OCTOBER 2017

REFUGEE TRANSITIONS

A Publication of the *Service for the Treatment and Rehabilitation of Torture and Trauma Survivors*

Issue 32

The Mandaeans

A Story of Survival in the Modern World

pg. 4

A Dancer in the Midst of War

pg. 40

My Time at the UNHCR

pg. 69

FASSTT Conference

pg. 20

REFUGEE TRANSITIONS

Refugee Transitions exists to report on a wide range of refugee and human rights issues of relevance to the work of STARTTS; to focus attention on the impact of organised violence and human rights abuses on health; to provide ideas on intervention models that address the health and social needs of refugees, to debate and campaign for changes necessary to assist refugee communities in their settlement process and ultimately bring together a vehicle for personal expression.

Refugee Transitions is published biannually by the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)

Address
PO Box 203 Fairfield NSW 2165

Tel: (02) 9794 1900

ISN 14416247

Editor
Olga Yoldi

Associate Editors
Richard Walker
Quentin Lambert

Sub-editors
Mark Symonds, John Hampshire, Peter Bartlett

Contributing Authors
Lachlan Murdoch, Derrick Silove, Dunja Karagic, Shaun Nemorin, Virginia Lee, Quentin Lambert, Gabriela Salabert, Naomi Halpern, Sarah Yahya

Art Direction
Whale Design Co.

Cover Image
Members of the Sabean Mandaeans on the banks of the Shatt al-Arab waterway in Basra, southeast of Baghdad, Iraq. May 2015. Nabil al-Jurani / AP Photo

CEO's Message

Welcome to the 32nd Issue of Refugee Transitions,

The period since the last edition has been one of the most demanding and busy periods for STARTTS. It has also been a fascinating and inspiring journey, in which STARTTS played a key role in assisting a record number of refugees from Syria and Iraq settle in NSW, by supporting them in their journey of recovery from their traumatic experiences. Australia's effort in this regards has been outstanding, as has been the coordination provided by the NSW effort under the guidance of professor Peter Shergold who was commissioned by Premiers Mike Baird and Gladys Berejiklian, to ensure services were well planned and resourced.

Sadly, this best practice model in assisting refugees is somewhat exceptional in today's world.

Every day, more people are tortured around the world. It happens in the context of political or religious repression, criminal investigations, war, and in a myriad other specific situations. This is not a new trend, yet there are worrying signs that in a world where many leaders of democracies seem to focus inwards, this trend may be deepening, even in countries where substantial progress was made until a few years ago.

Many victims of torture don't survive, but those that do face an uphill battle rebuilding their lives after their ordeal. The availability of services to assist in this process can be a crucial factor in this struggle. Unfortunately, there is also a worrying trend affecting the availability of such services. The same drivers that seem to be making torture more permissible in many places are also resulting in less funds being available to assist victims of torture heal and rebuild their lives. This affects the capacity to sustain existing services, and develop new services in places where they are needed. Even as we speak, several services around the world are facing a very real and pressing prospect of having to shut down due to a lack of funds, and many more have resorted to limited services fully manned by volunteers.

Assuming the role of president of the International Rehabilitation Council of Services for Torture Victims (IRCT) has been an enormous privilege, which has provided me with the opportunity to become better acquainted with the amazing work that is being carried out by the more than 150 services that are part of the IRCT, often under incredibly difficult conditions.

Understanding the circumstances in which torture took place and the context of recovery, and adapting interventions to fit these contexts has been widely recognized as a critical ingredient in rehabilitation and indeed, it is regarded as one of the pillars of our own work at STARTTS.

The implementation of this principle across the many IRCT centres around the world has given rise to a plethora of interventions, ranging from adaptations of well-known psychotherapeutic approaches, to interventions designed to assist whole communities that have been systematically enslaved and mistreated for over a decade, as well as interventions that combine recovery goals with torture prevention goals.

The result of this work is best measured in the intangible value of life and dignity regained, but it also has huge economic, social and population health implications, not to mention the value of prevention itself. Ensuring the ongoing sustainability of torture and trauma services around the world is one of the key challenges faced by the IRCT movement, and will likely need a more active participation and support from a larger number of people around the world that oppose torture and support the right to rehabilitation for victims. I promise you will hear more about this soon.

In addition to exploring the above issues further through two in-depth interviews, we take a look at the refugee experience from a dancer's perspective, examine the interface between culture and perinatal issues, provide a perspective on the settlement of refugees from Syria and Iraq, provide an introduction to the amazing history and current challenges of the Mandaean community, follow some young refugees experience with the UNHCR in Geneva, and explore the current situation in terms of therapeutic approaches to address the impact of torture… and much more.

I hope you enjoy this edition of RT!

All the best,

Jorge Aroche
Chief Executive Officer / STARTTS

PHOTO: ANGELA O'CONNELL

Contents

The Mandaeans

A Story of Survival in the Modern World

PHOTO: DAVID MAURICE SMITH / OCULI

PHOTO: ALEXANDER ZEMLIANICHENKO / AP PHOTO

MODERN CONFLICTS

Mandaeans are one of the smallest, oldest and most vulnerable of the minorities in Iraq and Iran. While their culture has survived for more than two millennia, it is now in danger of disappearing for ever. OLGA YOLDI spoke to Mandaean refugees in Sydney.

In a small office at the STARTTS headquarters in the Western Sydney suburb of Carramar, Yassmen Yahya, president of the Sabean Mandaean Association in Australia, talks about the extraordinary violence perpetrated against a tiny ethno-religious minority in Iraq.

Yassmen seeks to raise awareness among human-rights groups, government and the media in Australia of the extent of the Mandaeans' suffering as the international media continues to focus almost exclusively on the Islamic State and its exploits.

In recent years, the situation of the Mandaeans has turned from difficult to catastrophic. Those inside Iraq are trapped in the endless cycle of violence and lawlessness that has plagued the country since the 2003 US invasion. For many Mandaeans who fled the country, the situation is not much better. They are now languishing in neighbouring countries awaiting resettlement, desperately alone, with no protection or assistance, no rights, nowhere to go and nothing to do.

Yassmen, a refugee living in Australia, has just returned from a trip around Jordan, Turkey, Lebanon and Indonesia, where she has interviewed Mandaean refugees and spoken to immigration officials in Australian embassies and international NGOs about their desperate plight. She laments that the conditions in which they live are far worse than she could have ever imagined, and she fears they may have been forgotten by the international community overwhelmed by the massive displacement and the humanitarian disaster caused by the Syrian civil war.

There is no doubt that more of a decade of sectarian infighting has had a devastating impact on Iraqi society as a whole. But religious minority groups have borne the brunt of the violence. For the past 14 years Mandaeans, like many other minorities, have been subjected to persecution, murder, kidnappings, displacement, forced conversion to Islam, forced marriage, cruel treatment, confiscation of assets including property and the destruction of their cultural and religious heritage. Before the US invasion there were an estimated 60,000 Mandaeans in Iraq. Today fewer than 5,000 remain.

According to the report *No Way Home: Iraq's minorities on the verge of disappearance*, published in 2016 by the Minority Rights Group International, the Christian population has also dropped from 1.4 million before 2003 to fewer than 250,000. In Baghdad, only 15 per cent of the Christian population remain. Other minority groups, such as the Yazidi, Kaka'i, Turkemen and Shabak, have also suffered greatly when they were driven from their lands in the north by Islamic State. The report blames not only Islamic State but also the forces fighting it – Iraqi security forces, popular mobilisation units including unscrupulous militia groups and the Kurdish Peshmerga – for human-rights violations and atrocities committed against minority groups. Media reports also blame criminal gangs that justify their crimes on the basis of the victims' faith, while exploiting the power vacuum and lawlessness that has prevailed for more than a decade.

As of March 2016, internal displacement in Iraq exceeded 3.3 million and about four million people had lost their homes and livelihoods as a result of the conflict. The report highlights the despair of Iraqi ethnic and religious minorities and the continued deterioration of human-rights conditions.

As long as impunity continues, so will the killings, kidnappings and violence. According to a Freedom House report, the judiciary in Iraq is heavily influenced by political, tribal and religious forces, as well as bribery. "The Abadi government has lacked the political and legal authority to overhaul the judicial branch," the report says. "The combination of military conflict and general lawlessness continues to kill thousands of civilians in Iraq each year."

The Mandaeans appear to be one of the most misunderstood and vulnerable groups. Apart from being a small community, even fewer than Yazidis, they do not belong to a large religious organisation or have links with powerful tribes that can protect them, so their vulnerability makes them an easy target. To make matters worse they are scattered all over the country, so they are the only minority group in Iraq without a safe enclave. If the violence persists, it is feared their ancient culture and religion will be lost forever.

Mandaeans have a long history of persecution. Their survival into the modern world is little short of a miracle. Their origins can be traced to the Jordan Valley area and it is thought that they may have migrated to Mesopotamia in the 3rd century CE. So for two millennia they have been part of the rich mosaic of peoples who have inhabited the lands that today are Iraq and Iran.

Mandaeans witnessed the rise of Christianity and Islam. They survived the Mongol massacres, attacks by Arab tribes, the arrival of Europeans and the brutal reign of Saddam Hussein. According to historians, they did so by keeping to themselves and, when necessary, camouflaging themselves within surrounding religions. "The complete portrait of Mandaean history through the centuries is impossible to acquire, but glimpses appear here and there," wrote an internationally recognised specialist on the Mandaean religion, Jorunn J. Buckley, in her book *The Mandaeans*.

Also known as Sabeans, Mandaeans practise Mandaeism, a mysterious religion, a brand of Gnosticism that predates Christianity. Followers claim to be descendants of Adam, revere Noah as a prophet and John the Baptist, whom they do not consider to be the founder of their religion but he is revered as one of their greatest teachers. Mandaeans are born into the religion and must marry within it. It does not accept converts.

Nathaniel Deutsch, a historian from the University of California, Santa Cruz, described Mandaeans in *The New York Times* as "the only surviving Gnostics from antiquity, cousins of the people who produced the Nag Hammadi writings like the Gospel of Thomas that sheds invaluable light on the many ways in which Jesus was perceived in the early Christian period".

Edmondo Lupieri, in his book *The Mandaeans: The Last Gnostics*, describes Mandaeism as an esoteric religion that reserves knowledge of religious texts and mysteries to a tiny minority, "such knowledge has been preserved through centuries of adversity in an impressive collection

PHOTO: DAVID MAURICE SMITH / OCULI

of writings gathered over 2,000 years". He writes that this has exposed the group to constant danger through the biological extinction of the caste invested with this knowledge.

Mandaeans were unknown to the West until Ricoldo da Montecroce, a 13th century Dominican monk, went to Mesopotamia and wrote about them. He described them as a very strange and singular people in terms of their ritual: "They live in the desert near Baghdad … Many of them came to me and begged me insistently to visit them. They claim to possess a secret law of God, which they preserve in beautiful books … they live near a few rivers in the desert. They wash day and night so as not to be condemned by God."

Buckley claims that it was not until the 16th century that Europeans became more aware of the Mandaeans, when Portuguese Jesuit missionaries tried to convert them to Christianity. These missionaries were the first to bring Mandaean texts to Europe, which are now kept in the Vatican Library, the National Library of Paris, the British Museum and the Bodleian Library at Oxford University. They are written in Mandaic, a Semitic language of the eastern Aramaic subfamily. "These texts are barely studied these days, let alone fully known," Buckley writes. "And the religion's lengthy and detailed rituals resist easy interpretations."

Their doctrines are centred within a dualistic philosophy of life derived from the Gnosis of late antiquity – a world of light and a world of darkness. Buckley describes it as a three-dimensional view of life: an upper heavenly world, middle earthly human world and a gloomy underworld. "This is similar to other Gnostic systems, which see human beings living in fundamental alienation on Earth while the true home lies up above in the Light."

An essential element of this religion is the frequent ritual use of pure, running water for baptism, an ancient ritual meant to cleanse and purify the soul and connect with the Light (God). This is the reason Mandaeans have always lived and built their sanctuaries near the rivers that converge on the Tigris and Euphrates in southern Iraq and the Karun River in Iranian Khuzestan. Fresh water is believed to be the primary form in which the Light world manifests itself on Earth. Baptism is crucial in this religion, because it is seen as being capable of bringing the soul closer to salvation.

Mandaeans in Sydney practise baptism in white robes on the banks of the Nepean River, which every Sunday is transformed into a scene from the ancient world. The association has recently started construction of a baptism pool in Wallacia so they can practise the ritual in private.

The Sabean Mandaean Association of Australia, also known as The Mandi, is located in the Western Sydney suburb of Liverpool, where an estimated 8,000 Mandaeans live. Hidden on a side street stands a flat and unassuming building marked with the Mandaean symbol. Inside, the former fire station has been transformed into a sanctuary that houses a large prayer room with a carving of St John the Baptist on the wall, a large community hall and several meeting rooms.

This space has enabled Mandaean refugees to reconnect, to support those in need and keep their cultural and religious heritage alive. But life in exile holds new challenges, particularly the erosion of their identity and the collapse of the community that comes with being so far from their homeland.

When I visited the Mandi one Friday evening, a group of young women had gathered to analyse, discuss and gain a deeper understanding of Mandaic holy books. "Our religion is based on and driven by knowledge," says Ayat, one of the participants. "So we are exchanging knowledge and learning religious concepts. I enjoy building on the knowledge passed on to me by my parents. We are learning about where we came from."

Bahram Ber Howa leads the discussion. He says he wants to encourage young people to be more involved in their religion. "We have many challenges and we need to find our identity." Bahram says he wants to bring young people into the fold through a more active engagement. He plans to communicate with young Mandaeans about the religion through seminars, lectures, prayer ceremonies and the publishing of a journal, so that religious knowledge can be passed on to them and to future generations. "This way the religion will survive," he says.

Mandaean refugees started to arrive in Australia during the Iran-Iraq war of 1980-1988 and the Gulf War of 1991. Saddam Hussein forced them to fight in both wars, even though their faith forbids them to use firearms, even in self-defence. Many found themselves in the battlefields, some were caught in the crossfire, many Mandaean villages were destroyed by the war, particularly in Iran, and those who had been living in the Southern Marshes were forced out of their settlements when Saddam Hussein drained them to suppress a Shiite rebellion. Many sought refuge in the cities but even the cities were unsafe.

Yassmen was living with her family in Baghdad when one day the phone rang at her husband's jewellery shop. The call was for someone else who happened to be at the shop. The caller was a member of the opposition living in exile. Saddam's intelligence service was listening to the call and Yassmen's husband was immediately arrested. They thought he was a spy working for the opposition and was told to provide information. "Tell us what you know," Saddam's men said. But he knew nothing.

She lost contact with him and when she went to ask about him, the guards told her husband his wife had come to the prison. They also told him: "We could have arrested her, so tell us what we want to know."

Her husband then sent a message telling Yassmen to flee the country. She reached Jordan and waited for two years before her husband joined her there.

…it is estimated that about 90 per cent of Mandaeans were either killed or fled.

If times were hard under Saddam Hussein, worse was to come. When US and Allied forces invaded Iraq in 2003, the fate of Mandaeans changed overnight as the security situation deteriorated dramatically. The rise of Islamist extremism forced thousands to flee Iraq after they were given the choice of conversion to Islam or death. According to the Inter Press Service, it is estimated that about 90 per cent of Mandaeans were either killed or fled.

With the fall of Saddam, Mandaeans suddenly lost status and protection when they were deemed not to belong to "The People of the Book" – members of a protected religion under Islamic rule. The Quran grants special status to religions that predate the advent of Islam, namely Judaism, Christianity and the Sabeans because they possess a sacred scripture and have a recognised prophet.

When the late Shiite leader Ayatollah Al-Hakeem decreed in 2003 that Mandaeans were no longer The People of the Book and therefore were not worthy of protection and may be subject to being killed or forcibly converted to Islam, they became the most endangered and vulnerable people in Iraq. In 2005 another fatwa, reportedly issued by the Information Foundation of Al-Sadr Office, reiterated the edict, accusing Mandaeans of "systematic adultery and trickery". Thousands have

PHOTO: DAVID MAURICE SMITH / OCULI

been killed as a result.

Many Mandaean goldsmiths were kidnapped by criminal gangs for ransom. Since practising Muslims are forbidden to work with gold directly, the work of a jeweller is normally carried out by members of a religious minority. Mandaeans are now accused of hoarding gold and other precious metals. Their shops have been looted and in many cases they have been killed in front of their children. The police have done little to assist them.

Semat Bath Anher witnessed the violence perpetrated against her own family. Both, her niece and nephew were kidnapped. Her brother-in-law was killed. Her brother was shot. One evening, he and his son were closing their jewellery shop when three masked men approached them. They dragged his son out and put him in the boot of a car. When her brother tried to stop them, he was shot and left for dead. They drove away, fortunately the police stopped the car, told the driver to open the boot and his son was saved. But his father spent months in intensive care and still suffers from the massive injuries he received, as well as depression. They left the country soon after and now live in Sydney.

According to human-rights reports, kidnappings for ransom are endemic. Some children have been kidnapped and returned to their families dead, despite the payment of ransoms. There have been cases where Mandaeans have found placards affixed to the doors of their homes accusing them of witchcraft, demanding that they convert to Islam or leave Iraq and threatening them with death if they fail to comply.

Jorunn Buckley has stressed that the attempt to destroy Mandaean families is increasing, with a particular focus on women and young girls through pressuring them to marry Muslim men. According to the *Journal for the Study and Research into the Mandaean Culture, Religion and Language*, Mandaean parents fear their children will be kidnapped and forcibly circumcised, converted to Islam, raped and forcibly married. Yassmen told me that in order to protect girls parents marry off their daughters at a very young age, depriving them of a proper education. She describes cases where young women have been abducted by their neighbours, people they have known all their lives. Children are also being bullied at school. Many have to hide their identity out of fear.

The situation is no different for Mandaeans in Iran, who are also persecuted and have no rights under Sharia law. Nor are they recognised in the Islamic Republic's constitution.

Our children have seen the sacrifices we have made and the suffering we have experienced in order to keep our religion, culture and identity alive ...

Mandaeans had enjoyed complete tranquillity under the secular and pro-Western government of Reza Pahlavi, but with the Iranian revolution, the fall of the Shah and the rise of the Ayatollah Khomeini's revolutionaries, they also lost their status as People of the Book and told to convert to Islam.

They have tried to regain their position as a legally protected religion without success. Situated far from the power centres in Tehran, the Mandaeans are at the mercy of the local authorities of Khuzestan that encourage and enforce increased harassment and persecution. Since then the opportunities for Mandaeans to take part in higher education have been curtailed.

"We have been persecuted all our lives," Parih Simathbeth, an Iranian Mandaean told me. "In Iran we were worse off than in Iraq, because at school and at university we did not have any rights, so we could not participate in anything.

"Sometimes we had to identify as Muslims to avoid conflicts. We had to cover our heads and pray with them. This was very difficult. We did not belong there anymore."

Many have had to change their names but are still recognised by their appearance. Parih described her life in Iran as excruciating: "Some want to integrate because they want to survive, but we cannot just lose our culture, religion and heritage in the process."

Being defined as an infidel means being perceived as unclean and rendering unclean everything you touch. This makes it hard for Mandaeans to receive medical assistance, because if a Muslim doctor treats a Mandaean the doctor will not be able to treat Muslim patients.

Handling food is also forbidden. Non-Muslim purveyors of food must set up a sign declaring their religion in their shops. They cannot enter into a grocery business or work in the food sector. Parih says that when she used to go shopping for food if she touched anything she would be in trouble. "Sometimes we could not leave the house or go into the courtyard as they would throw stones at us, swear at us. That is why we decided to leave Iran. We simply could not take it anymore."

The suffering did not stop when they came to Australia. Parih described the journey by boat and her years in the remote Woomera Detention Centre as a time of great distress and uncertainty, but after two years the family was accepted. They now live in Liverpool in south-west Sydney and she describes her life as settled and happy. After 16 years in Australia, Parih says: "When I look back I realise we have achieved a lot – but everything was difficult, especially getting a job."

Will Mandaeans survive as an ethno-religious group? What will it mean for the new generations of Mandaeans living in Australia?

"Our community has adapted and integrated well in the Australian society," Bahram says. "Our children are getting an education and entering the professions." Parih has no doubt that Mandaeism will survive through to the next generation. "Our children have seen the sacrifices we have made and the suffering we have experienced in order to keep our religion, culture and identity alive … my identity is in my blood and it will be transmitted from generation to generation."

However, the scattered nature of the diaspora has raised fears among Mandaeans for their religion's survival. Noted German religious studies Professor Kurt Rudolph says their survival is not assured. "It is increasingly difficult for them to maintain the structures of their religion and the conditions through which esoteric knowledge is passed on," he writes. "The biggest problem is that few of the Mandaean diaspora communities are large enough to truly preserve their traditions or have a priest to maintain full religious observance, and even those that do have problems finding free-flowing, unpolluted water."

Yassmen told me that the best hope for them to survive is if a critical mass of Mandaeans is allowed to settle in Australia, where the climate is appropriate to practice their religion. If this does not happen individual Mandaeans may survive for another generation, but their culture may not.

The highest priority of the Sabean Mandaean Association in Australia now is to encourage the Australian government to accept the thousands of refugees who are stranded in neighbouring countries living in severe deprivation, and also to help Mandaeans leave Iraq safely. This is challenging because Mandaeans are a voiceless minority and the Diaspora in the West is minuscule and has no funds or political influence.

Only if Mandaeans are granted privileged status and allowed to enter Australia in significant numbers might it be possible to save them and their ancient culture from extinction. Otherwise after 2,000 years of history and survival, the last Gnostics will finally disappear for ever. R

PHOTO: SHUTTERSTOCK

The Quest for Better Mental Health Care

Dr Roger Gurr is a tireless human rights campaigner, trained in psychiatry in Australia and the UK, including Oxford University. Dr Gurr who set up Australia's first community-based integrated mental health service, is an associate professor in the School of Medicine at Western Sydney University. He spoke to OLGA YOLDI about a life dedicated to the service of humanity.

What drew you to work in mental health? Tell us about your work.

I almost became a chemical engineer like my father, but I applied too late for a cadetship so I studied medicine at the University of NSW. I chose the new medical school because their teaching methods were tutorial-based and included arts subjects, not just purely science, as well as a 10-week clinical term on mental health that was unheard of in 1968.

As a student I was actually allowed to treat patients and really enjoyed the interaction, so when I was a hospital resident I did a term on the psychiatry ward and again found it satisfying. Psychiatry is not a specialty most medical students are attracted to because there is a stigma attached to it. Some consider it not proper medicine, so you must be "mad" to do psychiatry.

My first year as a psychiatrist was at the Psychiatric Research Unit at Rozelle Hospital, where I was working in a neuro-psychiatric unit on cases sent from across the state. Patients experienced a mixture of biological and psychological issues. We took them off all their treatments and medications and started from scratch. The unit was staffed by psychiatrists, neurologists and neurosurgeons. I soon understood the connection between biology and psychology. I am convinced every problem is bio-psycho-social and I tend to be an evolutionary psychiatrist.

We have to look at how we have evolved as human beings. A lot of our behaviours are more programmed than we like to think. You only have to look at studies with identical twins reared apart from birth to find out they are similar as adults. What they have absorbed from their families is maybe a bit of vocabulary, but both like the same sorts of food, dress in similar colours and tend to marry the same sort of people. To believe that everyone is totally changeable is not a good idea. On the other hand, it does not make you a determinist to say we are all determined by our genes.

If one identical twin has schizophrenia only half the other twins will also have schizophrenia, so that tells you there are a lot of other factors that cause mental disorders. I now work in the prevention of early psychosis with young people at high risk of developing it, because I believe there are ways we may be able to change the trajectory set by their genes.

The literature points out that a lot of people with

schizophrenia, for instance, have trauma stories that tend to be neglected in terms of managing schizophrenia. A large proportion of the young people I see have experienced personal trauma. We should be trialling neurofeedback, now used at STARTTS, not only to deal with the basic development of psychosis, but also to get rid of verbal auditory hallucinations and to help traumatised brains to better regulate themselves.

A concern for human rights has obviously been central to your work. You were president of Amnesty International Australia during the 1980s. How did you come to be involved in Amnesty?

I spent time in Indonesia where I met an Amnesty International investigator. Indonesia went through a terrible time after Sukarno was ousted. Some 600,000 people were killed in an attempt to eradicate communism, others were put away in jail or sent into exile on islands. Afterwards their families had their identity papers coded as communist sympathisers and therefore a risk to the state. As a result, they were not allowed to get public sector jobs or education. I saw millions suffering so close to our shores in Australia, with very little outcry in our media.

I had been involved as NSW secretary of the Australia Party, which was a liberal centrist party – capitalism with a heart – largely funded by Gordon Barton. We campaigned against the Vietnam War and we almost got a senator elected in the 1972 federal election. We claim it was our preferences that enabled Whitlam to win office. The party morphed into the Australian Democrats.

I went overland to England to see the world and complete my studies in psychiatry. I wanted to remain involved in politics, but not party politics, so I joined the Ealing branch of Amnesty International (AI), where I learnt a lot and enjoyed it. That is how my direct connection with human rights started.

When I came back to Australia in 1978 I joined AI in Sydney. We managed to employ Harris Van Beek with the promise of funding his salary, and put a lot of energy into reactivating the Australian section. I was national president for five years, then national secretary through the rest of the 1980s. We set up direct mail and merchandise fundraising to turn the organisation around. We developed an AI federal parliamentary group of about 60 members and a NSW State Parliament Group. When John Howard was federal treasurer he refused to grant tax deductibility for donations to AI, but in a stroke of luck he had recently granted it to the RSPCA. I went to see him and suggested we would leaflet his electorate with the message that he would allow a tax deduction for donations to prevent cruelty to animals, but not to humans. Needless to say, we achieved our goal very quickly.

Through my work in AI and as a psychiatrist, I was aware of what was happening around the world with refugees and torture. Once I realised that an organisation had been set up in Denmark to provide treatment for traumatised refugees I became determined that we should have such a service in Australia, particularly in Sydney.

In 1988 we started the campaign and luckily managed to convince the then NSW health regional director in western Sydney to allocate funding for us to hire Professor Janice Reid, then a medical anthropologist, who had written about refugee health needs in Australia. She produced a report making the case for the establishment of a torture and trauma treatment service. We got bipartisan support in the NSW parliament, so the NSW government allocated funds and STARTTS was born in Fairfield.

We decided such an organisation should be owned by the Minister for Health for more certainty of funding. But we negotiated the creation of a management committee structure, with the members nominated by key stakeholders such as AI, Red Cross, Ethnic Communities Council, Ethnic Affairs Commission and universities, as well as some community members appointed by the minister on our advice. This structure meant there were good checks and balances and we reported directly to the minister to talk about any issues. Because we needed physical support (IT, HR, Finance) we were hosted by one of the area health services.

STARTTS began to get the majority of its funding from the federal government and local difficulties arose over the transfers of funds, so STARTTS had no choice but to become an independent non-government organisation, with the blessing of the NSW government.

You were a founding member of the Human Rights Council of Australia. Tell us about it.

AI has a narrow mandate and tight rules about local activities to protect human rights activists in perilous countries. We realised we wanted to take action on other human rights concerns, so a group of us reactivated an organisation called the Human Rights Council of Australia. Included in project work was producing The Rights Way to Development, which provided well-received advice to the UN and governments on how to include human rights conditions in foreign aid grants. Public servants who advise government were largely ignorant about this, yet governments can have real leverage in funding projects that lead to improvement in human rights and better community development

"Being mentally ill in most societies means being at risk of being discriminated against, in violation of human rights."

processes. Involving local stakeholders in the receiving country helps the design of effective programs and helps avoid loss of funds to corruption.

We also did some work for the Aboriginal Reconciliation committee, to come up with ideas as to how to run activities around Australia in order to get the message across and support reconciliation. We have encouraged peak organisations to question the Australian government, to force it to have better aid programs and international approaches to assist developing nations and to solve problems more effectively.

Where does your commitment to the advancement of health and human rights originate from?

I am sensitive to human suffering because as a psychiatrist I deal with human pain all the time, and seeing people who have been tortured and traumatised is very moving. I also happened to be born gay, which was very traumatic when I was growing up. That means you become more observant about people around you, more sensitive to nuance, and because of your own pain in dealing with those issues you are actually more sensitive to other people's suffering.

People with mental health issues and their families are stigmatised and traumatised by the onset of illness, and I had a maternal grandmother with late-onset psychosis. All these groups suffer trauma as a result of attacks on their human rights: there is no health if human rights are violated.

What do you see as the relationship between human rights and mental health? How have you seen them intersect in your work?

Because the relationship is significant, there is a UN Declaration on human rights and mental health because it is stigmatised, comparatively neglected in most countries and treated very cruelly in some. Being mentally ill in most societies means being at risk of being discriminated against, in violation of human rights. In Australia there is discrimination, including in life insurance, health insurance and employment. Many people do not understand mental disorders and link them to religious ideas, witchcraft and violence. So the UN standards for services for mental health are very important.

In 1989 I helped to organise the first annual Mental Health Services Conference of Australia and New Zealand to help ensure those standards were applied. Right from the start that initiative involved consumers, carers, mental health workers from all disciplines and other stakeholders. I am still on the board and the 2017 conference is in Sydney at the end of August. I am sure there will be presentations on transcultural mental health and refugee mental health issues.

We have an awards program that recognises achievements in mental health services in Australia and New Zealand, and by chairing the committee I get to see the progress being made in this field. It is sad to see the mental health services in some states going backwards, in spite of the evidence, because some governments focus on false savings rather than on delivering effective specialist services. It is unfortunate that the public system favours generalist teams in the delivery of mental health services, which have no fidelity towards any real evidence-based programs. The headspace Youth Early Psychosis Program that I am working for now, has a fidelity tool for the EPPIC evidence early intervention in psychosis model with 16 components of care, and we need to make sure that we don't stray from that.

It seems much of your career has focused on community-based integrated mental health service. What does that mean exactly and why do you think it is so important?

While studying in England I came across evidence that it is possible to manage people with mental disorders in the community as well as in hospital settings, and the treatments are the same. The only reason for keeping people in hospital is for short-term safety. When I came back to Australia I was determined to try it. The model is to provide a reliable, 24-hour service based in the community but with hospital back-up. The model is bio-psycho-social, holistically ensuring that physical health is managed with mental health, as the mind and body are not separate. The family needs to be supported and educated about the disorder.

The essential components include an extended-hours

assessment and acute care team that sees people at home or at the local hospital, and which is capable of providing continuing acute care in the community. Then multidisciplinary teams to provide longer-term service coordination, comprehensive treatment interventions and recovery programs.

People do best in their familiar home environments, where they can get on with purposeful activity and maintain relationships. Through a funding methodology roundtable I initiated with the Australian Health and Hospitals Association, PriceWaterhouse Coopers and the Mental Health Services Conference in 2008, we concluded that this would be best achieved by regional funding organisations commissioning these services on a population basis, as mental health usually loses out in the competition for health funds in current funding systems.

Early detection and intervention is essential for the best outcomes in most mental health disorders, 75 percent of which develop in the 12-25 age group. Fourteen health economic studies have shown that investing in best practice care of these young people is just about the best investment you can make in health, with a benefit to cost ratio of about 5.6 to 1. However, seems expensive initially because the rewards come through the rest of a person's life. Australia needs to invest about $2 billion more per year, which would dramatically reduce the current cost of impaired mental health of about $28 billion per year over time. The headspace Youth Early Psychosis Program aims to do this.

From a mental health perspective, what has changed over time? What has improved? What has got worse? What are the main challenges?

We still have not truly implemented the evidence from research in the 1970s and much of the evidence since then. The thinking is that mental health should be integrated with the rest of health services, but when chief executives lack funds they divert funds from mental health services to politically sensitive services. The diversion of funds intended for mental health services in NSW has been rife and hasn't improved over time. This is an argument for funding mental health services through separate independent organisations, such as the Mental Health Trusts in the UK or not-for-profit organisations such as STARTTS or Uniting Recovery in NSW.

The biggest problem in Australia is our federation and constitution. The states are supposed to be the service providers and the federal government was to provide high-level services like defence, foreign affairs etc. However the federal government has been progressively taking more tax revenue and power away from the states. It now receives 83 percent of tax revenue while the states only collect 17 percent. However states need at least 40 percent of the public dollars to provide services. So the state governments are always at the mercy of the federal government. Health sector academics and providers believe that responsibility for the health portfolio should be under one level of government. We don't care if it is under the federal or state governments. Canada and the UK have that arrangement and it works well.

When one level of government controls all the clinicians and all aspects of primary, secondary and tertiary care, it can work effectively as a unified system. Currently the federal government looks after paying private practice doctors and some allied health clinicians on a fee-for-service basis through Medicare, which is largely uncapped so they lack full control over costs. It is poorly distributed geographically and it eats up the budget, so there is less money to give to the states for health services.

While state governments look after public hospitals, they cannot cope with the growing demand. Health inflation runs at about 7-8 percent (1 percent population growth, 2-3 percent CPI, 4 percent because of new drugs and medical technology). The demand for emergency department services increases on average 2.7 percent a year, much higher than population growth, plus there are increased admission rates to other hospital wards.

State budgets can't cope, so mental health suffers as a result. It is invisible in a way: we talk to people, administer medication and the cost is not as high as physical health, yet it is very effective. It can save money having psychiatrists working in hospitals as part of health teams that reduce lengths of stay through holistic interventions. The traumatised people we care for at STARTTS are prime examples, as they use fewer physical health services when their psychological needs are met.

So, yes, there is a need for major health reform. We need to use financial incentives to shape the behaviours of clinicians and improve corporate systems to achieve the outcomes we want. At the same time we need a population-based budget for equity of access. The Medicare system is terrible at distributing the resources. Research has found that those who got the most benefit out of Medicare for mental health services lived in Malcolm Turnbull's electorate, while the area that received the least money and resources was Mount Druitt, because poorer people get the least subsidies

"Australia needs to invest about $2 billion more per year, which would dramatically reduce the current cost of impaired mental health of about $28 billion per year over time."

through Medicare.

What has improved in mental health has been family work. Now we understand more about the importance of dealing with people at the beginning of their disorder, because many react negatively when a young person develops psychosis. The reactions may be open hostility or over-protectiveness – a covert form of hostility – and the young person will not do well. We have learned that if you work with the whole family at the beginning, you can prevent many problems.

It was also true at STARTTS where, early in its development, we realised that providing holistic interventions for individuals was not enough, we needed to work with the family and community to create the best opportunities for renewal of trust, support and recovery.

So the main issue affecting the delivery of mental health in Australia is a lack of investment.

The Council of Australian Governments (COAG) decided to invest $2.5 million in developing the Mental Health Service Planning Framework, using 40 experts to pull together the best evidence for effective services and the resources required. This was completed in October 2013, but has been supressed because it shows we should invest more than $2 billion extra in community-based mental health services with an emphasis on the development years.

What are the solutions?

Until we get our Constitution fixed and a proper agreement between governments on an adequate amount of funding, the situation will not change. And of course, with partisan politics the way they are now, it is a very difficult thing to achieve.

More investment is needed and better leadership from our politicians, who need to make some hard decisions. Everyone knows there is waste in health, but nobody is prepared to address it effectively and politicians are scared of the power of invested interests.

That's why we campaigned for the state and national mental health commissions, because they can make proposals using the evidence base and in consultation with the stakeholders with less partisan interference. In practice, some are too attached to government policy, while others have been able to effectively make real changes.

What we also need is development of the commissioning of services through primary health networks and the funds to do so. Health sector consensus is that one level of government should manage and fund all health services, from primary to tertiary.

When I reflect on the 40 years of involvement in the politics of reform, you see the ebbs and flows and reactions. The problem is that often humans do not want to do what the evidence shows, they prefer to do the things they want to do. In psychiatry you see professionals falling into particular habits, attitudes and ways of working, and often they do not follow the criteria for fidelity to evidence.

Have you seen STARTTS changing over time?

STARTTS exists because it is clear that mainstream mental health services are not able to assist survivors of torture and trauma, because people have trouble hearing trauma stories and also feel unable to help effectively. This was shown in the early days, when we were trying to train professionals in public hospitals and mental health services. The problem is that you can get vicarious trauma from counselling survivors. You can also feel stressed because you are alone, without the teamwork and range of interventions required for successful treatment.

Initially we started to employ bicultural workers who brought the culture with them and spoke relevant languages, but then we learned several had their own trauma experiences and that can be problematic. STARTTS has had to dynamically change its clinician mix to match each wave of refugees from different parts of the world – Asia, Central and South America, the former Yugoslavia, Africa and now the Middle East.

STARTTS has been a great opportunity to innovate and apply research. In the past 28 years it has expanded and evolved. STARTTS has a community development approach as well as individual, family and group clinical care approaches, so it covers the whole spectrum and

PHOTO: DAVID MAURICE SMITH / OCULI

uses non-standard clinical mechanisms that have a positive clinical effect because they allow for physiological improvements in the brain.

The use of music, sport, Capoeira dance, craft groups and so on has been vital. For example, we had women from South-East Asia who had been raped, but who could not talk about it within their culture and were able to do so in the context of social activities such as pottery classes.

Refugees from South and Central America came to Australia needing ideologically based therapies, whereas those coming from South-East Asia needed more symbolic therapies. Because of the differences in culture, religion and political belief systems of different groups, STARTTS has had an incentive to keep changing. We now receive refugees from Africa and other long-term refugee camps because Australia has a non-discriminatory approach to taking refugees, which is to be applauded. A high proportion is from Arabic majority countries such as Iraq and Syria.

It has been very gratifying, providing opportunities for the excellent staff in STARTTS to innovate and seeing the results coming through. We have been blessed with having really creative and committed staff. The internal processes encourage staff to imagine better things, while also having the controls and the tools to ensure it is done effectively.

Sustainability of torture and trauma services around the world is of concern to our board. We need to look at how we can help improve the fund-raising efforts for the international torture and trauma services. There has been a contraction in government funding to the UN Fund for Torture Victims and with the surge in refugees into Europe, some governments are redirecting funding for refugee services to internal providers. There is a risk that the Trump Administration will dramatically cut its funding. Some services in poor countries have already closed because of a lack of funds.

STARTTS has an interest in sharing its skills with foreign services, helping them to provide improved services locally. Now you can run an interactive training course in Sydney that can be viewed around the world.

"We humans will remain humans. Our evolution can only take place very slowly and so changing the culture is slower than changing other things."

The training team will be a growing part of STARTTS because of its increased need to cope with growth and inevitable staff turnover.

Can you highlight your most fulfilling moments and achievements?
I have had the most joy out of involvement with STARTTS, because right from the beginning we saw the opportunities for great progress for very damaged people.

My involvement with Amnesty International (AI) was satisfying because it was about working with lots of other people in fighting for justice across the world. There are local groups writing letters about prisoners of conscience and raising funds. AI also enables you to go all the way through the political process. We had a federal parliamentary group with 60 members that I was responsible for, and we had a state parliamentary group that helped get bipartisan support for STARTTS. I remember when Bob Hawke was visiting China and there were five political prisoners AI had identified as really needing help, so we convinced Hawke to raise those issues in his discussions with the Chinese leader. To back him up so it was not Hawke alone, we also asked the Dutch and Canadian foreign ministries to raise the same cases at the same time so it was much more effective and those five political prisoners were released. It is about having the understanding of how politics works and if many voices say the same thing, it is very effective.

My clinical work is also very satisfying, especially seeing young people responding, and preventing problems. Experiencing young people emerging from their personal difficulties and finding new ways to go forward is always inspiring. I now have the opportunity to apply neurofeedback to help prevent some transitions to psychosis, eliminate verbal auditory hallucinations and reduce the effects of developmental trauma.

You are on different boards and groups, how do you fit it all in?
I did not have children so I have had more time and it is a case of running my life in phases. For instance, I was very involved with AI for 10 years through the 1980s and I made a conscious decision to leave. I had committed to build the organisation, but then there comes a time for a new generation to take over. Now I am 70 it is time for a decade of research activity.

In terms of human rights, do you think there has been an improvement?
People think we have more depression and oppression these days. It is more in the media, but I don't think so. We humans will remain humans. Our evolution can only take place very slowly and so changing the culture is slower than changing other things. But the world has not really changed – we just hear every detail because of global media. The concern now is that despots have new techniques to control populations with electronic surveillance and media. Where before they would do so by obvious brute force, now they can do it more subtly – but it is still brutal.

I believe Democracy is hard to bring into traditional societies. It took Europe many centuries and many wars, and the thought of going to Iraq and removing the strong man and just expecting instant democracy, was an act of great stupidity and ignorance. People who have power and money often do not have the knowledge to make the right decisions.

The philosopher Karl Popper says "For every action you take, there will be an unforeseeable reaction", and I think that's absolutely true. I have seen throughout my professional life that with all the reforms I have been involved in: you take two steps forward, but one step back. That is the way it is.

PHOTO: RYAN STUART

HUMAN RIGHTS

Refugee Trauma Recovery in Resettlement Conference

By Olga Yoldi

More than 650 people gathered at the Wesley Centre in Sydney to attend the Refugee Trauma Recovery in Resettlement Conference in March.

The event, organised by STARTTS on behalf of the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT), attracted international experts, NGO leaders, human-rights activists, researchers, health professionals, educators, community workers and volunteers from Australia, New Zealand and around the world.

Ahead of the event, STARTTS CEO Jorge Aroche said the conference was about sharing knowledge and gaining different perspectives across the sector – and share knowledge the attendees did, over three days filled with presentations, workshops, panel discussions and much-needed debate about the current refugee crisis.

The FASSTT network, with its eight specialist rehabilitation agencies, has collaborated over 28 years to provide innovative services, government advice and trauma research. Australian psychosocial services have built an impressive reputation on the world stage, standing for high-quality programs and vital capacity building that transform the lives of refugees damaged by the experience of torture and organised violence.

"There is something special about Australian and New Zealand services," Professor Derrick Silove said, "in terms of their comprehensiveness, intelligence and their capacity to provide care for refugees. What's also special about them is the leadership and the strong commitment to human rights: that's what defines our mission. If we lose sight of it, we lose sight of the very engine that makes this movement great."

This is particularly relevant now, because every element of the human-rights system is being questioned and threatened – the Refugee Convention, the Convention against Torture and other Cruel, Inhuman and Degrading Punishment and the Racial Vilification Law. "We thought we had won all those battles, but they are back on the political agenda," Professor Silove said.

The CEO of the Victorian Foundation for Survivors of Torture, Paris Aristotle, who has spent decades advocating for the rights of refugees and asylum-seekers, said protecting people fleeing war and persecution is a moral obligation for a country like Australia.

"The problem with the current policy is that it creates two types of refugees," Aristotle said. "The different ways in which they are treated have major implications for their wellbeing and resettlement. While we have one of the best resettlement programs in the world, the same cannot be said about our management of asylum seekers. The mixed nature of the flow of refugees [refugees and migrants] complicates how refugees, often demonised to justify harsh policies, are perceived."

PHOTO: RYAN STUART

PHOTO: RYAN STUART

Meanwhile, the number of refugees grows daily. A 2015 UNHCR report estimates that there are 65.3 million displaced people globally: that is, one in every 113 people in the world is either an asylum seeker, an internally displaced person or a refugee. This represents a 52 percent increase over the past four years. If they were able to form a nation, it would be the 21st largest in the world.

Of the 65.3 million displaced people, only 21.3 million are designated refugees. More than half are under 18, an increase of 41 percent in that age group since 2014.

Forty-five percent of the refugees, almost 9.6 million are in what UNHCR calls a protracted situation, noting that the Syrian war is poised to become the largest protracted refugee displacement crisis of the decade.
Suzanne Jabbour, CEO of the Lebanese Restart Centre of Rehabilitation of Victims of Violence and Torture, said that Lebanon – a small country of six million – received 20,000 Iraqi refugees, 350,000 refugees from Palestine and recently 1.5 million Syrian refugees. Many are living in tents in precarious conditions with little food and money, vulnerable to labour exploitation and human trafficking. Yet only 78 Syrian refugees were resettled in another country in 2016.

Jabbour estimates that between 35 and 69 percent of refugees had been subjected to torture, so more than 600,000 could be suffering from PTSD. She said only 23 percent of children were enrolled in public schools. The number of refugees in Lebanon is about the same as in Europe. The world's six wealthiest countries host less than 9 percent of the world's refugees, according to Oxfam. Yet the focus of the international media continues to be on the refugee crisis in Europe, losing sight of the fact that poorer countries host much larger numbers of refugees.

The conference provided an opportunity to reflect on FASSTT's trajectory from its pioneering days more than two decades ago to a mature, consolidated movement.

Jorge Aroche spoke about the treatment model developed by STARTTS, consisting of a multi-systems approach involving the individual, the family, social networks, the community and broader Australian society. Developed in the 1990s, it has become one of the most innovative and effective models in treating survivors, but it has not been adopted worldwide.

Professor Silove highlighted the importance of collaboration, particularly in developing countries with few resources and services. "It is estimated that about 30 percent of refugees have depression or PTSD-related disorders," he said. "Even if you define it narrowly to specific diagnoses, the number is reduced to 15 percent – which is a huge number of people when we consider that the number of refugees worldwide is three times the size of the Australian population."

Collaboration has already generated many benefits. The growing cooperation between international NGOs and agencies such as the UNHCR has enabled the development of guidelines and guiding principles, and made it possible for them to be adopted internationally. There is no doubt the challenges ahead are great.
According to the Institute of Navigation, the number of refugees flying to Europe was reduced from 1 million in 2015 to 363,548 in 2016. However, the number of known casualties from dangerous sea voyages still rose by 35 percent to 5,091.

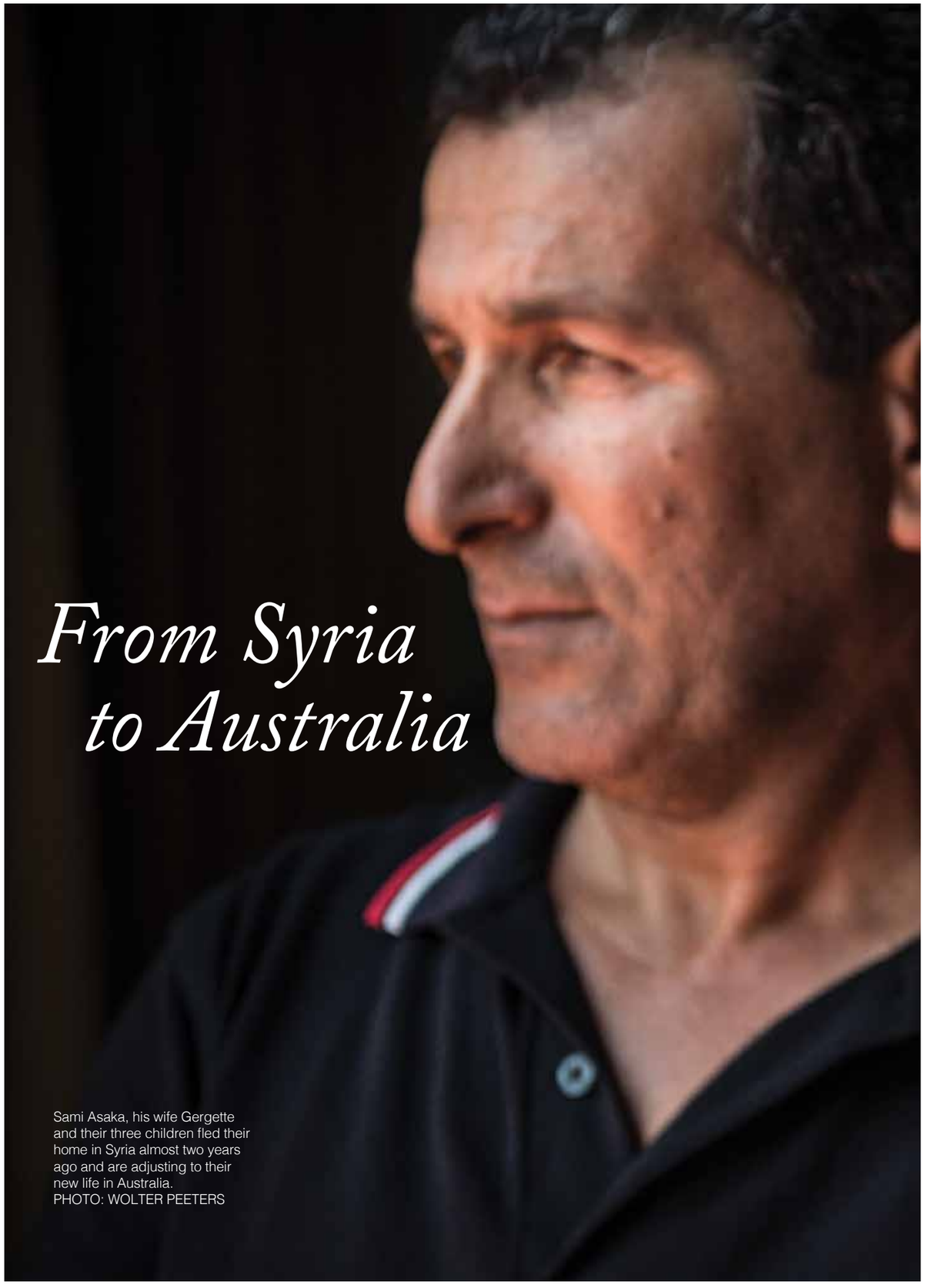
"Nobody really knows how many bodies have been washed up in Libya or how many warehouses there are containing bodies of asylum seekers whose smugglers could not move, but chose to murder instead," Paris Aristotle said. "But we know they exist."

Resettlement of refugees in other countries is vital, yet the US recently announced a reduction to its quota from 100,000 to 75,000. "Even if the international community increased their resettlement efforts, it would take 26 years to resettle today's refugees," Aristotle said. "Increasing resettlement places and establishing refugee protection arrangements is vital, otherwise people will resort to perilous journeys by sea organised by people-smugglers."

Only dealing with the root causes of conflicts will prevent refugee crises, so stabilising post-conflict populations and providing aid and economic development would go a long way towards rebuilding people's lives. Instead, many have to flee their countries to arrive on distant shores, only to face detention, harsh living conditions and delays in processing their refugee claims.

These and other issues were discussed in depth during the conference's workshops and panel discussions. Themes varied from the damage caused by war, to trauma recovery interventions, clinical treatment approaches, community approaches, resettlement programs and the outcomes of research projects.

There was certainly no lack of ideas, solutions and debating points. It was interesting to see that while the challenges of resettlement have changed, they still remain broadly the same 28 years on – yet the spirit and commitment of those dedicated to helping refugees has remained intact. ꟿ



From Syria to Australia

Sami Asaka, his wife Gergette and their three children fled their home in Syria almost two years ago and are adjusting to their new life in Australia.
PHOTO: WOLTER PEETERS

AGENDA

Syrian refugee Sami Asaka arrived in Australia not long ago. He told LACHLAN MURDOCH about his journey, his new life in South West Sydney and his hopes for the future.

After days of heavy fighting in Daish's (Islamic State) advance through Raqqa, it was too much for Sami Asaka. The almost incessant volleys of shells and bullets raining down on his neighbourhood had Sami and his family not just living on their knees but crawling from room to room and counting hour after hour under the constant threat of death.

A lull in the fighting brought Sami his opportunity to expel the suffocation of days of tension from the enclosed home he feared would become his family's tomb.

Sami flung open the doors and windows to let the air through and to sense normality, even if only for a few minutes. Sami knew the risks but it the fighting was too much to endure. His was a fateful decision.

Just as he opened his home to the destruction at his doorstep a group of Daish's foreign fighters made their way down Sami's street. His open house was an open invitation.

The fighters forced their way in at the point of their guns. They immediately demanded whether Sami and his family were harbouring members of the Shia community. Sami replied they were not.

The emir of the group brandished a large sword and asked Sami if he was Sunni, Shia or Christian.

Sami's response could mean life or death. He replied that he was Assyrian. The emir was visibly confused by what was said, it was a word he had never heard before. He paused and then instructed Sami, his wife and children to bring them water. The family complied as fast as they were able. With their thirst quenched the emir and his fighters had more pressing things to deal with than to understand what it meant to be Assyrian. They left the house to continue their advance.

Sami had placed his family in real danger and he knew it was time to flee Raqqa. As Daish tightened its grip on the city Sami took his family north east to Al Hasakah, a city still in Government hands with an Assyrian minority in which he felt they could be safe.

But after the fall of Raqqa, Daish's grip extended further into northern and eastern Syria. Al Hasakah too came under threat. As Daish advanced to take parts of southern and eastern Al-Hasakah and its surrounds Sami's family fortuitously found themselves on the northern side of the river and were spared the fate of more than 200 Assyrian families who were captured and held for weeks until their ransoms were paid.

The two encounters with Daish left Sami questioning whether it was better to leave Syria for the sake of the safety of his wife and children

Sami ran this over a thousand of times in his head. To leave Syria meant leaving behind thirty years of service as a mechanic in a depot for government vehicles. Thirty years of work entitlements would be gone. It would also mean leaving behind all he knew and starting again at the age of fifty.

Eventually at the urgings of other families who had been forced out, Sami made the impossible decision to leave Syria behind. He travelled to Damascus with his wife and children and then on to Lebanon and ultimately in August 2016 to Australia. Sami had concluded there was no life left to him in Syria anymore.

Sami and his family are four of the 12,000 who have been brought to Australia as part of the additional refugee intake. He now lives in Fairfield West. Sami's hopes for his future and that of his family are to find a job, a car and a home and for his children to get a good education. He wants to live a quiet life and raise his family just like Australians do.

Six Thousand Syrians and Iraqis make Fairfield their home

Around half of the additional humanitarian intake of Syrians and Iraqis to Australia are likely to make their home in one Sydney local government area, Fairfield City.

The Federal Government's announcement in September 2015 that an additional 12,000 refugees would make their way to Australia from the Syrian and Iraqi conflicts has resulted in the acceptance of many through links to relatives already living in Australia.

Australia has prioritised those from persecuted minorities such as Assyrians, Chaldeans and Mandaeans.

The Fairfield area has historically settled large numbers of people from refugee backgrounds from the Syria and Iraq conflicts and many of those arriving in the last 12 months are joining relatives, that were themselves subjected to persecution and made their way to Australia over the last fifteen years.

The neighbouring council area of Liverpool is receiving Mandaeans from the conflict in Iraq. Some amongst this group fled Iraq to Syria following the fall of Saddam Hussein and have been forced to flee their temporary homes in Syria since the conflict commenced there in 2012.

Small groups of humanitarian entrants have also made their way to the regional centres of Wollongong, Newcastle and groups from the heavily persecuted Yazidi minority have resettled recently in the NSW towns of Wagga Wagga and Coffs Harbour.

HEALTH

Refugee Trauma and Dissociation: Reintegrating Lost Parts of Oneself

Refugees and asylum seekers experience betrayal trauma at a 'meta level', says author and social worker NAOMI HALPERN, who spoke about trauma dynamics and the therapeutic relationship boundaries at a Clinical Master Class at START TS. This is a summary of her address.

PHOTO: WILDPIXEL

I will talk about the issues we come across when assisting complex-trauma clients, particularly relationship issues, which relate very strongly to attachment. As we know, relationships are the crucible for healing.

I will briefly cover the psychobiological impacts of trauma. I am sure that you are all very familiar with this subject. Then I will be looking at attachment, not just in terms of our clients' attachment styles, but also our own attachment styles, which ties in with issues of transference and countertransference.

Transference and countertransference are going to occur with any client who we work with, however these dynamics are far more complex and layered in the case of clients with a history of trauma or abuse. I will look at how we, as therapists, can very quickly and inadvertently find ourselves landing on Karpman's Triangle. I will point out some of the strategies that can get us onto the Triangle and how we can learn how to step off the Triangle as quickly as possible and get things back on an even keel.

So to start with, what is complex trauma? Complex trauma is the result of feeling threatened beyond our capacity to integrate, self-regulate and self-soothe in a given situation. So when people are overwhelmed by trauma and when trauma is persistent, which is the case for the clients we work with, it alters their capacity to self-regulate and to self-soothe.

Complex trauma is the result of feeling threatened beyond our capacity to integrate, self-regulate and self-soothe in a given situation.

This has many other flow-on effects in terms of how clients are able to be present or not in the here and now and how they might understand and interpret experiences, in the counselling room with you as well as in the outside world.

So when we refer to child onset of complex developmental trauma, we are talking about children who have been exposed to very chronic, pervasive and cumulative trauma, it is not just a one-off trauma. One-off trauma can have enough repercussions in itself. However, the clients we work with are exposed to ongoing traumatic events and situations. Very often for these clients the foundation of their trauma experience is relational. It may be happening within the family. Even if the family is quite functional, if they have been exposed to terrible situations in their country of origin and their parents are overwhelmed and unable to cope with the circumstances, it will have flow-on effects on their children, which can result in insecure attachment, especially disorganised attachment.

What we know about complex trauma and its impact is that it has a strong influence on neurophysiology, psychophysiology and bio-psycho-social maturation and development, including attachment styles - a child's capacity to attach and attachment that they may develop.

If we look at adolescent or adult onset of complex trauma, what we find is people who have been trapped in abusive relationships, it might be family violence, domestic violence, intimate partner violence; prolonged captivity with isolation or torture. I am sure these are the experiences of some of the clients who you work with, those who have been exposed to ethnic cleansing, annihilation, those who have been caught up in prolonged war situations, in violence and civil unrest and of course, human trafficking, slavery and prostitution. What we often find is that a person is not only exposed to one type of trauma but there has been exposure to multiple types of trauma.

I will be speaking about dissociation in particular. Dissociation is associated with disorganised attachment and/or childhood abuse. Dissociative disorders can develop in the aftermath of trauma and can occur any time in the lifespan.

In my work I have specialised in adults abused as children often by paedophile rings. I am talking about organised sadistic abuse, but also about long-term childhood abuse situations and neglect. I often work with clients who have developed dissociative identity disorder as a consequence of the trauma they have experienced. You may be familiar with the book I co-wrote with Dr Colin Ross, *Trauma Model Therapy: A Treatment Approach for Trauma, Dissociation and Complex Comorbidity*.

In the latest *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* there are five forms of dissociation and some significant changes in the criteria. It is important to remember that clients who have experienced complex trauma may self-regulate with dissociation but do not necessarily have a dissociative disorder. So it is important that a differential diagnosis is carried out so we understand what a client's situation might be.

It is important to understand the structure of the brain and how trauma is processed by the brain and teach our clients about it. Psychoeducation helps clients to understand what they are experiencing and feeling, and to recognise they are not "mad".

Psychoeducation is such a key part of the work we do because it is through knowledge, education and empowerment that we transfer the power of healing back to the clients so they understand that they can learn to regain more control over their minds and achieve better functioning.

Psychoeducation is critical. We need to explain things in simple language. They need to learn about the function of the cerebral cortex and the frontal lobes as being the part of our brain where we think and analyse, it is where our capacity to conceptualise and reflect takes place.

When someone is traumatised, or when a traumatic experience is triggered, the frontal cortex goes offline and the limbic system, the middle part of the brain, is activated. This is where the non-verbal and emotional memory is stored and processed. So when you have a gut feeling that something is good, or something is not okay, but you cannot put your finger on it, that is the limbic system at work.

The limbic system is where trauma memory is stored. External or internal triggers can activate the limbic system as well as memories.

The limbic system is where trauma memory is stored. External or internal triggers can activate the limbic system as well as memories. I remember a client of mine with cerebral palsy. One day he was at the Flinders Street station in Melbourne waiting for a train when a man walked past him wearing a particular type of cologne. When he smelt the cologne he was suddenly flooded with memories of the abuse inflicted on him by a family friend when he was a little boy.

He had no memory of the abuse before that trigger. That is what the limbic system does, it stores trauma memories in the unconscious. Down from the middle part of the brain is the brain stem, where all our instinctive responses are generated from. It is the part of the brain that regulates our breathing, heart rate, tells us if we are hungry, thirsty and, of course, this is also where the fight-flight, freeze and submit responses come from.

Our clients are not only dealing with one or two issues but many. It really brings home the overwhelming struggle that so many of our clients are dealing with on a daily basis, and it makes me wonder how some of our clients manage to get through life.

Our complex-trauma clients can display extreme behaviours. They can be too rigid and closed, too fixed and narrow in the way they present themselves, their perspectives and the way they navigate their world. They can also be very defensive, avoidant and overly closed when it comes to learning from the present. We find our clients are often continually trapped in the same situation over and over again, and it is as if they do not learn from experience but only respond with conditioned reactions.

On the other hand, they can also be too unstable and open to the influence of external experiences and perceptual distortions. Many times we have been surprised by our clients' reactions to things we say, how they understood or interpreted something.

Also, clients can be overly open to the influence of the past. They can be reflexive instead of reflective. They can be very impulsive and reactive and, of course, that can then lead to finding themselves in repeated situations that cause them harm and difficulty.

Trauma impacts on our clients in several different ways, including attachment styles. So if you have a child who has been exposed to traumatic experiences, you need to observe how he or she behaves, and see how that child, without the appropriate help and support, might respond in terms of adult attachment styles.

The Dismissive Attachment style in an adult will respond as if they do not need you. The client does not care if the therapist is on leave. According to them, everything is fine. The client is either shut down and disconnected, or shows the opposite reaction, preoccupied and anxious, the type who sticks to his or her therapist and is overwhelmed and traumatised when the therapist is away on leave, sick or has to cancel a session. Fears of abandonment and relection will be activated.

Attachment is a key part of the picture when we work with our clients. We like to think of ourselves as kind, compassionate, benign people who are there to do the right thing and help in the best way we can. But the client-therapist engagement is an unequal power relationship with an authority figure (the therapist) which will likely be reminiscent of a situation where

our client was abused or traumatised in the past.

We like to think we create a safe, private space for our clients to open up to us, but for the traumatised client therapy may feel secretive as it is conducted with the doors closed. They may fear that once the door is closed that they cannot get out if something goes wrong. So how we construct the room is important, such as where we invite our clients to sit. When I am giving a presentation I use my hands a lot. But when I am with a client I sit with my hands on my lap and barely move them at all because I noticed that any hand movement was observed by my clients and I realised it was very stressful and traumatic for them.

The message we are conveying to our clients is: "trust me". "For you to get better you need to trust me, you need to let me in enough so we can form that crucial therapeutic relationship where the work will be done." But it is a one-way street, isn't it? We invite them to enter into a trusting relationship where the power is all on one side. We invite our clients to tell us everything about themselves, but we do not disclose anything about who we are or what our experiences are, quite appropriately, but nevertheless it is an unnatural relationship and reminiscent of past relationships and experiences where there was an unequal power balance.

And we tell clients that our role is to bring them a step closer to those aspects of their lives that they might want to forget or stay away from. So because of that fact alone, at some level, we are going to be experienced by our clients as the perpetrator. So we need to be aware of post-traumatic transference, unmet attachment needs, the expectation that they are going to be betrayed by us and of re-enactments which will arise in the context of therapy and in the relationship with the therapist too.

Then, on top of all those transference issues, we may also have culture, language, gender and ethnicity factors that may make the therapeutic relationship difficult to navigate. Clients will test us in lots of different ways to gauge how safe we are.

So arriving late for therapy, going over time, non-attendance, non-engagement in the therapeutic process and excessive calls or emails between sessions can be part of testing the boundaries. We need to be clear and consistent with boundaries. One of the things I learned early on is that it is better to be firm about your boundaries early on and once you get to know a client you can loosen them a bit, rather than have looser boundaries at the beginning and then try to reign them in.

Then other symptoms and behaviours emerge – flashbacks, self-harm, suicidality, depression, and overt or passive aggression which are very difficult behaviours and experiences for our clients obviously, but also for us to manage.

It is likely that you will not have only one trauma client but many. So you are dealing with these behaviours many times a day with different clients, and that is where our post-traumatic transference comes in to play. We need to be aware of our attachment needs, vicarious trauma and history of abuse, if we have one, because all these issues will impact on the relationship with the client, in addition to any culture, language, gender and ethnicity factors I mentioned earlier.

The two types of countertransference responses that we need to be mindful of is Type I: enmeshment, rescuing and boundary violation behaviour, trying to love our clients back to health and being this nice, kind, generous person who is there to give and give.

Or the Type II person being counter-phobic, avoidant, experiencing a numbed response to our clients' stories, not having an appropriate empathic engagement with our clients. It is most important that we understand our own attachment style. It is not enough to understand our clients' attachment style, we need to understand our own and look at how the clients' and our own attachment style interact. Most of the case consultations I give see client and therapist in some kind of an impasse. Attachment issues are often the piece that is getting all caught up.

If we are not cognisant of attachment dynamics we will find ourselves stepping on the Triangle very quickly. We might go into rescuer mode and if we are in rescuer mode, what does it look like? Well we might go over time or we might have excessive out-of-hours contact with our clients. We might be the victim in the relationship and by that I mean accepting unreasonable behaviour from clients.

Now of course there's going to be a certain degree of unreasonable behaviour that is grist for the mill and we expect and accept that, but we need to know where the line is and when it is being crossed, or we could be the perpetrator. We could get angry or judgemental about our clients or emotionally withdraw from them.

It is important to understand the Triangle dynamics. No matter what our clients do, it is our responsibility to stay off the Triangle. If we find ourselves inadvertently stepping onto it, which is very easy to do, we must find ways to quickly get back on track and step off the Triangle. A therapeutic misadventure in the transferential relationship can lead to the re-victimisation of the client and the vicarious trauma of the therapist.

We are not always going to be able to avoid those situations. I want to highlight a case. I had the most distressing experience in 2009. At that stage I had been practising for 21 years and I had a client commit suicide. It was out of the blue, unexpected and, as you can imagine, it was absolutely traumatic. It happened a couple of weeks before Christmas, and we know that can be a very vulnerable time for our clients, they will often decompensate around holiday times because their family issues will be activated and they know we are going to be away.

I had a female client with dissociative identity disorder who I had been working with for about three years at that time. Every time I went on leave, and particularly if it was Christmas, she told me what an awful therapist I was as I knew that this is the worst time of the year for her. I had been through this with her many times and we had always worked through it and discussed how she was going to stay safe and who would be her back-up therapist and her contacts. I had done it so many times. But having just lost a client I was absolutely distressed and I could feel very quickly that my anxiety was rising and I could see her reacting to that. In the end I just snapped - I'll call her Jane. I said: "Jane, if you don't feel as though you can keep yourself safe then really you're going to leave me no other choice but to call the Crisis Assessment Team". She looked at me absolutely horrified and I thought, "Oh my God Naomi, what have you just said and done? You've really blown it now."

...do not be frightened of making a mistake, otherwise that will inhibit you, you will not be authentic.

So I looked at her and I said, "The bottom line is, if you kill yourself I can't keep on working with you". Luckily she had a very good sense of humour and we repaired very quickly and moved on. But these are the kind of situations we can very easily find ourselves in and we need to find a way to navigate ourselves and our clients through those issues.

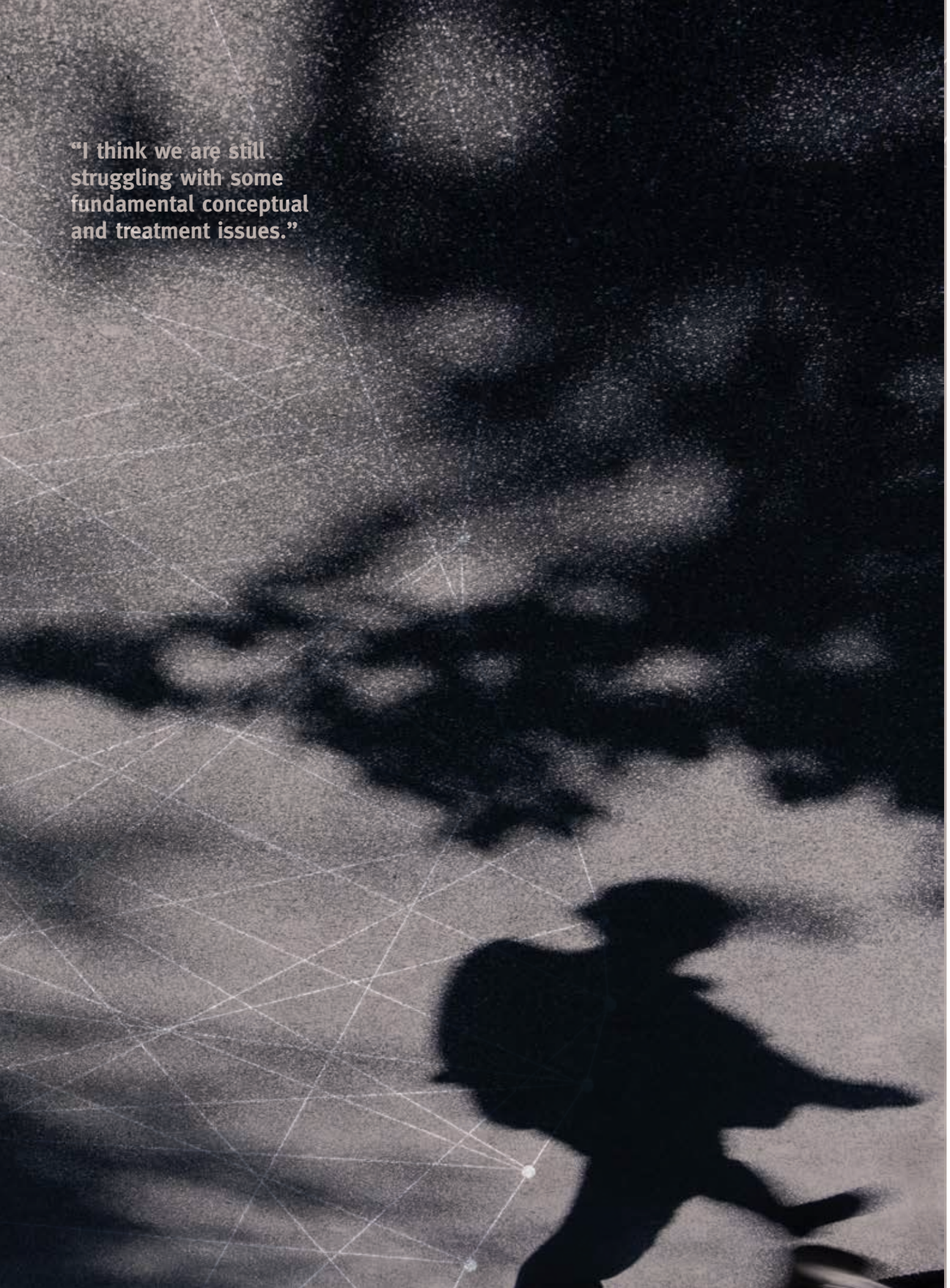
We need to look after ourselves first, because if we are not taking care of ourselves that is when we will find ourselves in vulnerable and risky situations with clients. So making sure we are being nurtured and rested; that we have good supervision; if we have got a trauma history and a client triggers our history, that we go back into therapy; that we do professional development; all these sorts of things are about taking care of ourselves first. It will not stop us from finding ourselves in situations where we get on the Triangle with a client, but it will minimise it and it will enable us to recognise it much quicker and get things back on track, rather than the situation spiralling out of control.

I mentioned at the beginning the importance of psychoeducation and stabilisation and this is the crux of the work with our clients. Many clients will not get beyond this stage. It took me a long time to accept that some will not progress beyond phase one, but it is better than where they were at before.

So focusing and getting phase-one work under the client's belt is going to minimise those risky situations, because it is when we are either pushing our clients, or they are pushing themselves that we get into those risky situations on the Triangle. We are aiming to work within the window of tolerance. We want those arrows to be a little bit peeking over the lines. So we stretch our clients a little bit beyond their comfort zone, but not so that they either shoot off into a hyperaroused state and go into fight or flight, or they shut down and go into freeze and submit.

In terms of staying off the Triangle I do not want to frighten you into thinking: "I've got to be so concerned about not harming my client that I'm not going to try new things and experiment". We need to be careful that we are not walking on eggshells and not prepared to try new things. We need to also stretch ourselves in terms of being open to different strategies, new things that might work with one client but will not necessarily work with another. As Einstein famously said, "Anyone who has never made mistakes has never tried anything new." I do not know about you, but I have found that if I make a mistake, if I stuff up, as I have done many times over the years, and I acknowledge it and I apologise, our clients are often very forgiving. Obviously we want to make as few mistakes as possible, but do not be frightened of making a mistake, otherwise that will inhibit you, you will not be authentic.

Finally, thank you for your commitment to assisting your clients and for making a difference to those who are suffering, because it is really hard work and it does take its toll on us. When you have worked with trauma you are changed forever. Once the veils are lifted and you know what is going on out there you cannot put them back. And that is a big price we pay, so it is important we acknowledge each other in the work we do. So I would like to extend my thanks to you. ℟



HEALTH

Professor DERRICK SILOVE is the director of Psychiatry Research and Teaching at the Mental Health Centre, Liverpool Hospital, he spoke at a research symposium at STARTTS about the latest research on refugee trauma.

Effective Interventions and Models for Refugee Trauma

It is great to be here and see so many interested people, which is encouraging. Healing goes back a long way, to the beginning of human history and I believe that as healers we have a major responsibility to be clear in our minds what exactly we are doing. Having been in this field for many years I must say that I am not sure I am that much clearer now than when I began. I think we are still struggling with some fundamental conceptual and treatment issues.

My talk today is about where we have been, where we are and where we are going, in terms of treatment research mainly. I will make reference to epidemiology and other research as I go along. Even though I have been involved with STARTTS from its beginnings, the exciting part is that we are constantly evolving in our efforts to bring order to the chaos, to achieve a conceptual overview and framework that covers the extraordinary phenomena we deal with – suffering, trauma and displacement.

There is what I call a disjunction between the treatment research and its development, and the more conceptually based epidemiological observational research. What I mean is that treatment research was slow to take off – I will come to the reasons for that soon – while the epidemiology and conceptually based observational research has been going longer.

We started with a very simple "trauma goes to PTSD" model, essentially borrowed from general traumatology. It really started in the late 1970s and 1980s, when Post-traumatic Stress Disorder (PTSD) was first adopted as a diagnosis. Even though there was a lot of controversy in our field, the major focus of research was to explore and describe the mental health effects of trauma among refugee populations. So we were very PTSD-fixated – then we rediscovered stress. Why didn't we do that at the beginning? I think the asylum-seeker research team and others brought to the fore how important ongoing stressors are in determining the mental health of refugees.

Then models have developed further to include other disorders as well as issues of functioning and adaptation. Then we tried to broaden it to family and community, which is not easy in research because of limitations in the methodology. So I think the researchers tried to follow the clinical cause, which is

learning from clinicians and service providers where the focus really is, and expanding and making more complex the models we test.

There has been a lag in treatment research primarily because there was opposition to conducting research on treatment among refugee groups: there were also simple technical difficulties.

It started with ideological opposition – that we should not be studying refugees and their treatment in an objective way, ignoring their subjective existential experiences. We span a huge range of disciplines, among them human rights, psychosocial issues, culture and anthropology. We did not really have the metrics, the tools or the methodologies well worked out at the beginning.

It was difficult to get representative samples of people in the community, rather than those selected because they volunteered or we chose them. Randomisation has always been an issue with services. Understandably, we are going to allocate some people to what we think is the most active treatment as opposed to treatments that might be inferior. To achieve that is a difficult thing for a service, but there are ways around it.

For example, the Danish Rehabilitation and Research Centre for Torture Victims has overcome these issues in clever ways. Then we also lacked the statistical and analytic techniques. So there were many reasons why treatment research lagged behind in the field.

But if we look at the past 10 years there is now sufficient evidence to say some positive things.

The first is that there is support for what I call expanded Cognitive Behavioural Therapy that is being adapted to the needs of refugees, taking into consideration cultural issues and so on. Narrative Exposure Therapy (NET) is the obvious example and I am sure many people are familiar with Frank Neuner's work and the others who followed his path.

Another approach has been a more flexible transdiagnostic approach and the Common Elements Treatment Approach (CETA) created by the team at Johns Hopkins University, who I work with. There is remarkably little data available to support what we have all believed in, the Comprehensive Multidimensional Approach characterised by STARTTS and many other agencies.

NET is basically a simple exposure technique done by lay people using a Narrative and Autobiographical Approach, where you trace the history of the person from early days through their trauma in a systematic way using timelines.

When compared, at least conceptually, with the Standard Prolonged Exposure Therapy used in PTSD in general (not refugee) populations (when the person is repeatedly put through the traumatic experience over and over until he or she appears to habituate to the stress of it), probably there is not a lot of difference between the two. Perhaps NET is better adapted to refugees, but conceptually it is doing roughly the same thing.

The Transdiagnostic Approach, developed by Laura Murray from the Paul Bolton group and others at Johns Hopkins, starts to recognise that in refugees who have suffered a lot of trauma and stress comorbidity is far more common than single diagnoses. Anyone who has PTSD very likely has depression, panic attacks, grief symptoms and a whole range of other things. Should we be treating one disorder or group of symptoms, ignoring any others?

At least the Transdiagnostic Approach allows you to be flexible in a limited way, so you can focus more on PTSD symptoms such as depression, anxiety. They also have a module for drug and alcohol abuse. They were not trying to invent something new, but took the best approaches that have been shown to work "off-the-shelf" as therapy components, put them all together, adapted them to the refugee population and packaged them in a way allowing for flexibility, depending on the main problem. If it is depression, you may go down the behavioural activation path more; if it is PTSD, you may do more imaginal exposure, and so on. So in a way that makes sense.

The Bolton group has tested this therapy rigorously using randomised, controlled trials in countries around the world – post-conflict countries, not necessarily only among refugees but conflict-affected populations – and, by and large, have shown good results. Interestingly they have not tested it for alcohol problems, but we all know how difficult it is to treat that, but for PTSD, depression and anxiety it is showing promising results. A new treatment supported by the World Health Organisation is somewhat similar, perhaps even briefer.

So there is a pretty good compendium of these treatments. They vary in detail and emphasis, but we probably have a reasonable package of these treatments if you want to do a structured, short-term intervention. Our University of Copenhagen colleagues tested what we would see as being the more "bread and butter" standard approach to treatment, which has many components and includes medication, Cognitive Behaviour Therapy (CBT), exposure techniques and, where necessary, stress management, problem solving and so on. They tested it within an agency setting, like a real-life setting perhaps like STARTTS, where people are put through a long and comprehensive intervention.

Being an honest group, in the *British Journal of Psychiatry* they published quite a spectacular result – virtually no change, particularly in PTSD symptoms. The symptoms were exactly the same at the end of the treatment as at the beginning. Depression showed a slightly better outcome, but still pretty modest given the extent of the treatments involved. Now I guess you have to ask yourselves then why is that the case? Why are we getting such discrepant results when a short-term CBT treatment is working so well in Neuner's studies, for example, and this comprehensive, flexible treatment conducted in an agency that specialises in treating refugees appears not to be working?

It raises several key issues we have been struggling with in the field for some time and I thought I would just detail some of them because I do not think we have fully resolved them. Should the focus of treatment be primarily on individuals or families? Or, at the wider level, the community, or the system? Should we change conditions in the public health system rather than treat individuals?

Diagnostically we have been focused on PTSD, but the more we look for other disorders, the more we find them.

Obviously there is no simple answer. We have not systematised our thoughts very much about how well and for whom this works. Should it be preventative, empowering, resilience - building, advocacy or therapy? Again, there is some blurring. Good services such as STARTTS do all those things, but there is some blurring of where lie the boundaries between these areas.

If it is therapy, is it really about relieving symptoms? Is it about rehabilitation or the functioning of people in spite of their symptoms? Is it about restoring a sense of humanity and meaning to the person and not worrying too much about symptoms? or are we just trying to encourage a broad notion of adaptation to their new eco-social system?

Diagnostically we have been focused on PTSD, but the more we look for other disorders, the more we find them. People with grief, adult separation anxiety, panic disorder – we have listed at least 13 categories in our new measure where people commonly score very high according to the *Diagnostic and Statistical Manual of Mental Disorders* or *The International Classification of Disease*. Does PTSD drive all these other disorders, or is it just one of many [factors]? If you treat one, do you treat them all?

It sounds like a kind of Buddhist axiom or something, but if you treat PTSD, is it good enough and everything else will fall into place? I mean panic symptoms, depression and so on, do they get better? Or is it more likely some of those symptoms are not going to improve unless you focus on them?

Then, trying to answer the question about why treatments work in some places and not others, does the population matter? I think we have not really paid enough attention to this because the obvious answer is yes. We all know that working with asylum-seekers it is a lot harder than working with settled refugees because of the stressors and fears for the future they suffer and the administrative and legal issues they go through. Many services in resettlement countries have much more specialised groups of people coming to them. There are many filters in the care of those people before they get to the refugee service. They have often seen GPs or others and been prescribed medication. They have been in the country a long time. They may have chronic symptoms.

If you look at the profile of the treatment group our Copenhagen colleagues did not do so well with, they are that hard-core group that has been severely tortured or isolated, unemployed, they might have head injuries and other organic disorders, chronic pain … it's a group we all know to be treatment-resistant. I have learnt that there is no option but long-term therapy for those who are so disabled. Providing an environment where you build up trust and deal with existential issues current and past while gradually unfolding the trauma story seems the only way you can do it.

There is no possible way of doing that quickly and if you go too fast you will do more damage than good. Now, that runs completely counter to the kind of treatment studies I've mentioned and, as I say, I think it is fundamentally about different populations, different subgroups needing quite different forms of care. Again, the research community has not really focused on the diversity of needs and the fact that treatments have to differ.

Some people may be familiar with the comprehensive ADAPT model – a conceptual framework for mental health and psychosocial support I have put up that tries to give a framework to explore all these issues in a coherent way without oversimplifying our notions about treatment.

It is founded on the notion that adaptation is a fundamental tendency among humans, that is why we are so successful and why we survive, and what is fundamental to the refugee experience is the sequential changes in the eco-social environment they live in.

Refugees go through all the phases of conflict: flight, transition and resettlement, and many others in-between. Every time they go through these phases their institutional foundations are shaken, which is more than just suffering discrete trauma, or discrete stressors: it is about the whole ecology of life.

What I have suggested – and this is derived from clinical experience, from talking to everybody about it and the existing literature – is the idea of organising the psychosocial pillars into five categories, framework we all rely on for a stable life. When they are disrupted and undermined, it is very hard to maintain mental health or a capacity to function and adapt effectively.

These pillars are:

- **Safety:** Without safety or a sense of safety we are always under stress and experience a sense of threat.
- **Interpersonal bonds:** We are herd creatures, living in groups and families and in smaller and larger collectives, and when that is disrupted or destroyed then we are in a difficult situation, as we know, we experience loss, grief and separation anxiety, among other things.
- **Justice:** A sense of justice is fundamental because, while also a legal and human-rights concept, it is a psychological, cognitive and very deeply seated existential notion. When we are abused or suffer gross injustices, the natural feelings of anger, frustration and resentment can become pathologies.
- **Identity:** Refugees often lose a sense of identity. They lose their roles, qualifications may not be recognised or they have to take on new and hybrid forms of cultural and national identity, so another fundamental system is disrupted.
- **Meaning:** The experiences refugees suffer challenge their notions of meaning, their religious and existential beliefs, their faith in humanity – just the sense of who they are. Re-establishing meaning is a big task and often a major focus of therapy. This is a conceptual model.

Researcher Alvin Tay tried to develop an ADAPT measure based on those five psychosocial pillars and we used it with West Papuan refugees living in shanty towns in Port Moresby. It showed that past trauma and ongoing stressors clearly predict PTSD and functional impairment.

If you apply ADAPT to it as a kind of background, then you can see it influences just about everything. It exerts an influence over stress and has a moderating influence over trauma: that is, the way you interpret the trauma depends on the background of these psychosocial pillars. If you think of a painting, it is about the background of that painting, not the immediate event [in the foreground], that influences people and the collective response.

We have been studying the link between the sense of injustice and anger in East Timor for some time. This is part of a cycle of violence model we are trying to test in stages because it is very complex. We are all familiar with and we often invoke it in our own work, which is the axiom "violence begets violence". What we see, and we are all familiar with this, is that unfortunately, in families where there has been extreme trauma, often the trauma is played out in the family in the form of domestic violence, abuse of kids and so on.

So the families are left with this residue of anger and violence and it can have serious consequences for the family and the wider community, as well as potential transgenerational effects on kids. Of course, that is not a linear model. That is not true of every family that has endured trauma: there are many positive resilience factors that can interrupt the cycle.

In our studies on explosive anger we have found that it is extremely common in the Timorese society where trauma is a major factor in causing explosive anger. The sense of injustice we measured plays a strong role in the pathways leading to that anger over time and the reasons why anger remains chronic and persistent and people explode over very small issues, leading to aggression.

What I found in places like Timor, Bougainville and others where we are trying to connect with policymakers and funders, we forget sometimes how difficult it is to seek money to treat mental health problems. It is hard in Australia, but it is far more difficult in post-conflict countries where funding priorities do not include mental health. Even within the health disciplines, other areas are given far greater priority and mental health is right down at the bottom of the barrel.

If you go to the policymakers and the funders and say the word "trauma" they say: "Yeah, trauma is terrible, we agree. We will give you a little bit of money for this little service for trauma." You say: "PTSD" and they say, "Well, yeah, I have heard of that, that is where you have people who have bad memories and that must also be awful, so we will give you $100 for that."

PHOTO: iSTOCK

...unfortunately, in families where there has been extreme trauma, often the trauma is played out in the family in the form of domestic violence, abuse of kids and so on.

But if you say "anger and aggression", then they say: "Oh, you mean you can deal with anger and aggression?" We say: "We aren't so sure, but we think it is a major problem" and they will say "well, that is the overwhelming problem here!" because it is affecting peace-building. People are exploding with anger at work and at home. There are reports of domestic violence, kids being abused and so on. If you talk to the community leaders they all say the same thing.

We have to be careful not to pretend we can solve all those problems, but it is interesting that anger, which in psychiatry has been buried away in PTSD as a subsidiary feature, is the thing that resonates with people outside our field. It's important that researchers speak the same language as the wider community and the wider aid community.

It is still a very new field and there are very few studies. The two I have spoken about are not even published. One is a brief intervention based on the ADAPT model that we have trialled in Timor, which seems very effective but is a very small study. The other is an ADAPT module for treatment that we are testing in several communities in South-East Asia. Again, early results look promising.

But it does suggest we have to broaden our conceptual foundation beyond PTSD and towards issues that really are seen and felt to be the most relevant in the communities we work with. R

A Dancer in the Midst of War

The Syrian war has displaced millions of people and killed hundreds of thousands. As the violence continues, 26-year-old dancer Ahmad Joudeh believes he can fight the war itself through art. DUNJA KARAGIC spoke to him.

PHOTO: MARC DRIESSEN

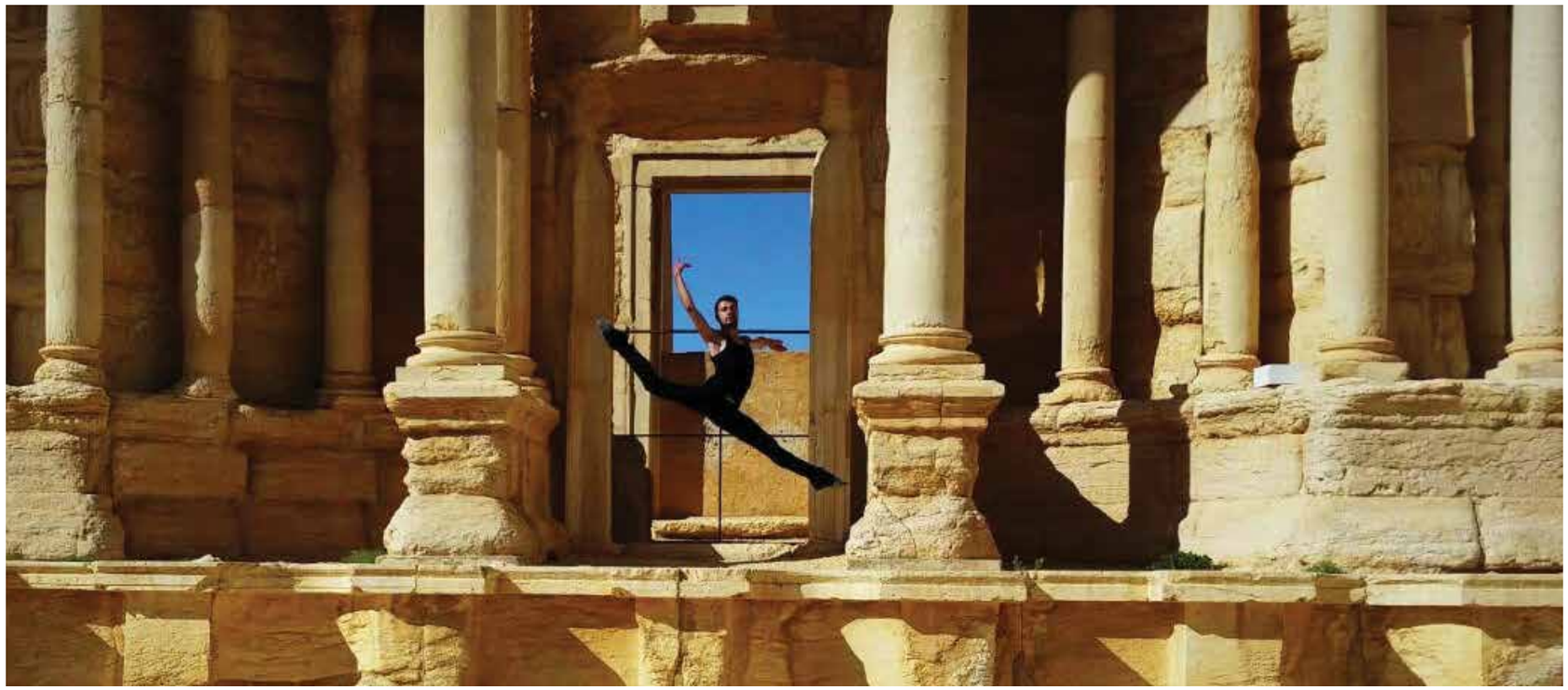


PHOTO: Courtesy of Ahmad Joudeh

"For me, dance was about healing people – helping them to accept themselves, to see life in a different way..."

Ahmad, a stateless Palestinian refugee who was born at the Yarmouk refugee camp in Damascus, became a ballet dancer at an early age, pursuing his passion for dancing despite war and the disapproval of his father and community.

In Syria he spent his time eagerly learning to dance and teaching orphaned children at children's villages run by SOS, an international NGO trying to protect the rights of disadvantaged children in war-torn Damascus. A documentary last year by Dutch journalist Roozbeh Kaboly, entitled Dance or Die, revealed Ahmad's story and talent, which resulted in an invitation from the Dutch National Ballet.

Ahmad is now studying in Amsterdam, improving his art in the hope of developing his talent to show his country the significance of dance. For Ahmad, dance is a symbol of strength and perseverance, a fight for freedom. He believes it can help others face loss and hardship as it has helped him.

His passion for dancing started as an eight-year-old during a school performance, where he sang and his brother played music. The whole city came to see the performance. "I felt that moving with the music was better than making music, so I went home and started dancing. My mother asked me: 'What are you doing? You need to stretch your knees.' She then showed me some flexibility exercises. Then she said: 'When you grow up you can go to Enana [Dance Theatre]'."

When Ahmad later decided to pursue dance he headed to Enana, where he took his first ballet classes. "My life was complicated living in the refugee camp, since it was not good to be a dancer in that society. So my father turned against me and tried to stop me, but he couldn't."

In Syria, he says, parents prefer their children to become doctors, engineers or teachers. His father was an art teacher, he painted and played music, yet still he objected to Ahmad becoming a ballet dancer.

An appreciation of how dance could help children grew on Ahmad. "For me, dance was about healing people – helping them to accept themselves, to see life in a different way, have the strength to face the war, face society and develop a strong personality as well.

"Of course, if I wasn't a dancer, I would never have this life now. Because I'm dancing I could survive, I could see the world from a different perspective, I could help a lot of people in Syria, I could come here [Amsterdam], so dance changed my life."

When the war started, a five-year-old girl was killed in front of him. "It shook me. I was so sad for her. Most of the time I kept thinking I should do something for those kids. I have to help them deal with war."

When Ahmad searched for orphan organisations he found out about SOS Children Villages and made contact. Children had come from Aleppo and other cities to war-torn Damascus without parents, without anything. "I was like, 'let me try to make them happy at least'. I was telling the director of the organisation about teaching and he was saying 'OK, but by dancing no one will be happy, blah blah blah … it's something not good'. I said 'just let me try and I will succeed' and he said OK.

Ahmad taught children to dance on a voluntary basis. They loved it and were waiting for his classes every Saturday. The director was happy and asked him to teach more during the summer vacation. According to Ahmad, dance changed the personality of the orphan children, and "when I taught kids with Down Syndrome, they showed happiness from dancing".

Is he still in touch with those children? "Yes. They are happier and now they have more hope. Dance could maybe help them in the future. I asked my friend to go there and teach them and keep the classes alive, so I never left them, really. Now we have this group on WhatsApp, we are in contact every week and I have videos from them saying 'look what we did!' I tell them every week I want a new video.

"They are working so hard; I want to keep them busy by thinking about creating something or just moving with the music. It's better to compete through art than by the gun. I want to teach them how to fight by art, and how to present themselves through art as well."

Ahmad's life changed radically when Kaboly came to Syria and made the documentary about Ahmad's life. He danced in front of the camera on rubble that once was the Yarmouck refugee camp, which had been destroyed by bombs.

Dutch National Ballet director Ted Brandsen invited him to work in Holland and the Amsterdam University of Arts also invited him to study there.

"Life in Amsterdam is totally different from life in Syria," Ahmad said. "In Syria I was surviving and now

"In Syria we were just living day to day, and if you say goodbye you say it as if you will never come back home."

I am living – something new to me. So I'm getting used to this life where everything is safe and I appreciate the electricity, water and the beautiful house I have.

"In terms of my dancing I am improving very much because now I have teachers, studios, things to do. I am so happy now that I'm working because I can help my family I'm sending them money."

According to Ahmad, the situation in Damascus is getting worse by the day. "I see on Facebook from my family it's so bad, the fighting surrounding the whole of Damascus is so bad. A lot of people are being killed."

I ask him about his plans for the future. "In Syria we were just living day to day, and if you say goodbye you say it as if you will never come back home. I really want to study, then I can build the Syrian National Ballet one day. If Syria is okay and safe I will go back."

"After the war we will need culture and art to heal our country, so I am learning to deal with dancers, how to be a choreographer, a good dancer. When I go to Syria I will have enough experience to be able to create the Syrian National Ballet. I would love to let all Syrian people accept ballet as something very important for society."

Dance has helped Ahmad face adversity. "When you are dancing, when you try to reach the movement, as in life if you try hard you will achieve what you want. This is what I have learnt."

You can watch the 'Dance or Die' documentary on YouTube.

PHOTO: MARC DRIESSEN

HEALTH

VIRGINIA LEE worked for Medecins Sans Frontieres in Jordan providing psychosocial services. She describes her experiences working with people injured by the war.

THERAPY AND CROSS-CULTURAL EXPERIENCES

Syrian refugee Sameh, aged 14 years, shares a light and loving moment with his mother and brother in their apartment on the outskirts of Amman, Jordan. PHOTO: UNHCR / S.BALDWIN / May 2014

In July 2014, I took a year's leave from STARTTS to work with Médecins Sans Frontières (MSF) in Amman, Jordan. MSF is an international humanitarian organisation that provides medical assistance to people affected by war and natural disasters, and supports people and communities where healthcare is not available.

I had followed the work of this organisation for many years and was aware that, along with doctors, MSF also took counsellors and other health professionals. It was during my postgraduate studies in international public health that I became interested in humanitarian work and the experience of refugees.

Little did I know that in the future I would have the chance to combine both interests in working with MSF.

During my seven years at STARTTS I met and supported refugees who were at the latter end of their journey of flight, in the resettlement phase, where they could stop fleeing and start rebuilding their lives in a safe place. But in Jordan I met people who were at a much earlier phase, some who would later become refugees later on.

My MSF mission in Jordan was with the Amman Reconstructive Surgical project where I was assigned as the manager of the psychosocial team. This project started in 2006 in response to the conflict in Iraq, where it provided surgical treatment to Iraqi victims. The scope of the project then expanded with other conflicts in the region.

My colleagues would describe Jordan as a safe haven in a ring of fire bordering Iraq, Syria, Yemen and Palestine, which are all amidst war. It is no surprise that Jordan is host to more than one million refugees.

I joined MSF in Jordan during a transition period when the project was moving its operations from the Jordan Red Crescent Hospital to Al Mowasah Hospital.

This eight-floor hospital was purposely refurbished to provide specialised surgical care and rehabilitation to the war-wounded, where patients could have access to maxillofacial, orthopaedic and severe burn surgeries.

There, survivors of conflict receive treatment and support to return to a level of functioning for increased autonomy to ensure their continued participation and inclusion in society. In most cases, this type of care is not yet available in their own countries, given that the health systems and infrastructures are only able to provide emergency medical care and are still ill-equipped for rehabilitating injuries, which may require multiple surgeries over a lengthy period of time. Some patients had lived with their injuries for a long time before their treatment by MSF.

The services provided by the MSF hospital are all free of charge, and patients of all ages eligible for such care are identified by a network of medical liaison officers working in those neighbouring countries as well as in the refugee camps in Jordan, and also through the outpatient unit at the hospital.

During my time in the project over 45 percent of the patients were Syrian refugees. Since 2006, more than 4356 cases have received care with in more than 9000 surgeries. There is a long waiting list with slow turnover considering the extent of the injuries and treatments needed.

The patients in this project are the faces of war who we do not always see or hear about. We are informed about the number of dead but we rarely see those who survive, nor are we familiar with the barriers they face in moving past those experiences, which are always turning points in their lives.

"The patients in this project are the faces of war who we do not always see or hear about."

In the project I learned what a barrel bomb was and saw the effects of it. I remember wincing inside when I first saw some of the patients. I did not know how I would be able to look at the patients in the eye and set aside my own reactions.

One young Iraqi man I met on my first day had his whole face covered with a towel. His counsellor was the only person to whom he had shown his face. On one occasion, the medical team was talking to him about his treatment plan which involved sending him

An explosion ripped out this 5 year-old boy's eye and left one of his feet in very bad condition. He has undergone several operations and regularly visits the orthopaedics department at the Al-Mowasah Hospital in Amman. PHOTO: JUAN CARLOS TOMASI

back home and bringing him back in a few months when the prosthetic surgeon arrived. The patient became very upset saying that he did not want to return home before the end of his treatment because he did not want anyone to see him the way he was looking then. He was hoping to return home when he felt he could show his face again. Understandably, he was devastated to have his treatment delayed and have to face the gaze of his family, friends and community.

The patients and their caregivers, usually a family member who would accompany them and support them through their treatment, would call Al Mowasah home for anywhere from three months to more than two years.

In addition to surgical care, patients also receive comprehensive help through rehabilitative physiotherapy and psycho-social support. The physiotherapy team provides rehabilitation activities designed to support patients to regain the use of injured limbs. In some cases, the physiotherapists and psycho-social team collaborated to support patients especially when they had to have limbs amputated, which was always a last resort, given the physical and psychological impacts this evokes in those individuals.

Injuries resulting from war and conflict go beyond the more evident physical trauma which can be treated through specialised surgical intervention. The less apparent psychological and social impacts come from multiple losses; the loss of health, independence, home and country. Thus, the role of the psycho-social team is essential in supporting all patients.

My team consisted of four psycho-social counsellors, a clinical psychologist and a psychiatrist. The team provided a range of psychological and psycho-social support for patients while they received treatment; from individual psychiatric consultations for a range of mental health issues, to individual counselling, building support groups and organising social activities.

Our interventions were designed to equip patients and their family members to cope during their treatment and create an environment where they could feel at home away from home. In this vein, we promoted social activities to engage patients and their families to combat homesickness and boredom. Table tennis competitions were fierce in the hospital. We had EID celebrations twice a year with singing and dancing and new clothes for the children, and monthly outings for the separate groups of patients – men, women and children.

While patients came from different countries, they shared a common language and similar culture which made it easier to live together harmoniously. Naturally, as in any community living together in a small space,

This 8 year-old girl from Sana was injured when she was 3 months old when her cradle caught on fire. MSF's reconstructive surgery project in Amman, Jordan, provides a unique vantage point on the conflicts that have roiled the greater Middle East in recent years. PHOTO: KATE BROOKS

there were times when conflict arose between patients and their families which required mediation. At times, these conflicts were very sensitive involving issues of domestic violence.

There was one case where a female patient receiving treatment was being beaten by her husband who had accompanied her as a caregiver. It was important to communicate to the husband that violence was not tolerated in the hospital and to inform the patient that there were avenues of support for the situation she was facing.

Concerning these and other delicate cases, it was challenging at times to know how best to offer support without becoming too controlling or interventionist in their private lives. What had a significant impact in these situations was the role of patient representatives from each community, who assisted our team in finding culturally appropriate ways to resolve these kind of situations.

The national staff became surrogate parents and family for patients and their families. As treatment could take anywhere from a few months to more than two-year stretches involving multiple operations and rehabilitation. The commitment shown by the counsellors, their willingness to accompany the patients throughout their treatment and hold their confidence was therapeutic in itself. Not only were they working to create a safe and supportive environment for patients, they often became that safe place for them.

Judith Herman talks about three stages of healing trauma: re-establishing safety, remembrance and mourning, and reconnection and integration. I found we had patients and families at all different stages. Some would return to their countries where the conflict was continuing while others were living in refugee camps and waiting for resettlement.

One of the aspects of the trauma experienced by our patients that stood out for me was the very visible wounds they carried. For many, the consequences of the trauma they experienced may remain hidden and unseen by others. They may hide it and only address it when they feel safe and ready.

However, for many of our patients, their faces and bodies are a constant reminder of what they have been through. Even if they have managed to accept those changes and put aside that trauma within themselves, often they must revisit it in front of others and the challenge lies in finding a safe space in relation to oneself and the others.

I believe the environment and community created

in the hospital provided this space for patients to find that personal and interpersonal safety. Here the patients encountered people who had similar experiences to their own and they could learn to accept themselves through accepting each other. I think this was particularly healing for the younger patients. They found peers with whom they could relate and build trust, friendships, and solidarity through mutual support. This was essential given that they were far away from their families and friends.

I had the privilege of participating in the children's outings, which were organised by one of the counsellors. I remember the first time I joined them and their caregivers, they didn't quite know what to make of me. I was a foreigner who could speak only a handful of words in Arabic. The children were shy and stayed away from me at first. When I started to run and they realised it was a game of chase, the barriers fell and we quickly became friends with lots of bonding through many selfies! It became obvious to the counsellor and I that the children needed time away from the hospital in open spaces to run around and explore and play.

The therapeutic value of play and the building of relationships were not lost on us. Later on, some other expats in the project who normally didn't have the chance to interact with patients joined the children's outings and beautiful friendships developed with the children. I learned that big kids also need time to play.

My time in the project was a constant education. The cultural lessons I encountered were the most memorable. For example, at the EID parties I had observed that only the men and children would dance. My first thought was the women were not interested. But they were very interested and always dressed their best to every party. However, I found out that it was not appropriate or comfortable for them to dance in the presence of men.

Our female psycho-social counsellor was patient in teaching me the cultural norms and unspoken rules. She explained that we could have a separate party for just women if we could guarantee that no men would be present and the space would be safe. Through her enthusiasm and hard work, we were able to hold women-only dance parties. The female patients and female staff in the project enjoyed these parties.

Like this example, working in Jordan presented a long list of cultural shocks for me. I was surprised that the counsellors chose to wear doctors' coats and referred to each other as 'doctor'. I questioned the counselling skills of some of my colleagues when I heard them giving advice rather than helping the patients to find their own solutions.

When I asked them about how they would respond to a suicidal patient, the counsellors replied that they would bring up the fact that suicide is haram (forbidden) and those who commit suicide would go straight to hell. When asked the rationale for this, the counsellors replied that it was to make the patient feel guilty to prevent them from attempting suicide again.

The fact that I was experiencing this surprise and shock made me realise that I was coming into a different community with a perspective informed by my own education, socialisation, personal values and culture.

A few months on from these initial observations, I had to ask myself if I had been imposing my own cultural values in assessing how the counsellors go about their work. I reasoned that perhaps the doctors' coats are as much a uniform to be identified as staff, than a show of status and importance. And perhaps addressing each other as 'doctor' is a way of showing respect, much like in my own Korean culture where we often call a learned person 'teacher' even if they are not a teacher by their profession.

Having spent a significant amount of time with the patients and counsellors in the project, I saw that the patients greatly respect and trust the counsellors, confide in them and take on their advice. Much like doctors are expected to prescribe medication rather than tell the patient to rest a few days, there is an expectation that counsellors will give advice and provide solutions to the patients. Upon reflection, I became more keenly aware of the culturally-coloured glasses I had been wearing to judge how the counsellors carry out their work and I realised that counselling is greatly influenced by one's cultural context.

One activity which I was able to introduce from my time working with STARTTS was the Tree of Life activity. In Amman, I had the fortune of meeting one of my former STARTTS colleagues who was also living and working there. In the STARTTS spirit of collaboration, we brainstormed ways to support the patients in the project, especially the younger people.

My former colleague graciously donated her time to train our counsellors and co-facilitate a pilot support group for young people using Tree of Life.

Two groups were run, one with the young men and a separate one with the young women. Through these activities, they were able to share some valuable insights and reflections which highlighted their losses and learnings. These are some of the participants' comments:

"Life is more beautiful than it appears in our eyes. Whatever we think we see in life, there are always hidden parts we can't see. It is more beautiful than we can ever know." – IRAQI BOY

"Life is more beautiful than it appears in our eyes. Whatever we think we see in life, there are always hidden parts we can't see. It is more beautiful than we can ever know." - Iraqi boy

"Before I drew the tree, I thought that life was very hard. Afterwards I realise life is better than that. I want to try and jump over these difficulties so life can be better than before. I want to join school again and have relationships with my friends like I had before I got injured." - Iraqi girl

"I think in this group we learned many new ways to think about things." - Iraqi boy

"I have lost a lot in life. A lot of leaves have fallen (NB: the leaves of the tree represent loved ones). This is a bad thing and can pull you down. But I am hopeful that peace can return to my country and things will be good again as life before. I can be around all the things that made me who I am, that made me strong." - Iraqi girl

Since my time in the project, the war in Syria has escalated. The conflicts in Yemen and Iraq have not subsided and there is an even greater need for the services like the MSF Amman Reconstructive Surgical project. The transition to Al Mowasah Hospital was almost complete by the time I finished with the project. We had been working closely with the patients to ensure they settled smoothly into the new hospital.

One aspect of the project was to establish a school in the hospital. Previously, there had been a part-time teacher who ran classes for younger children, but there was nothing for adolescents. I met with NGOs working in the education and disability spheres to find a model and curriculum that would suit the needs of our patients.

Being able to continue their education to some degree was important for the patients and their families. There were some children who could not finish their treatment in hospital as the parents feared they were missing too much schooling. The building of skills and confidence that comes through education is also pivotal in promoting healing and well-being. I am pleased to hear that the classroom and recreational spaces for the patients are now well established and children can attend classes in between their treatments.

It has been more than a year since I left Jordan and when I reflect on my time there, the warmth of connections built with the patients and staff remain with me. As much as my job was to support them, they did so much to support me and teach me how I could be a better support for them and others.

I am reminded of the approach we take at STARTTS working with individuals from so many different backgrounds and cultures. We need to be curious and keep an open spirit so that we, as counsellors, can learn from their individual experiences - whether those experiences are of trauma and escape, or of solidarity and support. It is this learning and sharing that advances their journey towards healing and recovery. R

Perinatal Experiences in a Foreign Land

PHOTO Mu Cang Chai, Vietnam - Hmong ethnic mother carrying her child. May 2017. QUANG PRAHA

PHOTO: IS EPROM

HEALTH

Giving birth in a foreign country can be fraught with difficulties and misunderstandings. Cross-cultural psychologist GABRIELA SALABERT writes about child-bearing practices across cultures.

The perinatal period – the time from pregnancy to the first year after the baby is born – is an exciting and happy time for most mothers, as well as a time of great emotional and physical changes. However, national and international research tells us about 15 percent of women will experience antenatal or postnatal depression or anxiety.

Women who have already suffered mental health problems fear a relapse during this time and the same happens to husbands. Refugees and migrant families are also more vulnerable to depression from past traumatic experiences, having suffered multiple losses, different forms of violence, social isolation and psychosocial presentations.

This means perinatal depression and anxiety tend to be prevalent among migrant and refugee women, who in some cases cannot identify depression, have little understanding of the health system and often do not receive the care they need.

At the same time resettlement in a new country and communication barriers also have a severe impact on the stress of the mother during pregnancy and after the birth, which make this population more vulnerable and at risk.

So it is crucial to increase awareness among these communities, and particularly among health workers, of maternal stress and its impact on the baby's brain development, different cross-cultural child-rearing practices and intergenerational trauma. Health providers need to look at these variables to improve strategies, overcome barriers and facilitate culturally and linguistically diverse communities' access to services and treatment.

The National Perinatal Depression Initiative (NPDI) has been developed to identify women at risk of perinatal mental health disorders. Also, the NSW SAFE START programs implemented within the Families NSW framework seeks to identify and support women and families with social and emotional issues during pregnancy and following birth.

There is lack of knowledge among professionals in the reproductive health care system about trauma in relation to birthing experiences.

SAFE START is an interagency of primary health workers covering midwives, early childhood nurses, drug and alcohol services, NSW Transcultural Mental Health, Aboriginal health, Family and Community Services, Karitane, and so on. It runs this program in public hospitals and offers appropriate care and support. It has been designed for antenatal prevention, risk management and proper follow-ups of cases after birth. Fathers and families are also referred to these agencies for them to gain an understanding about the relationship between mental health and the parenting role.

One of the ways NSW SAFE START achieves this is through the provision of comprehensive psychosocial assessments (including screening for domestic violence, substance abuse problems, anxiety and depression). Psychosocial assessments include the Multilingual Edinburgh Antenatal Depression Scale and are conducted at the first point of contact during pregnancy, before birth (36 weeks) and in the first 12 months after birth. Psychosocial difficulties and other mental health problems emerging during the critical perinatal and postnatal periods are screened by SAFE START for high-risk pregnancies.

In the case of refugee women, multiple bereavement before and during the refugee journey, rape, sexual assault and family violence resulting in pregnancies and miscarriages, impact not only on women's mental health but also in the consequent attachment to their babies.

There is lack of knowledge among professionals in the reproductive health care system about trauma in relation to birthing experiences. Experiences of torture and rape can create difficulties with the birth experience, which as a painful, life-threatening situation may trigger traumatic memories, worsening preexisting mental health conditions and interfering with mothers bonding with their babies. At the same time, feeling shame as a result of experiencing emotional and mental health problems is very prevalent in some communities and as a result "bad mothers" or mothers experiencing difficulties are at risk of stigma, social isolation and violence.

The most frequent perinatal clinical presentations include antenatal-postnatal depression, anxiety disorders, post-traumatic stress disorders (PTSD), puerperal psychosis, grief and loss/bereavement, and borderline personality disorders. Sometimes medications prescribed by doctors overseas are continued in Australia and women do not have information on the possible impacts of these drugs on their baby's development.

Previous history of trauma, post-traumatic stress disorders, obsessive compulsive disorders, panic disorders plus unresolved grief and loss from miscarriages and traumatic deaths of children tend to cause high levels of anxiety and, if unresolved, leads to the use of rituals and social isolation. These symptoms occur particularly at eight months of the pregnancy cycle, when symptoms tend to worsen due to the fears of childbirth and physical changes.

In clinical practice we see how violence affects women's reproductive health as some women are unable to access reasonable contraception, protect themselves against infections like HIV or sexually transmitted diseases and are unable to plan their pregnancies. They

PHOTO: Cambodian mother, Cambodia. AAP IMAGE / UIG / GODONG

PHOTO: SOL STOCK

PHOTO: PIX DELUXE

are also unable to feel safe from an assault during their pregnancy, or to access antenatal or postnatal care. Unfortunately, family violence on pregnant women seems to take place more frequently than other obstetric complications such as pre-eclampsia or gestational diabetes, which happen frequently as well.

Separation from family members who could provide emotional and practical support is another problem especially when women come from countries where the extended family plays an essential role in everyday life. Losing husbands, mothers and other relatives who offered support are common presentations. At the same time many women become depressed and anxious and fear for the safety of family members in countries of origin, particularly in cases where their husbands and older children find themselves in warzones at risk of being killed.

Cultural contexts and perinatal culture

There is a need to review contrasting beliefs, values and birthing practices among different refugee communities (including female genital mutilation). Families have different cultural, spiritual and religious understandings of the birth process, distress and illness.

According to psychologists G. Stern and L. Kruckman, there is cross-cultural evidence that birth is almost universally treated as a traumatic event. According to them, birth and the immediate postpartum period are times when both mother and infant are vulnerable. Societies have beliefs and practices in place to manage the physiological and social problems associated with birth that make sense in their own cultural context.

Access to perinatal formal education and exposure to perinatal information does help refugee families to adjust to the new environment, system and health culture in a new country. The migration process also affects cultural birthing customs and causes gaps in women's knowledge that is normally passed across generations in the family. The health system in Australia often challenges different birthing norms.

For instance, in most countries of Asia, including China and India, it is believed that women are predisposed to attacks from the wind or cold. After giving birth they have rituals that involve diet restrictions, plus minimal physical activity such as confinement (putting mothers at risk of thrombosis),

The individualistic, nuclear family approach of Australian health care interventions is often rejected by people from other cultures because in collectivistic societies, the self is defined relative to others via a sense of belonging, dependency, empathy, and reciprocity.

and they need daily assistance from their mother and other female relatives who pass on knowledge about child-rearing and offer practical support.

In particular, the Cambodian culture believes postpartum women are in fragile health, that they get cold after giving birth and are at risk of developing "Tos" – a similar but more physical and benign form of postpartum depression. Rituals such as roasting, steaming and fire-warming rocks are practised to avoid long-term complications.

Somali women are usually young mothers, who have numerous children who are considered gifts from Allah (God). Female circumcision is a common practice. This means they have to have more caesarean births in Australia and have a high incidence of perinatal loss; however, it is accepted because of their religion.

Cultures also differ in terms of the emotional expressiveness at the time of birth. It is expected that in some cultures women should not be loud at the time of birth, while in others women usually cry and scream as the birth approaches. In many cultures the placenta may be disposed of by burying it under the floor of the room where the birth occurred, or in the courtyard of the house. The placenta is buried to keep an enemy or evil spirit from seizing it and influencing the well-being and longevity of the child.

Hospitals should offer the placenta to a postpartum woman for the symbolic effect of safety. For instance, in some cases offering hot water and soup after birth, instead of cold water with ice and sandwiches, could be a more culturally appropriate practice for hospitals, it will not involve an extra cost and families will be more at ease.

In terms of parenting, health providers should realise that in migrant and refugee communities the male-female roles are defined differently than in Western countries and the meaning/value of medical treatment and the level of acculturation to Australia can be different as well.

In terms of birth practices and parenting, first- and second-generation refugee families are divided by conflicting loyalties between their own family belief systems, practices and traditions and those policies and practices embraced by NSW health services. Cultural norms usually come from successful survival experiences and expectations of adult behaviours valued by a particular society.

Women who successfully gave birth and raised children in their own countries are often told by health services and postnatal groups that the type of birth and parenting practices they are familiar with are actually unsafe and they need to change them in order to fit into the mandatory requirements of mainstream health services in Australia. This causes a withdrawal from health services and from participating and socialising in important parenting programs.

Cultural differences mean that people have fundamentally different constructs of the self and of others, which impacts on family dynamics. There is a lot to say about socio-cultural ideologies in families. The individualistic, nuclear family approach of Australian health care interventions is often rejected by people from other cultures because in collectivistic societies, the self is defined relative to others via a sense of belonging, dependency, empathy, and reciprocity. Personal space, time for oneself and privacy are

PHOTO: Mother and child, Bangladesh.
AAP IMAGE/UIG/MAJORITY WORLD

considered by many mothers as secondary or even foreign to them, because their role and identity is defined through relationships and interdependence.

Asian, African, Latin American, African and Mediterranean countries value interdependence, group achievement, sharing and collaboration with the family group. Feeding practises, sleeping arrangements, acceptance of family roles are also influenced by their collectivist ideology.

According to African mothers who carry their babies on their back (like many other mothers of the world), the mother is the expert on the baby's needs: "Read your baby, not the books" is the common saying. Research also supports the fact that the emotional learning and mother-child bonding goes beyond verbal stimulation. Children need touch and attention, not just a verbal response.

For example, the practise of putting babies in separate beds or bedrooms and not responding to their cries causes horror among most of the cultures of the world. However, the latest research in the US in the field of anxiety demonstrates that these practices teach helplessness to newborns, impacting on their brains and nervous system development, and may lead to a greater incidence of post-traumatic stress and panic disorders among adults.

Asian, African, Latin American, African and Mediterranean countries value interdependence, group achievement, sharing and collaboration with the family group.

Some strategies for intervention

Perinatal mental health needs to consider the mental health needs of both parents. The social isolation of the family, the different presentation of emotional distress as somatic symptoms, the cultural and spiritual belief systems and a reluctance to share personal information with unknown clinicians are some of the issues health professionals may encounter.

Linking families to cross-cultural services and to clinicians is essential to re-establish trust and improve access to health services. The early intervention of families at risk in the perinatal period is very important. All migrant and refugee women should attend a hospital for the birth of their babies. Family needs and risks can be identified and organised through appropriate interventions before mothers are discharged into the community.

Working with care providers who are not mental health specialists can also expand the scope of these interventions, addressing service barriers and advocating on behalf of family needs in the broader system, as well as appropriate postnatal and parenting programs, which could be run by migrant resource centres.

Screening tools include the Edinburg Scale for Antenatal/Postnatal Depression (EDS), validated and translated in many languages and clinical interviews, as well as health professionals being familiarised with specific SAFE START referrals and the protocols and assessment forms designed to screen the emotional and psychosocial needs of mothers and families. All public hospitals have SAFE START meetings where high-risk pregnancy, psychosocial and mental health presentation are reviewed.

Other recommended strategies for health professionals to work effectively with mothers and families during the perinatal period include being familiar with different cultural values and historical experiences, and examining health professionals' own cultural beliefs and values to avoid imposing ethno-centric values and unnecessary interventions, instead respecting cultural preferences. Clinicians should assess the history of trauma across generations, take into account family and network concerns and follow a strengths-based perspective.

Parents need a better partnership with their child's paediatrician. Women's beliefs about sleep practices should be explored to avoid alienation or judgment for not following Australian professional guidelines. ℞

Mexico hosts International Rehabilitation Council for Torture Victims Conference

Shaun Nemorin

More than 400 participants from nations around the world gathered in Mexico City last October for the International Rehabilitation Council for Torture Victims' (IRCT) 10th Scientific Symposium, aimed at sharing expertise among health professionals in the field of torture rehabilitation.

The three-day event provided a platform for 132 practitioners and experts to speak about research findings and share their experiences.

The IRCT, an independent international health organisation set up in 1985 to work on the prevention of torture globally, today has a network of 152 rehabilitation centres in more than 75 countries, and is the world's largest membership-based civil organisation specialising in torture rehabilitation.

STARTTS staff from across its services delivered presentations, including a keynote from board member Professor Derrick Silove on the challenges facing the sector in evidencing survivors' rehabilitation needs.

Other standout presentations came from Mirjana Askovic, who spoke on the use of electroencephalograms in the assessment and evaluation of treatment outcomes among refugee survivors of torture and trauma. Yvette Aiello spoke about MANTRA, a self-help group for male survivors of torture and rape where participants remember, process and record their unspeakable and painful experiences. Dr Shakeh Momartin presented a session on Capoeira Angola: an alternative intervention program for traumatised adolescent refugees.

The symposium also saw contributions from prominent speakers such as Edith Escareño, coordinator of the IRCT's Mexican member of the Collective Against Torture and Impunity; Suzanne Jabbour, former IRCT president and vice-president of the United Nations Subcommittee on Prevention of Torture; Şebnem Korur Fincanci, president of the Human Rights Foundation of Turkey; Andrew Standley, European Union ambassador to Mexico; Débora Benchoam, human-rights defender and Inter-American Commission on Human Rights Attorney, and Victor Madrigal-Borloz, IRCT Secretary-General and member of the United Nations Subcommittee on Prevention of Torture.

In addition, the event was honoured to receive messages from United Nations High Commissioner for Human Rights Zeid Ra'ad Al Hussein and the President of Chile, Michelle Bachelet.

In her message, Ms Bachelet said: "We know that any strategy is incomplete if we do not recognise the central role of the victim, and of an integral reparation aimed at reverting the harm caused. I would like to highlight the committed work of the IRCT which, on this occasion, has summoned more than 400 practitioners. I hope that through these sessions you will be able to identify better forms of rehabilitation for torture victims and inspire states and authorities to adopt all measures to build societies based upon unrestricted respect for everyone's rights."

The Academic Symposium fed into the IRCT General Assembly held in December 2016. Member organisations represented Europe, Asia, North America, Latin America, Sub-Sahara Africa, the Middle East, North Africa and the Pacific. Each IRCT member centre was invited to designate a delegate to serve as a representative to join the general assembly.

The General Assembly is a fundamental platform for the IRCT membership. Its democratic principles are essential to the success of our daily work and the sustainability of the greater movement. It is also a key event for the movement to engage in lively debates, provide input to vital discussions and formulate the organisation's policy positions that will guide and advance the global work on the right to rehabilitation of torture survivors.

A new executive committee was elected along with a new president and vice-president.

The Council unanimously elected Jorge Aroche, STARTTS CEO, as the new IRCT president. Ms Sana Hamzeh, psychotherapist at Restart Center for Rehabilitation of Victims of Violence and Torture in Lebanon was elected vice-president.

Mr Aroche takes over from Suzanne Jabbour, who excelled in her duties at a time when the global movement saw a lack of will in public policy to provide victims with adequate rehabilitation and a decline in funding from all quarters – even though, as a result of war and conflict there are millions of torture victims with an unfulfilled right to rehabilitation.

It is important to point out that holistic rehabilitation to support these victims is not only a legal and moral imperative, but it is also an integral component of eradicating torture in concert with other actions to prevent torture, overcome impunity and provide redress. "I would like to thank the IRCT Council and the General Assembly for putting their trust in me," Mr Aroche said.

"I believe the outgoing council has put the organisation in an extremely strong position, which has been evident throughout the symposium and general assembly. Under their leadership, the global rehabilitation movement has become stronger and more united – well placed to take on any challenges facing the sector. We hope to build on this and to continue the progress already made."

Mr Aroche presided over the formulation of a resolution entitled the Mexico Consensus. This agreement, formulated and debated by Council members, includes conditions under which states must provide victims with access to a choice of rehabilitation services. Among these conditions are the inclusive and multidisciplinary nature of services and the participation of the victim in decisions concerning rehabilitation.

"We know that any strategy is incomplete if we do not recognise the central role of the victim, and of an integral reparation aimed at reverting the harm caused."

MICHELLE BACHELET

Mr Madrigal-Borloz said: "It is an extraordinary opportunity to start the next strategic period with such a strong and committed executive committee. The appointed officers are an extraordinary blend of competencies, cultures and skills, and share the vision of a rehabilitation movement that works for the benefit of torture victims."

The Mexico Consensus also includes an ambitious agenda, including a concerted effort to advocate for increased funding, support for the research and documentation of torture, awareness actions and campaigns, and an agenda for international cooperation through sharing good practices, capacity building and the promotion of ratification of the United Nations Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment and its Optional Protocol.

Through the Mexico Consensus, members of IRCT demand that all countries comply with their obligations to prevent and prosecute torture, provide reparations to the victims, and increase the funding available to fulfil the victims' right to rehabilitation.

HUMAN RIGHTS

JORGE AROCHE has a long history in working with survivors of torture and trauma. His involvement in this area precedes the establishment of STARTTS in 1988, and he has played an important role in laying its foundations, then in its growth and evolution since he joined STARTTS in 1989. Now he takes on a new challenge as president of the International Rehabilitation Council of Torture Victims (IRCT). He spoke to OLGA YOLDI.

The IRCT Elects New President

The last IRCT conference was a defining moment in the history of this movement. Tell us what happened.
This was the biggest event – 124 member services out of 152 – and the first conference to be organised around concrete themes. It focused on the right to rehabilitation. There were several concurrent streams and more than 100 presentations. The plenaries brought together the perspectives of people who had lived through the experience of torture and of health professionals who have dedicated their lives to help heal the wounds of torture.

For example, there was a very poignant and inspiring presentation from a group of Mexican women who had been detained and raped. Indeed, rape has become a widespread practice by police. They described what had happened to them, how they were affected by the ordeal, their struggle to regain control of their lives and how they came to terms with it by helping other women who had been through the same experience.

The conference also brought the perspectives of health professionals who risk their lives every day working in rehabilitation centres in countries governed by repressive regimes. This is an experience quite foreign to people like us living in free democracies. Other plenaries focused on the global political situation and what is being done to prevent torture. There were clinical plenaries that looked at advances made in rehabilitation in different places and very different contexts. One of the particular aims of this conference was to share advances in documentation and evaluation of programs. Enhancing our capacity in this area is critically important for the movement at this point in time.

In addition, there were 100 oral presentations in concurrent streams and also a session that displayed more than 100 posters. It was very successful indeed and the presentations I attended were of very high quality. It demonstrated the maturity of the trauma rehabilitation movement and how quickly it is evolving. All together it was an incredibly inspiring experience.

It became obvious to me that this should not be an isolated event. The last face-to-face general assembly and conference was 10 years ago.

How would you define the Mexico Consensus?
The Mexico Consensus embodies the essence of the IRCT movement – a consensus on the work the movement does, its values and its aims. Essentially, the IRCT advocates for the right to rehabilitation. It advocates the existence and provision of rehabilitation services and the exchange of information, knowledge, ideas and materials about rehabilitation. It has a role in the prevention of torture by working in partnership with organisations such as Amnesty International, and by providing input from a clinical and service providers' point of view.

The IRCT approach is to provide holistic rehabilitation, the type of rehabilitation that involves not only the individual but also the family, community and

society in which the individual lives through pathways and strategies that involve clinical services and community development approaches. The aim is to ensure victims receive help to overcome the effects of trauma on the body, psyche and nervous system, and to foster an environment for them to regain control of their lives.

How are these services funded in the different countries?
Access to reliable funding is one of the major challenges we confront as a movement. The situation can vary even within the same country. Only a few services receive funds from their governments in one way or another, and even fewer do it as part of a deliberate social inclusion strategy, such as in Australia and New Zealand.

In addition to the humanitarian commitment principle, the Australian government has learnt over many years the importance of providing survivors with resources to regain their capacity to be part of an inclusive society, so funding is perceived as an investment: investing in people's health will result in a more productive, more cohesive and healthier society and ultimately better integrated, more productive individuals who rely less on government assistance.

From a health perspective, torture survivors have had experiences almost unimaginable to the rest of us, so they need additional services to overcome the effects of trauma as a result of torture and other human rights violations in the context of organised violence.

So investing in services means survivors have a chance to regain their mental and physical health not only to contribute to their new society through their work, but also to support their children, families and communities. When survivors do not have an opportunity to rehabilitate, they are often a burden to others. So overall, investing in torture and trauma services is the best investment a society can make. Not every government has reached this conclusion, of course.

In many countries rehabilitation services are funded exclusively through international humanitarian funds or private donor sources. However those funding sources tend to be less reliable as they are associated with government foreign aid or private donor priorities, which tend to be reactive and change in response to current concerns and global politics.

There are countries that have no services at all, particularly where the situation is so unstable and dangerous it is too difficult to invest in them because it would put health professionals' and clients' lives at risk. This is the case in Syria and Libya, for example. In other countries, the situation is deteriorating rapidly. In this decade Egypt has gone from a nation where torture and trauma rehabilitation services could operate without risk to a place where it is increasingly dangerous for our colleagues to work. Turkey is moving rapidly in the same direction. This is an unfortunate development, but in countries such as Iraq services are being expanded, despite enormous difficulties and significant dangers.

IRCT's biggest challenges are the fight against torture in a world that is becoming more reluctant to invest in humanitarian causes...

You have recently been elected president of the IRCT. What do you want to achieve during your mandate?
This is a big question… and commencing my mandate at the same time that Trump was elected has meant that many of the priorities I had in mind had to be reorganised in order to deal with the challenges of massive changes in the global stage. One of my priorities was to broaden, enhance and diversify the funding model of the IRCT movement so that it can keep up with the increasing levels of demand. The plan involved enhancing the Secretariat's capacity to target new donors for particular member agency projects that fit within their priorities and by developing the means to obtain direct small contributions from people all over the world who are concerned about the way things are going and want to support the recovery of torture survivors directly. We have a very strong and incredibly compelling message, but it hasn't been projected as well as it could be. While that goal continues to be the ultimate aim, stage one now involves ensuring the survival of existing services. This means fast tracking this transition, and doing so with less resources at our disposal.

Other things I would like to achieve and that came to the fore in our discussions in Mexico in the context of the General Assembly, is an increased capacity to evaluate our interventions and develop an evidence base for the incredible work that is taking place in very difficult circumstances. The third priority is enhancing the movement's capacity to protect colleagues when their work or their own personal safety is threatened. This, unfortunately, is also becoming a much more urgent priority than it seemed a year ago.

Last but not least, I would like to leave a stronger, more empowered movement at the end of my three year term.

This, of course, means that we have to be prepared to listen and adapt our strategies to reflect the concerns and aspirations of our member agencies and their clients. The governance structure of the IRCT is quite democratic, with a council elected by the general assembly where every region is represented by a different number of delegates reflecting their constituency, and an Executive Committee made up by a delegate per global region – Latin America, North America, Europe, the Middle East and Northern Africa, South Saharan Africa, Asia and the Pacific.

Naturally, there are different issues and priorities in different parts of the world. Being elected president by acclamation was significant, since I see the period ahead as very challenging because more people openly support torture and some of the traditional sources of funding for torture trauma services are likely to be reduced. We hear the US is going to allocate an unprecedented amount of money (close to US$60 billion) towards building up the military and obviously this means money will be reallocated from other parts of the budget, such as foreign aid. Money from the US supports the bulk of the U.N. voluntary fund against torture, which in turn funds to a significant extent about a third of the torture and trauma rehabilitation services in developing countries. In this context it would be easy to overlook particular local priorities and concerns. I will be relying on my fellow Council and ExCom members to ensure this doesn't happen.

The other side of this coin, is that the IRCT is made up of more than 150 centres with an enormous wealth of human and intellectual resources and capabilities that can be leveraged to achieve these objectives. The IRCT movement is also incredibly fortunate to have an extraordinary Secretary General and Secretariat team based in Copenhagen but drawing talent from all over the world, so, despite the many challenges I feel optimistic about our prospects of meeting these rather ambitious goals.

Modern technology lets you reach everyone through video conferencing, such as Skype. Do you think you will be able to provide significant e-learning to centres with few resources?
Capacity building is one of the arms of the IRCT Strategic Plan, the others being government policy development, research and advocacy. Modern communication technology gives us the capacity to share knowledge across distances and reach huge numbers of people. While this has enormous potential for capacity building, we also need to be mindful of its limitations. While training someone remotely seems great in terms of cost and efficiency, it also means we lose the context. We need to be sensitive to the specific needs of survivors in different situations and must respect the ways workers have evolved to operate in their context, therefore the strategies that will work in different environments are going to be diverse.

While I'm proud of the services STARTTS provides, I wouldn't say the STARTTS model is the most appropriate for providing services to, for instance Libya. The therapeutic approach needs to be adapted to the circumstances of the country, the culture, the social and political context and the resources, human and financial – so to train people in the way STARTTS works may not be relevant or effective. At the same time, there are aspects of our model and interventions that could be very relevant if packaged and adapted to the different context, provided this is done with respect and good dose of humility.

Other ways we can build services' capacity within the movement is by providing scholarships, holding regular conferences and enhancing partnership both within the sector and with other sectors.

IRCT has negotiated for centres around the world to link to the STARTTS PSYCHE VISUAL clinical evenings, lectures, presentations and workshops. That means all IRCT members not only will have access to that library but will also be able to archive material uploaded into PSYCHE VISUAL, which is now available for all IRCT services to use for training and staff development. We are looking at other areas in which technology might help, such as the development of an intranet or digital collaborative platform, a shared structure for all to use. For example, all papers presented at the Mexico Conference have been captured in video and uploaded onto the IRCT's website.

What are the highest priorities for your presidency?
One is to develop our capacity to raise funds. That means going beyond existing sources to create additional revenue streams, enabling member services to thrive – or at least survive.

I would also like to contribute to the process of

We need to convey the message that torture not only harms individuals, but also damages the fabric of society by forcing people to participate in horrible practises that violate the sense of decency.

members becoming more empowered, so they become more engaged and feel more ownership of the IRCT. If services are better prepared and more proactive, in terms of sharing resources and adapting them, they will be in a better position to grow.

Apart from making STARTTS available to the larger IRCT membership, we can better leverage the different areas of expertise across IRCT members. This way we do not have to reinvent the wheel.

I also want to ensure we continue to advocate against torture, especially when there are constant messages coming from powerful sources arguing the effectiveness of torture as a method to gain information or avoid terrorist attacks, which is false. We need to convey the message that torture not only harms individuals, but also damages the fabric of society by forcing people to participate in horrible practises that violate the sense of decency.

What motivates you to be involved in the IRCT?
I served on the committee of the International Society for Health and Human Rights in the past, but being part of an international movement positions us in the right context in terms of our work and professional development. I always come back from international conferences with a sense of humility because the work our colleagues do in such high-risk environments is awesome.

I have been involved with the IRCT for a long time. I had roles in various committees, but my role as vice president between 2009 and 2012 introduced me to the work it does at another level. The IRCT has changed a lot over the years, and I am very happy about the direction it has taken and how it has evolved. It has transformed itself into a far more democratic structure over the last couple of decades.

I guess having two languages and having a long history in this field places me in a position where I can contribute in a meaningful way, but it is also a very big responsibility that I hope I can fulfil in a constructive way. There is much to be done, in project development and governance. We need to bring the movement together and ensure we are all pulling in the same direction.

We are developing structures to articulate an effective message, to the public at large and to particular bastions of power, within and between countries and to peak organisations such as the United Nations, European Union and other key international bodies. It is very important work and if the Secretariat is to carry it out, it will need support and guidance.

I have a vision to make the IRCT stronger and better resourced, but cohesion among the players will be needed. If we are more agile in communicating and exchanging information, there is no doubt the movement will be strong.

The benefit of this position is that you are in contact with a lot of extraordinary people who work in difficult environments. The human quality of the people is very high, very inspiring, so it is a privilege being part of it. We are certainly unhappy about the world situation. Since Trump was elected US President his views on refugees are making some people deeply unhappy. There is potentially a group of liberal-minded people committed to human rights that could donate to humanitarian causes because they see the world is going in the wrong direction.

We need their support. We need to appeal to them, as small amounts of funding can make it or break it for small services worldwide. R

Shaun Nemorin worked as a field officer for the UNHCR in Africa and Asia, resettling refugees in different countries. He describes his journey to QUENTIN LAMBERT.

My Time at the UNHCR

When did you start to work for the UN?
I began working for UNHCR in 2007 in the Regional Office in Beijing, which was also overseeing Hong Kong and Mongolia. I was posted to different places in Asia and Africa, initially to Nepal, then to the Rohingya crisis in Cox's Bazar, Bangladesh, and northern Rakhine State in Myanmar; to the northern Mali operation from the border with Burkina Faso; and lastly I worked in the Great Lakes region of Burundi before beginning with STARTTS in 2014.

Given the situation in Burundi, we also forget that many refugees find themselves seeking asylum there, too. What was your role?
Since 2012 there has been a renewed impetus on the part of the international community to establish a durable solution for Congolese refugees languishing in various Great Lakes areas as a result of the war in Eastern Congo. Many have been refugees for well over a decade and the prospects for return look grim. At the same time, the opportunities for integration in Burundi are extremely limited. Various resettlement countries, spearheaded by the US, agreed to take tens of thousands of Congolese within their yearly resettlement intakes and those who met certain vulnerability criteria.

While most of my roles in UNHCR had been management and coordination of community services programs, my experience in case identification involving specific needs – and perhaps linguistic skills – coupled with a foolish optimism, made me an ideal candidate to set up the resettlement program in Burundi, basically from scratch.

I was tasked with leading a new team, training interpreters, setting up and implementing field mechanisms for referral and logistical structures for people to be interviewed in a fair and confidential manner, and helping set up a child-protection framework. All this within a limited time frame, an insecure environment,

PHOTO: SHAUN NEMORIN

PHOTO: SHAUN NEMORIN

with scarce resources and large expectations from UNHCR headquarters, the Country Office itself and the resettlement receiving countries.

I would say the work was Dickensian, as it was perhaps the best job I have ever done, yet also the worst in many ways.

Can you explain?

Many people do not understand how labour-intensive the resettlement process is, as each applicant goes through a thorough interview to document his or her history of flight. The submission criteria for resettlement were almost exclusively for women at risk and for survivors of violence and torture categories. After interviewing four women for several hours each day, I started to wonder how people can do such evil things to others, yet I was marvelling at the sheer amount of resilience and the desire to keep going even by those who had experienced the most extreme examples of exploitation and abuse.

There were truly few tangible victories in the best part of the decade I spent with UNHCR. There were moments were you saw a clear win for refugees, when their lives were normalised. I tried to do more than simply bear witness through some of the most challenging moments in their lives. Counselling would often be based more around containment, given that their situations were protracted and unlikely to change in the near to intermediate future.

However, the work in Burundi was massively empowering for me as a humanitarian worker and similarly for those interviewed, as it meant we were actively working towards a realistic solution – something I found spectacularly elusive in other cases.

All of a sudden, however, it was no longer about containing frustration in a hopeless situation, it was about facilitating a process to remove a woman at risk or a separated or unaccompanied minor from an environment where they were likely to be exploited, often sexually.

Yet it should also be said that, for people in often desperate situations, resettlement becomes a valuable commodity. With this in mind, the integrity of the program is susceptible to fraud and must therefore be managed with extreme nuance and care.

Given that the environment for refugees was one of severe poverty and deprivation, this added to the challenges of not raising expectations about resettlement within the refugee community, many of whom would not be resettled.

Of equal importance was managing affairs with the host community which was not under UNHCR's protection and support yet often had the same needs as refugees in terms of health, education and nutrition. In fact, some of the most difficult conversations I have had were with local Burundians, who were increasingly suffering because of government oppression and had the severe misfortune of not being refugees, but simply extremely poor. I recall several times where locals would ask me if they too could be resettled. They would present their children with very treatable ailments, in Australia and elsewhere, and ask for help to live where they would have access to adequate food and basic services. To explain to them that such a possibility was only open to refugees frankly rang hollow, and remains something I still have difficulties processing.

Burundi was my last assignment before returning to Australia and beginning work with STARTTS, yet it provided me with time to reflect.

Towards the end of my assignment I had the honour of resettling several hundred people whom I had interviewed and submitted, families that had been accepted to the UK and Belgium. Within this group was a woman who had been gang-raped, children as young as 10 who had been violated by rebels and children who had travelled alone for days to reach safety,

PHOTO: SHAUN NEMORIN

I have a photo with that group which is very dear to me. When I need a reminder on perspective, I have a look at that picture.

crossing into Burundi via the Ruzizi River. They had survived crocodiles and persecution while others weren't so lucky, then had to endure years in refugee camps.

I felt it was a fitting end to see them off, a gift of sorts in the belief that in whatever small way, I might have made a difference in the lives of a few. I have a photo with that group which is very dear to me. When I need a reminder on perspective, I have a look at that picture.

It must have been difficult for small children.

The context for refugee children differs worldwide, but one phenomenon remains constant: the high numbers of women and children in refugee operations. In the past 10 years there has been an increased interest in child protection as a thematic issue in emergencies, yet resources are often not commensurate to their needs.

In Burundi, the situation was multifaceted. On the one hand there was a protracted caseload of some 40,000 Congolese who had fled the Democratic Republic of Congo wars of 1996-97 and 1998-2003. On the other, the security situation in the Kivu region of Eastern Congo meant that sporadic flare-ups of fighting caused further influxes into Burundi, many of whom were children and some unaccompanied.

This meant that investment was placed to ensure the basic needs of children were covered through safe places to live, learn and play, while also ensuring the children's participation in their protection. It was important for them to have access to legal documentation, while girls and boys with specific needs (psychosocial and physical) received targeted support.

Lastly, to achieve durable solutions for children was a key priority. Local integration and return to Eastern Congo was not feasible, so resettlement became a key protection tool. The UNHCR employed a child-protection team to work alongside me to conduct training for local partners and community members to identify children with specific needs.

PHOTO: SHAUN NEMORIN

PHOTO: SHAUN NEMORIN

“It never seemed to be a priority to focus on my own self-care when the needs of others were so acute.”

How did you process these experiences?
You never really have an opportunity to process such experiences during the time in the field, despite coming from a background in psychosocial wellbeing myself. It never seemed to be a priority to focus on my own self-care when the needs of others were so acute. Looking back, I admit that was foolish – not only for me and my family, as the symptoms of severe secondary stress only really became apparent after returning home, but also because vicarious trauma can impact on the wellbeing of those we are there to protect. I feel it is almost unethical, in a way, for humanitarian workers to not place an emphasis on self-care.

At the organisational level, UNHCR and other humanitarian actors bear a responsibility as well. While serving, there were few opportunities to properly debrief. The issue became cumulative because staff often jumped from one post to another, parachuting into environments that were very foreign to them.

Essentially, staff psychosocial issues were poorly handled by UNHCR, which bred a culture of bravado and an inability for field workers to properly express their inner struggles, their experiences or the impact on future deployments/assignments and their livelihoods.

What could have made it better?
I had the opportunity to speak about this to the forum of the recent annual UNHCR NGO Consultations in Geneva. While making the presentation, on behalf of STARTTS and the International Rehabilitation Council for Torture Victims, I acknowledged that many field workers were doing excellent work and took the organisation’s protection mandate to heart. However, I was honest in acknowledging that in many circumstances field workers were having difficulties and refugees reported stories of disempowerment from staff.

Linked to this is how I felt staff in the field processed their own experiences: substantial research shows that the impact of vicarious trauma on field workers is similar to the effects of those who have personally experienced trauma themselves. With this in mind, psychosocial issues such as severe secondary stress and post-traumatic stress disorder are pervasive within UNHCR, which obviously impacts on the association between staff and those whom they protect. A common defence mechanism is to emotionally detach from refugees or to victim-blame.

I urged UNHCR to establish concrete strategies and investment to combat vicarious traumatisation and mitigate the effects of cultural biases and privilege amongst staff, to place a focus on wellness and self-care coupled with adequate accountability and checks and balances.

I pointed towards external support and supervision, as a minimum, to be given to all field staff and the provision of psychosocial expertise from partner agencies to remedy this endemic issue.

Does one story stand out for you?
I feel massively honoured to have been part of the journey for so many over the years, yet a few people do stand out in my mind.

Pertaining to my time in Burundi, I have vivid memories of young Sampson, who lived in the Bwagiriza Refugee Camp close to the town of Ruyigi. He would wait for me every morning when I arrived in my vehicle, speaking basic but reasonable French, and he would also be there to wish me good evening when I went

home after a full day of consultations and interviews.

At the time, there was a song going crazy throughout the region called Leka Dutigite by the Kigoma All Stars, which had the catchiest of choruses. You could not travel a hundred metres without hearing it. Ten year old Sampson could often be seen singing and dancing to this song, which was impressive because he had a disability since birth, meaning he had to walk around with crutches.

Sampson's disability would later create an impediment to his mother's resettlement case, who was classified as a woman at risk in the camp. Her husband had been killed in Eastern Congo and the risks for exploitation in a country of asylum for young women without means and other support was extreme.

Why is that?

When given the resettlement criteria, some receiving countries would specify against individuals with disabilities, citing lack of support and resources. In one correspondence I received, immigration officials pointed to lack of wheelchair ramps in social housing as being an insurmountable obstacle. This effectively crossed out swathes of individuals maimed during the war or by landmines. Such discriminatory practices are quite pervasive and persist today.

But I was not having a bar of that in this circumstance and when the time came to "explain" the disability of this beautiful boy, I did with vehemence. His case was accepted and he would join his other five siblings, into the unknown, for new lives in Manchester, England. He did not leave before giving me a huge hug in my office.

I wish I could tell you that Sampson's story was not an exception to the rule and that all stories had a happy ending. One vivid story comes to mind from several years earlier in China, involving a Congolese woman who had been trafficked. Noel found herself on the doorstep of the UNHCR office, alone and eight months pregnant, presumably having just arrived in the country. It was the middle of winter and she had no place to stay. Having no understanding of Chinese, with no one from the Congolese community present, her situation was critical.

As a policy, unwritten or otherwise, UNHCR did not provide financial assistance to asylum seekers. It was argued that the potential pull factor and influence on the movement of people in the region where financial support and the prospects for resettlement where more readily available influenced such measures.

Noel's extreme vulnerability, however, presented no other option but providing her with some financial support, so I became a bridge between her and the office.

Not a week goes by that I do not think about her story.

Asylum seekers within urban settings have unique challenges in penetrating restrictive legal frameworks and gaining access to basic social services. In China, refugees and asylum seekers have no legal rights. This is coupled with an environment that is restrictive because of language and cultural isolation. The authorities restrict civil society support to refugees and asylum seekers, meaning that there are no NGO partners intervening and the only source of support is the UNHCR.

Yet despite the challenges, for an outreach or community services officer within this context, there is an intimacy with clients I have found in few other places. While people are completely disempowered within an oppressive environment, the work – to get places for children into schools, provide counselling to those in limbo, sort out shelter and housing for vulnerable unaccompanied minors – was actually intensely rewarding.

So within a context whereby someone could not speak a word of English or Chinese, the fact that I could converse with Noel in her native French meant that a lot of my resources where invested into one individual.

A month and a half had passed and her situation had stabilised, with accommodation found and ongoing assistance for food. Then I received a call late at night. Bleary-eyed, I was told Noel was in labour and that there were complications. An interpreter was required who was linked to UNHCR and who could speak Chinese and French. Being the only candidate, I was required to be in the delivery room to relay the doctor's instructions and provide support to the mother with whom the hospital could not communicate.

All went well that evening and the lady was kind enough to name me the godfather of the child, a lovely baby girl. I remember walking to the office that day, half asleep and my boss greeted me with a small UNHCR pin from the merchandise we sold. In jest, he presented me with the "Nansen Award" and we had a good laugh.

Noel was deported back to Congo with her baby a few months later. Not a week goes by that I do not think about her story. R

SARAH YAHYA, a Mandaean refugee living in Australia, travelled to Geneva as a delegate representing young refugees in Australia and globally. This is her story.

Young Refugee Rises to Geneva Challenge

How much do you value a plastic bag? An odd question, I know – but for me, a particular plastic bag set the course of my life and led me here to Australia. It contained my future.

I remember carrying that bag, clutching it tightly, when I first arrived.

I didn't speak or read English, but I could make out the letters that were written in my favourite colour, blue. I spelt it out: "UNHCR", which stands for the United Nations High Commissioner for Refugees. I made up my mind then that this was the place I wanted to work. I was 13, had so many dreams, and working at the UNHCR was one. So when the UNHCR announced the theme of Youth for the 2016 NGO Consultations, I was thrilled.

Little did I know I would be one of the delegates representing young refugees in Australia, and worldwide, at the UNHCR headquarters in Geneva.

I already knew that, in my capacity as a volunteer assisting resettlement services, I would be part of a team holding consultations with young people across the state. The outcomes of those consultations would be drafted into a report to be presented in Geneva.

For the first time the Australian team's report would not be presented by senior employees working in the refugee sector, because this year the UNHCR had specifically requested the contribution and participation of young people from a refugee and asylum-seeker background – a rare event.

So the Refugee Council of Australia (RCOA) and the Multicultural Youth Advocacy Network (MYAN) called for young people to apply to participate as delegates. I thought I would simply apply and get accepted, but it didn't work out that way: while I made

it to the interview stage I was not accepted. I was upset, but I didn't waver.

During the years I had been giving so much of myself to the community and young people, I had learned something very valuable: to never give up when you have come so far. When I applied it was not only for me. I did so because I believed I was ready to represent young people. I am passionate about them, so I continued to lobby.

I was getting ready to conduct the consultations and travelled to regional NSW to make sure every young person stood a chance to be heard, meeting three delegates, Elizabeth Lang, Arif Hazara and Arash Bordbar. Arif and Arash were selected to attend the Global Refugee Youth Consultations (GRYC), while Elizabeth was to attend the NGO Consultations.

While I thought it was fantastic for young people to be offered this opportunity, I was upset when I realised no young women would be at the GRYC meetings, not because it was not offered to me but because I had thought gender balance would have played a part in the selection process.

Female representation matters, because exclusion may discourage other young women from applying. Coming from an ethnic minority from the Middle East, I am all too familiar with the lack of female representation in institutions.

How can you encourage young women when they look around them and see no female representation? How can you motivate young women to participate when they face prejudice and bigotry? Gender equity matters because it inspires, motivates and encourages young women.

A few months later I was in a lecture room when my phone started vibrating. I was already crippled by stress about my studies, so didn't return the call until later. Nadine Liddy, the national youth coordinator of MYAN, had called to tell me a spot had opened up for a young representative to go to the GRYC and offered it to me. I was stunned. I accepted in a heartbeat.

Everything happened very fast. I had frequent teleconferences in preparation for meetings. I was asked to sit on panels and connect with young people from all over the world.

The truth is, I had no idea what to expect. An academic who had worked for UNHCR told me: "It's a good thing you're going, but you're going to be bitterly disappointed." He had quashed my hopes before I went! Little did I know he was right.

When I arrived in Geneva, I barely had a rest before starting work on the GRYC with participants from all parts of the world. Some had been resettled, others were still living in refugee camps and the rest had just made their journey to Europe by boat.

All of us worked tirelessly to help refugees and asylum seekers, but no one at the GRYC meetings seemed to care about that. We, the young participants, appeared to be defined largely by our personal stories – stories we had to repeat over and over at every panel we sat on and every event we attended.

Everyone wore a name tag, I did not. I carried one with the word "youth" on it. Every time I was asked to tell my story there would be an expert who would deconstruct it. I absolutely hated it. My main concern was for those young participants who had to share their painful experiences about living in refugee camps or those who had just travelled across the seas.

The organisers seemed to have forgotten that sharing such traumatic experiences repeatedly can trigger negative feelings and, in some cases, that is what happened. There was no one on-site to offer support. I was lucky because I had the Australian delegation continually checking up on me and ensuring I had the support I needed.

My enthusiasm plummeted within the first week. I felt patronised, but most of all I felt worthless. I had the opportunity of a lifetime to be part of the work carried out by the biggest refugee organisation in the world that I had admired for as long as I could remember: but none of that mattered. What was I doing there?

Arif and Arash, the other young Australian representatives were perhaps stronger than me. They kept going despite the disappointments. I could not do that, and had a breakdown I kept secret.

In Australia I have met refugees and asylum seekers who have been through hell. All of them are trying to recover, to move forward. But the situation in their war-torn countries – where many of their family members, including my own, are stuck in limbo – leaves us constantly worried. And those I've met in detention centres are struggling to live each day.

I was representing all of them but all I was asked to do was to share my story in front of people who worked in the field and knew all too well what it is like.

So, what did we accomplish? I posed that question to others who attended and they admitted they found the whole exercise pointless. That is when I came to realise and appreciate the type of grassroots advocacy and activism we do in Australia. Real change, I learnt, does not take place in such formal conferences. It happens in communities at a local level and it is driven by passionate people.

I felt a bit rebellious when it was my turn to speak to one last panel. Again I was asked to tell my personal story and gave an example from it, but before I ended it I decided to explain to all the NGOs present about best and worst practice in helping young refugees and the practical, useful ways in which they can assist young people move from opportunities to solutions.

"Real change, I learnt, does not take place in such formal conferences. It happens in communities at a local level and it is driven by passionate people."

This time my talk sparked some interest and I was asked many questions. Many people asked for a copy of my suggestions, so I was glad that I took that approach. I realised that this is what should have been happening.

As a result of my talk I went to Malaysia to make presentations at workshops for young people at the Dignity for Children Foundation, which provides education to refugees and young people seeking asylum. It was that particular panel that led me here. The workshops aimed to empower young people, whose resilience I would like others to see and appreciate.

I have been harassed in social media for my work with refugees. But when you come face-to-face with young people who, through no fault of their own, are displaced, stateless and living in difficult conditions, you start to think about how to change people's views.

Last December I travelled again to Geneva to attend the UNHCR Annual Dialogue on Protection Challenges. This year's focus is on children on the move.

In spite of the initial disappointment, my experience at the NGO Consultations ended up being crucial and enlightening and I intend to use of what I learnt there to do better next time. This Dialogue is one of them. I have no intention of being a storyteller. This time, I will take the initiative and I will say what I want to say.

I once told an Australian delegate that after what happened at the consultations I was ready to let the dream go, but she said to me that my unhappiness should be the ultimate motivation to improve the process. And you know what? It has.

When I returned to Australia, young women were thrilled. They asked me how I got there and told me they aspire to do the same. This was perhaps the highlight of my trip to Geneva, to demonstrate that young women can go places and achieve things when we put our minds to it.

As a result of this experience I have met many people around the world and gained a new perspective. I learnt how international advocacy works and had a chance to co-present at the UN in Geneva for diplomats and officials, which was exhilarating – and very rare for non-diplomats. It was there that Arash, Arif and I called for the international body to address the issues young people face and the human rights abuses occurring in Australia. It was received warmly (except by the Australian officials).

In 2017 the theme "Youth" may be over for the UNHCR, but for us it has only just begun. It's time we participate in the talks to find solutions to the problems.

The rising xenophobia the world faces, coupled with the biggest refugee crisis since World War II, has only made us determined not to be the leaders of tomorrow but the leaders of today. We are more than storytellers, we are change-makers and have no time to waste. R

Travels in India

Dunja Karagic

I'm only 20 years old and my eyes are now open. I say to myself "My family influences every decision I make" – including the one where I decided to board a plane to India to spend a month living in a rural village. It's New Year's Eve and I am waiting, all alone at Sydney Airport, for my flight to Bangalore. Boarding pass clutched in hand, I'm already sweating at the huge shock that must await me.

After an exhausting 42-hour transit I was greeted by the most magnificent array of colours, sounds and scents, an immediate sensory overload. With its raging population of 1.3 billion and rich culture, India has always been a place I have dreamed of visiting. For years I have wanted to meet its incredible people, breathe its aromas, taste its spices and be blinded by its magnificent colours – but as soon as I was there I froze in shock and panic, which at that moment seemed ridiculous.

It was late last year when I applied to do a month-long internship with 40K Globe, a social enterprise organisation that encourages university students to drive sustainable change in rural India. Being a media student, I was placed in the Plus Media Project, which involves scripting, filming and editing culturally relevant educational videos for teaching children English in rural villages near Bangalore. These videos are to be distributed on learning tablets called Plus Pods in the after-school centres 40K Globe has set up.

My home for the month was Meenakunte, a village an hour out of Bangalore. Day to day, we wandered through the colourful streets, forming relationships with the village community and working with them to come up with culturally relevant and engaging video ideas.

Initially I was sceptical about the way 40K Globe emphasised the importance of teaching English in India. Why should I just barge into this country and attempt to impose my language on its people? I never understood until I experienced first-hand the shocking contrast between India's rich and poor. Every billboard or commercial aimed at those with a substantial income is in English. To the people living in Meenakunte, an advertisement for an Audi is no more than jumbled letters.

It soon became obvious that English is the leading symbol of wealth in India. Knowing the language opens up many more job opportunities. And as much as this makes me grit my teeth in anger, it also motivated me. My first experience visiting a Plus Pod in a neighbouring village was overwhelming. I had to step outside to stop myself from breaking down in front of a room full of children at seeing how much impact the Plus Pods, developed by young individuals like me, had on the children.

My travelling companions are also only 20. Travelling as three females after we finished our placement was the most shocking and eye-opening experience. We found comfort among other women when we were ignored and barged into by men, when their prejudice made us feel small and frail. Women in India have impacted me for the rest of my life. I have never seen such strength in human eyes as I did in the mothers and young women of India. Experiencing first hand a glimpse of the gender injustices so deeply ingrained in so much of their culture was appalling. India opened up my eyes to so many of the world's inequalities, it dragged me out of my bubble, it made me value real human connection. It also made me understand the complexity of the world and

PHOTO: The author with a group of children in Meenakunte, India.

human will power. It made me think of the values my parents had raised me with, the reason I boarded that plane to Bangalore in the first place.

My parents were also only 20 when they fled the war in the former Yugoslavia and moved to Germany, where I was born. They lived on a temporary protection visa until eventually they found protection and a home in Sydney.

Being connected through a lifeblood of human injustice and having been a refugee myself has inspired me to see the world, meet people, experience different cultures and – most of all – listen to peoples' stories similar and different to my own.

Nothing did this more than India, and the people who I had the privilege of meeting, in particular one girl. She was 20, too. Her family invited us in for chai tea one day, although the only way we could communicate was through stares, smiles and gestures. I'll never forget her hand grabbing mine as I began to walk back to our home and she said to me in broken English, 'please I want to study in Australia". I'll never forget her sister's roaring laughter, as if it was the funniest joke she had ever heard. Her stare made my heart throb and I prayed that the efforts made by myself and others, through 40K Global, would one day make her dream come true.

My month in India made me realise so much about the world and myself. It made me aware of the extent of human injustice in our world. But, although they hardly have much in the material sense, these people surprised me on a daily basis with their kindness and gratitude. After returning my heart ached at the thought of leaving behind all those incredible people I had met who have changed me forever, especially the women.

During my two months in India the colourful streets of Meenakunte became my home, the local villagers my family. The children left their fingerprints in my heart forever and the goodbye was one of the hardest moments I had ever had to face.

India is hard, incredibly challenging most of the time. Every minute is sensory overload and absolutely nothing was familiar compared with my home back in Australia – except the startling resemblance between the Indian peoples' courage and that of my own parents. ℟

YES, I WOULD LIKE TO HELP REFUGEES AT STARTTS

AMOUNT $.

☐ I attach my cheque/money order
☐ Please debit my credit card (Mastercard/Visa)

Card No. / / /

Expiry date /

Name on card

Signature

☐ I will be making a direct deposit into STARTTS account.
Please write 'STARTTS donation' in the subject line.

ACCOUNT NAME

STARTTS
BSB: 032 072
Account number: 114 851

To make an online donation visit www.startts.org.au **and click on 'Donate'.**

YOUR DETAILS

Name Tel number

Address

Suburb State

Postcode Email address

For more information about STARTTS' programs or making a donation, telephone (02) 9794 1900.

Please send your form to:
Public Affairs Coordinator
STARTTS
PO Box 203
Fairfield NSW 2165

STARTTS is a registered charity. Your donation is tax deductible.

STARTTS

The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) helps refugees deal with their past experiences and build a new life in Australia. Our services include counselling, group therapy, programs for children and young people, community development activities and physiotherapy. We also work with other organisations and individuals to help them work more effectively with refugees. Opened in 1988, STARTTS is one of Australia's leading organisations for the treatment of torture and trauma survivors.