needs and priorities, and the ability to work with stakeholders, service providers and to commission services to address the identified gaps. We ask for additional consideration to be given to the service commissioning capability of PHNs to enable the funding of longer-term interventions, and the ability to initiate joint service commissioning with neighbouring PHNs.

RECOMMENDATION 7
FASSTT recommends to the Productivity Commission that a national mental health standard on trauma-informed care is developed and implemented as a key priority of the National Agreement. This would ensure that there is a nationally consistent approach to trauma-informed care, reducing potential duplication (noting that NSW Health has developed an integrated Trauma-Informed Care Framework[1]), providing a common practice base for all services, and contributing to an improved person-centred service system.

About FASSTT

FASSTT is a network of Australia's eight specialist rehabilitation agencies that work with survivors of torture and other trauma. Most clients of FASSTT agencies have refugee and refugee-like backgrounds and have come to Australia as humanitarian entrants or as asylum seekers. There is one FASSTT agency in each state and territory.[2] FASSTT agencies seek to combat the impact of torture and other trauma on the individual, the family, and the community by:

- providing direct counselling services to individuals, families, and groups
- delivering community development and capacity building activities
- providing education and training to health and other service providers
- delivering regional, rural, and remote outreach services
- the development of resources
- advocacy and referrals to health and other services
- delivering community education and systemic advocacy.

The pre-arrival experiences of many clients include exposure to violence and loss, persecution and forced displacement, with lengthy periods in refugee camps or other places of displacement. Each person will have their own individual experiences of direct and indirect violence, however common experiences can include: prolonged harassment and intimidation, fear of threat and violence, witnessing violent acts, forced separation from loved ones, detainment and imprisonment without trial, killings and disappearances, sexual abuse or rape, attacks, raids and war. The legacy of such experiences shapes psychological and social functioning at individual, family, and community levels.

[1] Prevention and Response to Violence Abuse and Neglect Government Relations (PARVAN). (2023). Integrated Trauma Informed Care Framework: My story, my health, my future, NSW Health, St Leonards, NSW. https://www.health.nsw.gov.au/patients/trauma/Publications/itic-framework.pdf
[2] A list of FASSTT member agencies and contact details is contained in Appendix 1.

FASSTT agencies collectively work with approximately 21,000 clients each year who have been tortured or survived other highly traumatic experiences before their arrival. Of the 277,539 humanitarian entrants to Australia over the last 20 years, it is estimated that at least 46% have been enrolled in individual counselling services with a FASSTT agency at some point since settlement.[3] FASSTT agencies are regarded as expert specialists both nationally and internationally.

Common experiences of humanitarian entrants to Australia

People with refugee and refugee-like backgrounds who have come to Australia as humanitarian entrants or as asylum seekers, including survivors of torture and other trauma[4] will each have their own individual, uniquely dynamic inter-relationship of trauma, settlement, personal life and intersectional challenges that require a specialised response within the mental health service context.

The circumstances for this client cohort are commonly characterised by the following:

- extreme adverse life circumstances such as experience of war, persecution, torture, displacement and prolonged periods in refugee camps or countries of asylum prior to arrival
- limited or disrupted schooling
- family dislocation, separation, and unknown or ambiguous loss
- limited health care before arrival in Australia
- stressful nature of settlement demands, including acculturation distress
- limited employment opportunities for new arrivals
- limited social support and networks because of the small size of refugee communities and fragmentation within those communities
- cultural and language barriers to accessing mainstream health services and lack of culturally responsive service provision in the mainstream services
- for asylum seekers and people on temporary and bridging visas, uncertainty about their future status and ability to remain in Australia.

The profile of the refugee and humanitarian population in Australia shifts and changes because the make-up of this group reflects the humanitarian demands created by contemporary global conflicts and by the response and decision-making of the Australian government on the policy and composition of Australia's Refugee and Humanitarian Program.

The main groups resettled to Australia recently include,

In the offshore Humanitarian Program (2023-24):

- Afghans located in Pakistan, Iran and Türkiye
- Iraqis predominantly located in Jordan, Lebanon and Türkiye
- People from Myanmar located in camps along the Thai–Myanmar border, Malaysia and India

[3] Queensland University of Technology, Australian Centre for Health Services Innovation, Evaluation of the Program of Assistance for Survivors of Torture and Trauma, June 2022, https://www.health.gov.au/sites/default/files/2022-12/evaluation-of-the-program-of-assistance-for-survivors-of-torture-and-trauma-pastt-final-report.pdf

[4] A snapshot of torture and trauma experience of FASSTT clients is provided in Appendix 2.

- Citizens of the Democratic Republic of the Congo located in Malawi, Kenya and Burundi and
- Syrians located in Iraq, Lebanon and Türkiye.[5]

In the onshore Humanitarian Program (2022-23):

- People from Myanmar
- Citizens of China
- Citizens of Pakistan and
- Citizens of Papua New Guinea.[6]

Given the complex web of interrelated challenges faced by survivors of torture and other trauma and the frequently changing and growing client cohort, it is essential to have mental health services that comprise a mix of specialised and general services that are accessible, innovative and responsive to the needs and strengths of this diverse client cohort.

Furthermore, while the humanitarian intake changes over time reflecting global conflicts, forced displacement and geo-political dynamics, FASSTT agencies provide recovery services to those with refugee like experience regardless of their date of arrival to Australia. FASSTT agencies supported clients and communities from 99 countries of origin in the year 2023-2024 including.

- Afghanistan (27%)
- Iraq (21%) - including people of Yezidi/Ezidi ethnicity
- Syria (9%)
- Iran (7%)
- Myanmar (5%)
- Democratic Republic of Congo (3%)
- Pakistan (2%) - mainly children of parents born in Afghanistan
- Sudan (1%)
- Ethiopia (1%)
- Ukraine (1%)
- Venezuela (1%)
- Eritrea (1%)
- Sri Lanka (1%)
- South Sudan (1%)
- Somalia (1%).

Additionally, 3% of all clients supported were born in Australia as they are the children of humanitarian entrants. FASSTT agencies also began supporting people affected by the conflict in Israel, Gaza and Lebanon.

In relation to age distribution, 20.6% were under 18 years old, 9.5% were aged 18 to 25 years, 64.8% between 26 to 64 years and 4.9% were 65 years or older. Almost 61% identified as women or girls, 38% identified as a men or boys and a small number identified as non-binary or transgender.

[5] Department of Home Affairs, (2025), Australia's offshore Humanitarian Program: 2023–24, https://www.homeaffairs.gov.au/research-and-stats/files/aus-offshore-humanitarian-program-2023-24.pdf

[6] Department of Home Affairs, Onshore Humanitarian Program 2022–23, https://www.homeaffairs.gov.au/research-and-stats/files/ohp-june-23.pdf

Addressing the scope of the inquiry

Responses to matters (a) and (b) in the scope of the inquiry:

a. The impact of mental health and suicide prevention programs and services delivered under the National Agreement to Australia's wellbeing and productivity

b. The effectiveness of reforms to achieve the objectives and outcomes of the National Agreement including across different communities and populations

Refugees as a Priority Population Group

FASSTT observes that refugees together with culturally and linguistically diverse (CALD) communities are identified as one of fifteen 'priority population groups' in the *National Mental Health and Suicide Prevention Agreement* (National Agreement).[7] And relevantly, the National Agreement states that implementation of initiatives as part of the agreement or associated Bilateral Schedules will consider and support the mental health and wellbeing of the listed priority populations groups.[8] Furthermore, the National Agreement underscores the importance of improving outcomes for priority populations by stating so as one of its five outcomes:

> ***"Outcomes***
> *26. The Commonwealth and the States will work in partnership to implement arrangements for a unified and integrated mental health and suicide prevention system which will seek to:*
>
> > *(a) Improve the mental health and wellbeing of the Australian population, with a focus on improving outcomes for priority populations..."*[9]

FASSTT endorses the inclusion of refugees as a priority population group in the National Agreement and we believe that this is necessary and appropriate given the particular characteristics and needs of this cohort.

However, we express our disappointment that the National Agreement and its associated Bilateral Schedules lack specific details on programs, services, or initiatives tailored to address the needs of this priority population group. Without clearly defined measures, it is difficult to assess the direct impact of the National Agreement on refugees, particularly in relation to mental health and suicide prevention programs and services delivered under it.

There is also a critical need for stronger collaboration between the Commonwealth and State/Territory Governments to ensure better planning and support for priority populations.

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[7] At clause 111(c) of the National Mental Health and Suicide Prevention Agreement, https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-05/nmh_suicide_prevention_agreement.pdf

[8] National Mental Health and Suicide Prevention Agreement, https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-05/nmh_suicide_prevention_agreement.pdf

[9] Outcomes, 26(a), of the National Mental Health and Suicide Prevention Agreement, https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-05/nmh_suicide_prevention_agreement.pdf

We note that each Bilateral Schedule contains a standard Implementation clause – 18(c) – which states that the Parties agree to "*ensure the particular needs of vulnerable population groups [...] are addressed and services delivered in a culturally appropriate manner*".[10] However, neither the agreement nor the schedules provide details of any specific interventions or actions related to this agreed approach to implementation. There is no plan or information on how the Parties will undertake, monitor or evaluate it. And it is not included as a reporting requirement in the schedules.

Research conducted by the University of Adelaide similarly identified that there was an absence of proposed policy actions linked to specific priority population groups in the National Agreement and Bilateral Schedules.[11] This research, which was funded by the National Mental Health Commission, found that this issue was of significance because "*it provides evidence that there is no necessary connection in policy between being named as a PP [priority population] and commitments to actions to address the needs of that group*", and that this "*undermines the whole rationale of naming PPs [priority populations] in the first place.*"[12]

In the Productivity Commission's Mental Health Inquiry Report, it supported the call for improved collection and use of CALD-specific data, to help develop and target interventions, and "*facilitate future examinations of the effectiveness of programs aimed at increasing access to (and take-up of) mental health services for specific community groups.*"[13] While the National Agreement contains a range of commitments on improving data collection and sharing, it has not yet eventuated in publicly available CALD-specific datasets that can be utilised to examine the effectiveness of programs and services for the CALD and refugee priority population groups.

We note that Building a New Life in Australia (BNLA), the first Australian longitudinal study of humanitarian migrants, is a significant research project which has been able to provide some insight into the mental health of humanitarian entrants in Australia. The study investigated the settlement outcomes for humanitarian migrants and was first commissioned by the Department of Immigration and Citizenship in 2013 and is managed by the Australian Institute of Family Studies (AIFS).

In November 2024, the 10-year report of the study was released. The study provided insights on how various social determinants (such as secure and stable housing, and employment) impact upon mental health. Research from the BNLA study has shown that awareness – knowing about government services – is positively associated with help seeking for mental health problems.

The study found that "*around 3 in 10 (29%) respondents met the criteria for PTSD in the year 10 survey, which is also significantly higher than the proportion recorded in the general Australian population – approximately 5.7%*". It went on to summarise that addressing PTSD among humanitarian migrants "*requires a multifaceted approach such as enhancing access to mental health services, provision of culturally appropriate trauma-informed psychotherapy programs*

[10] The National Mental Health and Suicide Prevention Agreement, Bilateral Agreements, https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement
[11] Fisher, M., Freeman, T., van den Berg, M. and Baum, F. (2023) Priority Populations in Mental Health and Suicide Prevention: Research report. University of Adelaide: Adelaide SA.
[12] Fisher, M., Freeman, T., van den Berg, M. and Baum, F. (2023) ibid.
[13] Productivity Commission, (2020), Mental Health, Report no. 95, Volume 2, Canberra, https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume2.pdf

and peer support" and that "*[t]argeted interventions, such as comprehensive social integration services and psychological interventions, are effective in reducing postmigration stressors*".[14]

FASSTT is aware that scoping of a new longitudinal study into the settlement experiences of humanitarian migrants is commencing. This is being undertaken by AIFS and has been commissioned by the Department of Social Services. We are of the view that this presents as an opportunity to explore how a further study of this type can help deepen our collective understanding of the changes in the mental health needs of humanitarian entrants and their patterns of supports and service usage over time (and to a lesser degree, the effectiveness of those services and supports).

RECOMMENDATION 1
FASSTT recommends to the Productivity Commission that in the conduct of its final review of the National Agreement that it includes a comparative analysis of the quantity of programs, resources and funds targeting priority population groups. This analysis should include details of programs and activities that are delivered by federal and state government services, non-government services, and those delivered in partnership with priority population community organisations.

RECOMMENDATION 2
FASSTT recommends to the Productivity Commission that future iterations of the National Agreement continue to identify priority population groups, with the continued inclusion of people with refugee backgrounds as a priority population group. This must be done alongside the inclusion of specific programs, services, or actions that address the needs relevant for each priority population group, and specify related indicators, measures, and policy or guidance in the agreement or other instruments of the agreement (eg. bilateral schedule).

The need to address the mental health of asylum seekers

FASSTT is concerned that the National Agreement and the broader mental health system fails to address the mental health needs of people who are seeking asylum. Asylum seekers who spend long periods in detention suffer more severe mental disturbance[15], and those with a temporary visa have been shown to have a significantly higher risk of depression, post-traumatic stress disorder and mental health-related disability.[16]

[14] Australian Institute of Family Studies (2024), Building a New Life in Australia: 10 years of humanitarian settlement outcomes, November 2024, https://aifs.gov.au/sites/default/files/2024-11/BNLA-10-year-Report_FINAL.pdf
[15] AASW, NSW RHS, STARTTS (2022) *Working with people from refugee backgrounds: A guide for Social Workers*, https://www.startts.org.au/media/Working-with-people-from-refugee-backgrounds-A-guide-for-social-workers-2nd-Edition_2022.pdf
[16] Steel, Z., Silove, D., Brooks, R., Momartin, S., Alzuhairi, B., & Susljik, I. N. A. (2006). Impact of immigration detention and temporary protection on the mental health of refugees. The british journal of psychiatry, 188(1), 58-64.

A person seeking asylum or an asylum seeker is someone who is seeking international protection but whose claim for refugee status has not yet been determined.[17] Australia has a differential system for responding to people who seek asylum in Australia based on the person's mode of arrival. This has a resulted in a complex mesh of situations for people who are in this cohort. In a very generalised way, this includes people seeking asylum who: are awaiting the outcome of their refugee status determination; are seeking a review or intervention of a negative outcome of their refugee status determination; and/or have received a negative outcome with a final departure visa and expected to make arrangements to leave Australia. Additionally, a person seeking asylum can be subject to different detention and residence determinations across the intervening period, which includes: immigration detention, community detention, and permission to reside in the Australian community. The majority of people seeking asylum will have been issued and be a holder of a valid visa, while there is a proportion who do not hold a valid visa[18].

In Australia, people who are seeking asylum have fewer rights and access to services and support to what the general population have.[19] A person seeking asylum has no access to Centrelink social security support or payments, and depending on the type of bridging visa granted, they may not be afforded eligibility for Medicare, and the right to study or the right to work.[20] Furthermore, if a bridging visa is not renewed before the expiration because of an administrative reason or delay then any access to Medicare and work rights cease, and the person is considered to be unlawfully in Australia[21] [22], which compounds their vulnerability and heightens their anxiety and mental distress.

People seeking asylum who do not have access to Medicare, have few options for mental health support. They have no access to a mental health plan through a GP and are also not able to afford private mental health services. The often-long wait for the determination of their application for protection and the severely limited access to financial and social supports means that many people seeking asylum experience poverty and homelessness. These factors significantly impact a person's mental health and places them at higher risk of mental distress, including a higher rate of suicidal ideation and suicide.

The vulnerability to mental distress is increased by a number of contributing factors including:

- uncertainty about their future in Australia
- fear of being returned to a country where they may face harm or persecution
- previous and/or current detention centre experiences

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[17] Parliament of Australia: Parliamentary Library, *Asylum seekers and refugees: what are the facts?*, 2 March 2015

[18] This includes 112,870 who have lodged a permanent protection visa application and 9,892 people who arrived by boat, of which 7671 hold a current BVE and 2221 have no valid visa. See Department of Home Affairs, 'Unauthorised maritime arrivals on Bridging E visa – March 2024' (30 May 2024), https://www.homeaffairs.gov.au/research-and-stats/files/unauthorised-maritime-arrivals-bve-mar-2024.pdf

[19] AASW, NSW RHS, STARTTS (2022) *Working with people from refugee backgrounds: A guide for Social Workers*, https://www.startts.org.au/media/Working-with-people-from-refugee-backgrounds-A-guide-for-social-workers-2nd-Edition_2022.pdf

[20] AASW, NSW RHS, STARTTS (2022) ibid.

[21] Refugee Council of Australia, Australia's asylum policies, https://www.refugeecouncil.org.au/asylum-policies/9/

[22] UNSW, Andrew & Renata Kaldor Centre for International Refugee Law, Factsheet: Bridging Visas, November 2020, https://www.unsw.edu.au/content/dam/pdfs/unsw-adobe-websites/kaldor-centre/2023-09-factsheet/2023-09-Factsheet_Bridging_Visas.pdf

- stress associated with the refugee determination process, which for some applicants has taken close to a decade to finalise[23]
- separation from family, including not having the right to have family members join them in Australia. As well as limiting access to the protective effects of family support, anxiety and guilt about the fate of family members left behind is a common consequence of prolonged separation
- negative attitudes toward asylum seekers in the community.

The National Mental Health Commission has previously stated that *"[a]sylum seekers and refugees should have access to effective support for their mental health and wellbeing, irrespective of where they are located"* and that "*[m]aintaining connections should be a key consideration, particularly the connections between children and parents"*.[24]

Additionally, the National Mental Health Commission outlined that best practice mental health support provided to refugees and asylum seekers should be:

- *accessible – regardless of detention or refugee status*
- *trauma-informed and culturally appropriate*
- *shaped to support the needs of children in particular*
- *family-centred – seeking to maintain family connections*[25]

RECOMMENDATION 3
FASSTT recommends to the Productivity Commission that future iterations of the National Agreement identify people seeking asylum as a priority population with distinct mental health and suicide prevention support needs. This commitment must be undertaken alongside the inclusion of specific programs, services, or actions that address the needs of this cohort, and specify related indicators, measures, and policy or guidance in the agreement or other instruments of the agreement (eg. bilateral schedule).

Positioning the National Agreement alongside relevant national strategies

The National Agreement scaffolds all mental health and suicide prevention programs and initiatives supported by Commonwealth, State and Territory Governments. As such, it is of strategic importance to locate the National Agreement alongside other relevant national strategies to ensure that there is robust evolution of best practice, equitable access and consistent outcome to work toward the improved wellbeing of all people living in Australia. To this end, we reference below the National Suicide Prevention Strategy and the work to finalise a National Stigma and Discrimination Reduction Strategy.

National Suicide Prevention Strategy

The *National Suicide Prevention Strategy 2025-2035* was released in February 2025. FASSTT commends the holistic approach of the strategy and its acknowledgement that suicidal distress

[23] Refugee Council of Australia, Fast tracking and 'Legacy Caseload' statistics, Fast-track processing timelines, https://www.refugeecouncil.org.au/fast-tracking-statistics/5/
[24] National Mental Health Commission (n.d), Statement on the mental health of refugees and asylum seekers, https://www.mentalhealthcommission.gov.au/publications/statement-mental-health-refugees-and-asylum-seekers
[25] National Mental Health Commission (n.d), ibid.

arises from the interaction of social determinants and individual factors. The strategy identified that people who enter Australia as humanitarian entrants experience disproportionate impacts of suicide and have nearly twice the rate of suicide as other permanent migrants to Australia. Additionally, it noted that the self-harm rates for asylum seekers in all types of onshore closed immigration detention are many times higher than rates found in the Australian population.[26]

Whereas the National Agreement identified priority population groups, the National Suicide Prevention Strategy is structured around and focussed on addressing social and economic issues, informed by its understanding that the disproportionate rates of suicide experienced by different population groups are "*driven by disparities and inequities in social and economic circumstances, not inherent vulnerabilities*." [27]

FASSTT contributed a submission providing feedback for the public consultation on the final draft of the national strategy. We provide a full copy of this submission as a supporting attachment, as it contains matters that are relevant for the Productivity Commission's consideration in the final review of the National Agreement. We draw the Productivity Commission's attention to our recommendation that the National Suicide Prevention Strategy should recognise both the impact of social and economic determinants in conjunction with the distinct needs and vulnerabilities of people from refugee and asylum-seeking backgrounds. Without this dual focus, we are concerned that the National Suicide Prevention Strategy will fail to precipitate actions that meaningfully address the social and economic issues experienced by people from refugee and asylum-seeking backgrounds; to address these factors and reduce the risk of suicide.

National Stigma and Discrimination Reduction Strategy

The development and implementation of a National Stigma and Discrimination Reduction Strategy is listed as a 'national priority' (clause 27(g)) and a stated output (clauses 113-114) of the National Agreement. In 2020, the National Mental Health Commission was tasked with developing a National Stigma and Discrimination Reduction Strategy.[28]

Mental health stigma and discrimination is a matter of significant relevance and importance for FASSTT clients, and FASSTT agencies took up the opportunities to participate in the consultations for the development of the strategy. Refugees and people seeking asylum experience intersecting discrimination and stressors that compound their experience of mental ill-health arising from their experience of torture and other trauma involving organised violence and forced displacement.

Additionally, refugees and people seeking asylum are subject to separate and additional stigma arising from negative community attitudes towards them. People seeking asylum have been negatively and erroneously referred to as "illegals" or "queue jumpers".[29] Similar negative attitudes towards refugees also persist in Australia, influenced by the political and media

[26] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025-2035. Canberra: 2025, https://www.mentalhealthcommission.gov.au/sites/default/files/2025-02/the-national-suicide-prevention-strategy.pdf
[27] National Suicide Prevention Office. Ibid.
[28] National Mental Health Commission, National Stigma and Discrimination Reduction Strategy, https://www.mentalhealthcommission.gov.au/projects/stigma-and-discrimination-reduction-strategy
[29] Parliament of Australia: Parliamentary Library, *Asylum seekers and refugees: what are the facts?*, 2 March 2015

discussion of the government policy on stopping asylum seekers arriving by boat.[30] As mentioned above, structural impediments also exist, with people seeking asylum, in particular, having lesser rights and access to services and support than the general population.[31]

Cultures, customs and traditions of a community can contribute significantly to the stigma that surrounds mental health. A community's attitude towards emotional and psychological distress may influence the way individuals deal with it, and whether they attribute any stigma to themselves. Addressing stigma in the community is important as it can encourage those who are experiencing signs of mental health distress to come forward and seek support.

The National Mental Health Commission indicates that the draft National Stigma and Discrimination Reduction Strategy was delivered to Government in June 2023 for consideration, however, it has not been publicly released to date and there appears to be no plans to do so.[32] FASSTT agencies and clients, like the broader community, attribute a high-level of importance to addressing mental health stigma and discrimination. The significance of this piece of work was reflected similarly and apparent in the National Agreement. It is critical that this overdue important piece of work is finalised promptly and publicly released.

RECOMMENDATION 4

FASSTT recommends for the Productivity Commission to request a copy of the draft National Stigma and Discrimination Reduction Strategy from the Department of Health and Aged Care, to examine and review as an important aspect of inquiry in the final review of the National Agreement. Additionally, we ask for the Productivity Commission to give consideration to recommending that the government promptly finalise and publicly release the National Stigma and Discrimination Reduction Strategy, in the interest of maintaining accountability and transparency, as a genuine commitment to addressing mental health stigma and discrimination.

RECOMMENDATION 5

FASSTT recommends to the Productivity Commission that the future iteration of the National Agreement recognise the essential need for mental health and suicide prevention programs and initiatives to be co-designed and delivered with priority population communities to effectively address stigma and discrimination, for it to be guided by the lived-experience and cultural expertise of those communities. This complementary commitment will bolster the impact of a national strategic approach to reducing mental health stigma and discrimination.

[30] SBS News, *Australian attitudes to refugees are hardening, survey finds*, 20 June 2019, https://www.sbs.com.au/news/article/australian-attitudes-to-refugees-are-hardening-survey-finds/1f6mh7u1k

[31] AASW, NSW RHS, STARTTS (2022) op. cit.

[32] National Mental Health Commission, National Stigma and Discrimination Reduction Strategy, https://www.mentalhealthcommission.gov.au/projects/stigma-and-discrimination-reduction-strategy

Partnerships with Primary Health Networks

FASSTT agencies have had positive experiences of working in partnership with Primary Health Networks (PHNs) to respond to the mental health needs of people from refugee backgrounds. PHNs play an important role in identifying gaps and addressing primary health needs at a local level. The localised approach enables close-to-community planning and the provision of tailored and targeted approaches to address the needs that have been identified. All PHNs must operate in accordance with priority areas that are set by the Australian Government, which includes mental health as one of seven priority areas.

FASSTT is of the view that PHNs and their ability to commission services based on identified community needs, such as through the Mental Health Flexible Funding Stream (MHFFS), are important initiatives that, in our experience, has demonstrated capacity and agility to respond to identified service gaps and emergent primary health care needs of people from refugee backgrounds. The partnerships between FASSTT agencies and PHNs have facilitated the provision of a range of preventative and early intervention programs and services targeted at CALD and refugee communities, which has included but is not limited to: mental health literacy programs, group interventions for people from CALD or refugee backgrounds with intersectional needs (eg. older persons, LGBTIQA+), and community-based suicide postvention support.

There are some constraints however with the PHN model of commissioning services. A significant matter is the short-term nature of funding which impacts upon the ability to provide a sustainable service solution that is successful in achieving enduring outcomes and can meet ongoing client demand. Separately, the localised nature of PHNs means that programs that have proven to be successful and delivered at one PHN cannot be scaled-up to extend into the geographical areas of other PHNs, to address the same or similar needs experienced by the client cohort.

RECOMMENDATION 6

FASSTT recommends to the Productivity Commission for the ongoing inclusion of PHNs as part of the National Agreement; retaining the initiative's localised approach to the identification of local needs and priorities, and the ability to work with stakeholders, service providers and to commission services to address the identified gaps. We ask for additional consideration to be given to the service commissioning capability of PHNs to enable the funding of longer-term interventions, and the ability to initiate joint service commissioning with neighbouring PHNs.

Responses to matter (c) in the scope of the inquiry:

c. the opportunities under the National Agreement to adopt best practice approaches across Australia, particularly where productivity improvements could be achieved

A National Trauma-Informed Framework

FASSTT clients are survivors of torture and other trauma. Trauma-informed practice is a foundational service delivery principle, and trauma recovery is a common client-centred service objective for all FASSTT agencies. In our service context, trauma can impact clients from refugee backgrounds at multiple levels: biological, psychological and social. Taking a trauma-informed approach in our practice with clients and communities equips us to:

- understand the impact of trauma and trauma recovery pathways
- be able to recognise the symptoms of trauma in clients and their families
- avoid re-traumatising clients, for example by avoiding things (e.g. loud noise, enclosed space, etc.) that might trigger their traumatic experience
- involve clients in their treatment plan as much as possible
- support clients' self-determination by providing clear information and options for them to make informed decisions.[33]

The importance of trauma-informed approaches in mental health services is detailed in the final report of the Royal Commission into Victoria's Mental Health System:

"*Trauma is unseen. The close relationship between trauma and mental illness and the need for trauma-informed mental health treatment, care and support are starting to be recognised, but there is much work still to be done. The system needs to provide more holistic approaches for consumers and must be responsive to trauma and the potential for consumers to be retraumatised. A failing system can itself cause trauma*."[34]

The Royal Commission went on to recommend the establishment of a new statewide trauma service for Victoria to help deliver "*the best possible mental health outcomes for people who have experienced trauma*", and "*develop and deliver education and training that supports Victoria's mental health and wellbeing workforce to deliver trauma-informed care*".[35]

RECOMMENDATION 7

FASSTT recommends to the Productivity Commission that a national mental health standard on trauma-informed care is developed and implemented as a key priority of the National Agreement. This would ensure that there is a nationally consistent approach to trauma-informed care, reducing potential duplication (noting that NSW Health has developed an

[33] Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Trenton: Center for Health Care Strategies, Incorporated.
[34] State of Victoria, (2021) Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations, Parl Paper No. 202, Session 2018–21 (document 1 of 6).
[35] State of Victoria, (2021) ibid.

integrated Trauma-Informed Care Framework[36]), providing a common practice base for all services, and contributing to an improved person-centred service system.

[36] Prevention and Response to Violence Abuse and Neglect Government Relations (PARVAN). (2023). Integrated Trauma Informed Care Framework: My story, my health, my future, NSW Health, St Leonards, NSW. https://www.health.nsw.gov.au/patients/trauma/Publications/itic-framework.pdf

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APPENDIX 1

FASSTT Member Agencies

ACT

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companionhouse.org.au

NSW

STARTTS | NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors

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stts-startts@health.nsw.gov.au
startts.org.au

NORTHERN TERRITORY

Melaleuca AUSTRALIA
Everyone belongs

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QUEENSLAND

QPASTT

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SOUTH AUSTRALIA

sttars

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TASMANIA

phoenix CENTRE

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VICTORIA

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The Victorian Foundation for Survivors of Torture Inc.

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WESTERN AUSTRALIA

asetts
rebuilding lives together

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APPENDIX 2

Snapshot of the Torture and Trauma Experiences of FASSTT Clients

Torture[37] has a specific definition and can take many forms. It may be physical or psychological. It may consist of beatings, electric shock, sexual abuse, solitary detention, mock executions, sensory deprivations, being forced to witness others being tortured or killed, and detention in harsh and inhumane conditions. It is estimated that world-wide up to 35% of refugees have been physically tortured or psychologically violated.[38]

Torture is not merely used to extract information from an unwilling person. The ultimate goal of torture and organised violence is to institute and reinforce social and political control. This is achieved by attempting to destroy the capacity of the tortured person to function normally and to sustain control over his or her life. Torture has no political, religious, cultural, gender, class or age boundaries. Children, women and men are all targets.

Torture has an impact on the individual, the family and the community. Refugees and other survivors of torture experience the impact of torture in many different ways. It has a profound, immediate and long-term impact on physical and psychological health. Research suggests survivors of torture are a particularly vulnerable group for health disorders of different kinds.[39]

Additionally, many refugees have experienced other traumatic events in countries of origin, during flight and in transit countries. A high percentage of torture and other trauma survivors suffer from extreme levels of depression and anxiety, which manifest in many ways. These can include sleep disorders, recurring and intrusive memories, poor self-esteem, difficulty in concentrating, sadness, fear, anger, psychosomatic complaints, and breakdown in family and personal relationships.

People from refugee backgrounds will have several intersecting and overlapping identities at the same time, which impact upon the person's experiences. The theoretical framework of intersectionality provides a useful way to recognise and understand how different aspects of a person's identity affect the way they are viewed and treated by others and how that can affect their life.[40] These intersecting and overlapping identities can include but are not limited to, gender

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[37] "[T]he term 'torture' means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions."
Article 1 of the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1975), the United Nations Office of the High Commissioner for Human Rights

[38] Higson-Smith, C. 'Updating the Estimate Of Refugees Resettled In The United States Who Have Suffered Torture ', The Center for Victims of Torture, September 2015
https://www.cvt.org/sites/default/files/SurvivorNumberMetaAnalysis_Sept2015_0.pdf

[39] UNHCR, *Refugee resettlement: an international handbook to guide reception and integration*, UNHCR and VFST, Melbourne, 2002, p233.

[40] UNHCR & UNSW, Intersectionality, Age, Gender and Diversity: Presentation notes,
https://www.unhcr.org/media/presentation-kit-intersectionality-age-gender-and-diversity

identity, sexual orientation, disability, religion, ethnicity, sex, age, and socio-economic status.[41] In a 2022 international study involving the University of Melbourne, it was estimated that up to 70% of women and girls in refugee populations have experienced sexual and gender-based violence prior to arrival.[42] Those fleeing persecution or who are in conflict zones and identify as LGBTIQ+ are likely to have also experienced sexual violence including violation of sexual autonomy and integrity. [43]

In the four years between 1 July 2020 and 30 June 2024, 91% of FASSTT clients reported a pre-arrival experience of torture and/or other trauma. This included physical torture (including environmental, sensory, and chemical manipulation), psychological torture, sexual torture, arbitrary imprisonment or kidnapping, and experience of communal violence. Of note, 6% of clients reported death or assumed death of a significant other.

For clients engaging in the PASTT program in the 10 years between 2012-2022:

- 7% of children and 14% of adults experienced suicide ideation.
- 48% of children and 69% of adults experienced anxiety that impacted on their daily living.
- 27% of children and 61% of adults experienced depression that impacted on their daily living.
- 5% of children and 13% of adults had a disability.
- 51% of children and 49% of adults reported family difficulties that were moderate or severe in nature.
- 44% of children and 40% of adults experienced interpersonal difficulties.
- 11% of children and 40% of adults experienced pain or other somatoform symptoms.
- 8% of children and 15% of adults had a severe mental illness.
- 6% of adults and 2% of children experienced a substance dependency.
- 29% of children and 46% of adults expressed social isolation.
- 35% of children and 57% of adults experienced traumatic grief.
- 43% of children and 65% of adults experienced traumatic stress that impacts on daily living.

The rationale for the specialist service response provided by FASSTT agencies, is not only the prevalence of mental health concerns associated with the legacy of the refugee experience but also their enduring vulnerability in the course of their settlement and integration in Australia, at an individual, family and community level.

[41] The United Nations. (n.d.). The United Nations Disability Inclusion Strategy. https://www.un.org/en/content/disabilitystrategy/

[42] Pertek, S. and Phillimore, J. with Akyüz, S., Block, K., Bradby, B., Özçürümez, S., Perez Aronsson, A. and Vaughan, C. (2022) "Nobody helped me": Forced migration and sexual and gender-based violence: findings from the SEREDA project. Research Report. University of Birmingham.

[43] Ollé Tejero, P (2023) Long Overdue: exploring sexual violence against LGBTI+ people in conflict. Global Journal of Medicine and Public Health. GJMEDPH Special Issue, 2023.

APPENDIX 3 – FILE ATTACHMENT

File attachment of the FASSTT Response to the Consultation for the Draft Advice on the National Suicide Prevention Strategy (1 November 2024).

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