Australian Parliament
Joint Standing Committee on Migration
Submission no. 430

VICTORIAN REFUGEE HEALTH NETWORK

5th May 2011

Ms Maria Vamvakinou MP
Chair
Joint Standing Committee on Migration
jscm@aph.gov.au
PO Box 6021
Parliament House
CANBERRA ACT 2600
Australia

Dear Ms Vamvakinou and committee members,

Thank you for the opportunity to provide a submission to the Inquiry into Multiculturalism in Australia. This submission is made on behalf of the Victorian Refugee Health Network, auspiced by the Victorian Foundation for Survivors of Torture Inc, which was established in 2007. The network brings together health, community and settlement services to build their capacity to provide more accessible and appropriate health care for people of refugee backgrounds. A reference group oversees the work of the network and is comprised of senior representatives from primary, acute and mental health care, general practice, settlement services, asylum seeker agencies and relevant state and commonwealth departments. The network works with representatives of refugee communities to identify and address emerging health issues. The Victorian Refugee Health Network is a member of the newly formed Refugee Health Network of Australia (RHeaNA).

Reflecting the work of the Network, this submission focuses on 'settlement and participation' with a particular focus on supporting the health and wellbeing of new arrivals to Australia from a refugee background. Supporting the health and wellbeing of people of a refugee background is fundamental to addressing economic, social and cultural participation. Within this context the Australian Government's Social Inclusion agenda will be referenced as appropriate in this submission.

Introduction

As signatories to the 1951 Convention relating to the Status of Refugees, Australia has a very long and proud tradition of accepting humanitarian entrants - people who "owing to a well founded fear of persecution" are unable to live in their homeland. People who are humanitarian entrants are unique as they have not made the choice to migrate, rather through horrific circumstances they have fled from their homelands. Victoria received 3939 people via the humanitarian program in the 2009/10 financial year (DIAC settlement database: extracted 30/03/2011). Appendix 1 illustrates the Victorian intake by county of birth for the past 10 years.

The Australian Government's Social Inclusion agenda launched in 2010, assists in providing a framework for assessing the settlement experiences of people who arrive in Australia as a humanitarian entrant (Australian Government 2010). The Australian Government's vision of people being enabled by resources, opportunities and capability to learn, work, engage and have a voice is very much in line with the work of the Victorian Refugee Health Network.

People from refugee backgrounds often experience poor health as a result of living in impoverished conditions where they may not have had access to the most basic resources for good health such as safe drinking water, adequate nutrition, shelter, preventative health care and education, and as a result of prolonged persecution or targeted state sanctioned violence or torture (VFST 2007). Combined with these pre-migration experiences and (often prolonged) time in transit, are resettlement stressors such as being a minority in an unfamiliar dominant culture, low English language proficiency, engaging with an unfamiliar bureaucracy, not having skills recognised, separation from loved ones and continued bad news from their homeland. These experiences pre-migration, in transit, and during resettlement, all impact on the health and wellbeing of those from refugee backgrounds. Health problems may require multiple investigations and referrals at a time when people are in their early settlement period and are least equipped to negotiate complex service systems (Kulkens 2009). Primary and specialist services are vital within the initial stages of settlement to reduce overreliance on emergency departments and to reduce the number of people presenting after becoming significantly unwell (Kulkens 2009).

Key documents focusing on refugee health in Victoria

Towards a health strategy for refugees and asylum seekers in Victoria published in 2004 by the Victorian Foundation for Survivors of Torture (VFST) for the then Department of Human Services Victoria outlined the particular health needs of people from refugee backgrounds and the gaps in service delivery. The Department of Human Services Victoria went on to develop a Refugee Health and Wellbeing Action plan for the periods2005-2008 and 2008-2010.

The Victorian Government's *Refugee Health and Wellbeing Action Plan 2008-2010* includes three strategic priorities; providing "timely and accessible services for refugee new arrivals", building "the capacity and expertise of mainstream and specialist services and health care practitioners in the area of refugee health care" and to "support and strengthen the ability of individuals, families and refugee communities to improve their health and wellbeing outcomes".

Access to specialist services by refugees in Victoria: A report prepared for the Department of Human Services was commissioned by the Victorian Refugee Health Network (Kulkens 2009). This project was undertaken to explore existing care pathways for refugee requiring specialist health services in Victoria. Based on existing practice it outlines two service delivery models to provide better co-ordination of primary health and specialist services in response to the sometimes complex health presentations of people from refugee backgrounds who are seeking healthcare. It is a useful resource for health services in planning local service delivery with significant refugee background populations.

Responding to TOR 3 "Innovative ideas for settlement programs for new migrants, including refugees, that support their full participation and integration into the broader Australian society"

"Health is vital in people participating in society" (Social Inclusion Board 2010). Victoria has an integrated health care model for humanitarian new arrivals and has developed a range of innovative service models as outlined below. The model focuses on building capacity across primary care and specialist mainstream service to enable them to effectively engage and work with people from refugee backgrounds.

Refugee Health Nurse Program – established in 2005, Refugee Health Nurses are located in community health services in areas of significant settlement in rural and metropolitan Victoria. Refugee Health Nurses provides direct care to local residents from refugee backgrounds, together with a key role in health promotion and support for broader service development. There are 26 nurses (some part time) and a statewide facilitator. This $4 million dollar program is funded by Department of Health Victoria.

The Victorian Foundation for Survivors of Torture and Trauma – Foundation House (VFST) was established in 1987 to assist survivors of torture and trauma, of refugee backgrounds, who have settled in Victoria. VFST provides direct services to more than 4,000 survivors each year, as well as developing resources, provides training, consultancy and support to increasing the capacity of service providers in the health, education and welfare sectors to meet the needs of survivors. VFST also conducts and commissions research to improve policies, programs and services that affect the health and wellbeing of people of refugee backgrounds.

Refugee Health Fellows – two specialist Fellows are based at the Royal Children's Hospital (RCH) and Royal Melbourne hospital (RMH). The Fellows provide education around health issues commonly experienced by refugees and immigrants to GPs, specialists, nurses and allied health in metro and rural areas. Their role also consists of secondary consultation to doctors working with people from refugee backgrounds, as well as direct service in refugee health clinics at RCH and RMH.

Support for GPs – General practice plays a pivotal role in providing comprehensive health care for new arrivals from refugee backgrounds. *Caring for Refugee Patients in General Practice: A Desk top guide* (VFST, 2007) and *Promoting Refugee Health: A guide for doctors and other health providers caring for people from refugee backgrounds* (VFST 2007), are key publications to assist GPs in assessments, referrals and ongoing care. General Practice Victoria in 2007 developed the *Refugee Health Assessment* proforma under the guidance of an expert reference group, to support GPs in providing comprehensive assessments to people from refugee backgrounds. In recognition of the expertise required to identify and appropriately treat people from refugee backgrounds a range professional development opportunities for GPs have been developed including an introductory 6 hour active learning module (accredited with RACGP and the Mental Health College) run by Foundation House and an intermediate learning and development series coordinated by a number of Victorian GP divisions (accredited with RACGP). This growing area of expertise has lead to the

application for a specific interest group through Royal Australian College of General Practice (RACGP) to foster a community of learning and knowledge around refugee health.

Victorian Refugee Health Network (VRHN) Website and E-Bulletin (www.refugeehealthnetwork.org.au) – VRHN website provides information on services, resources, protocols and training opportunities focusing on refugee health. It links service providers and gives updates on relevant news, policy developments, research, reports and useful websites. The monthly E-Bulletin provides a regular forum to share news and information to support practitioners and services in providing health care to people of refugee backgrounds. Currently this is circulated to 600 active subscribers.

Responding to TOR "The role of multiculturalism in the Federal Government's social inclusion agenda"; Enabled by resources, opportunities and capability to learn, work, engage and have a voice.

The following recommendations while focusing on refugee health relate to improved services for all CALD communities.

Health reforms

Access to appropriate and affordable health care is a key enabler in order to learn, work, engage and have a voice. The current health reforms including the establishment of Super Clinics in outer metropolitan and rural & regional Victoria and the role of the Medicare Locals potentially provide significant opportunities to enhance access for this often vulnerable population group. Practitioners and health services managers in the Victorian Refugee Health Network are very keen to explore these potential opportunities as the reforms unfold.

Recommendations

1. That the needs of disadvantaged population groups, including new arrivals from refugee backgrounds, be taken into account in current health and hospital reform service planning and consideration of funding models.
2. That the Commonwealth fund the Australian Refugee Health Network (RHeaNA) as a National Lead Clinicians Group.

Language Services

The delivery of health care is dependent upon adequate communication, for all aspects of care including assessment and diagnosis, care planning, gaining informed consent and discussing sensitive health concerns. The failure of medical practitioners and other health care providers to use professional interpreters when required is of increasing concern to VRHN. VRHN receives regular reports regarding health professionals not utilizing professional interpreters. Many incidents of health professionals refusing to see patients that do not speak English are also reported to VRHN. Too often VRHN receives reports of the use of family members to interpret personal and what should be "confidential" health material which is clearly inappropriate. Furthermore engagement in procedures where an interpreter has not been used to seek informed consent is another scenario that is reported to VRHN. The Australian Government has gone some way in creating an enabling environment for health professional to utilize interpreters by providing the Doctors Priority Line and

allowing GPs to bill for extended time experienced when using an interpreter. However there are some significant gaps with a number of Australian Government services making no provision for interpreting, effectively denying access for those with low-English profiency. These services include:

- Access to Allied Psychological Services (ATAPS) through the Better Outcomes in Mental Health Care Initiative (BOiMHC) which is facilitated by Divisions of General Practice for provision of services by psychologists, social workers, occupational therapists, mental health nurses and ATSI workers on referral from a GP for up to 12 sessions (and 18 sessions in exceptional circumstances).
- Better Access to Mental Health Care Initiative which provides up to 12 sessions (and 18 in exceptional circumstances) under Medicare for provision of services by psychologists, social workers and occupational therapists on referral from a GP (with mental healthcare plan in place).
- The Medical Benefits Schedule allied health item numbers which enables people with chronic conditions and complex care needs who are being managed by their GP under an Enhanced Primary Care (EPC) plan to claim Medicare rebates for a range of allied health services, including Physiotherapy, Mental Health workers, Dietician, Podiatry, Osteopaths, Occupational Therapy etc under a teamcare arrangement.
- The Mental Health Nurses Incentive program, where mental health nurses can be employed by general practices, divisions, or psychiatrists and reimbursed by Medicare.

A related concern is the inadequate supply of adequately trained and accredited interpreters in new arrival languages. With ever advancing information technology, there is an urgent need for more dedicated workforce planning and a need to review the approach to language services provision in Australia within an international context.

Recommendations

3. Support the expansion of fee-free interpreting services through TIS to the range of Department of Health and Ageing and Medicare funded allied health and mental health services. These programs include ATAPs, Better Access to Mental Health Care, Medical Benefit Scheme allied health item numbers used for treatment of chronic conditions, and the Mental Health Nurse incentive program.
4. Promote and support the use of interpreters in all health programs through service agreements and key performance indicators.
5. Ensure new health programs have funding for interpreting services.
6. Interpreter work force planning and timely accreditation of new languages.
7. Further investigation and trialling of use of remote access telephone and video technology for interpreting nationally and internationally.

Data

Data limitations in relation to CALD populations often impact on the ability of research and reports to provide a full account of social inclusion in Australia (Social Inclusion Board 2010). A recent example of this was the evaluation of the Better Access program that stated: "The summative evaluation was not able to assess this question for all groups who are traditionally disadvantaged in their access to mental health care, because no data were available for some (e.g., people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander people)" (Pirkis, Harris et al. 2010). Given that data for the Council of Australian Governments (COAG) national health care agreement is currently being developed (Social Inclusion Board 2010), this is an important time to ensure that country of birth, interpreter required and language spoken at home information is routinely collected. Data about service access and usage that separates out those that have a refugee background would enable more targeted service provision, demonstrate trends in and help as to measure progress in the degree that people from refugee backgrounds are socially included. Furthermore, Australian health research focusing on people from refugee backgrounds is sparse due to the cost of providing interpreters and perceived methodological difficulties (NHMRC 2005 as cited in Davis, Riggs et al. 2010). This effectively means that there is very little population level data available regarding health inequalities experienced by those with low-English proficiency.

Recommendation

8. Inclusion of country of birth, interpreter required, and language spoken at home category in health data that is collected as part of the COAG national healthcare agreement.
9. Funding for interpreters to be provided when population data is collected to ensure that low English language proficiency groups are represented.

Social determinants of health

The social inclusion agenda recognizes the social determinants that impact on opportunity, choice and capability. Many people from refugee backgrounds in Victoria settle in the outer suburbs of Melbourne impacting significantly on the access to services (see attachment 2). "Those not proficient in English have greater difficulty accessing public transport"; having access to transport is an important aspect of participation in various community domains (Social Inclusion Board 2010). Furthermore people who arrive on humanitarian visas, given their often traumatic exit from their country of origin and eventual relocation to Australia, will have significantly less access to individual, family and community resources than the broader population. Peoples' individual refugee experience impacts on health, their ability to fulfill previously held life goals and aspirations, the ability to utilize skills and work history that may not be recognized in Australia, and family and social networks which are often fractured. Resettlement, while necessary for survival, means for many people existing within a country with foreign cultural practices, service systems and language. This may also be overlaid with racism and negative media coverage.

Recommendation

10. Support vocational programs that target people from refugee backgrounds, build relationships with industry and match appropriate skills.
11. Support NGOs that harness the strengths of the communities.

12. Engage in a positive discourse around the contribution of people from refugee backgrounds to Australia.

Separation from family

Families play an important role in health care in many cultures, as part of decision making processes, in imparting wisdom or information about health care, by providing support via transport or child minding, and by providing direct care (Desouza 2006). People from refugee backgrounds are quite often part of separated family constellations impacting them in multiples ways. Often family members are still in the country of origin or transit in precarious situations which causes great anxiety and stress and sometimes survivor guilt to those who have resettled. Furthermore many traditional cultural practices and wisdom rely on family networks such as support in parenting and caring for those who are ill. Loss of traditional support networks can cause great strain.

Recommendation

13. Support programs such as the Refugee Family Mentoring and Resource Program, which recruit and train community leaders to provide supported play groups http://www.vicsegnewfutures.org.au/vicseg-programs/family-and-childrens-programs/
14. Support the development of culturally competent service provision that enables practitioners to engage with various family beliefs.
15. Support a Productivity Commission inquiry into the economic contribution of families particularly with reference to migration.

Thank you again for allowing us to present some of our experience to this inquiry. Please feel free to contact me or the Victorian Refugee Health Network project worker Philippa Duell-Piening (03) 9389 8972 to clarify any content in this submission.

Kind regards,

Lenora Lippmann
Chair
Victorian Refugee Health Network
Ph. (03) 9341 5200

References

Australian Government. (2010). "Social Inclusion." from http://www.socialinclusion.gov.au/Pages/default.aspx.

Davis, E., E. Riggs, et al. (2010). Progress Report 2: Supporting Health and Wellbeing for Families with Children of Refugee Backgrounds: Understanding the needs of families and services The McCaughey Centre, Melbourne University: 1-25.

Desouza, R. (2006). New Spaces and Possibilities: The adjustment to parenthood for new migrant mothers. Wellington, Families Commission New Zealand.

Kulkens, M. (2009). Access to specialist services by refugees in Victoria: A report prepared for the Department of Human Services by the Victorian Refugee Health Network. Melbourne, Victorian Refugee Health Network.

Pirkis, J., M. Harris, et al. (2010). Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summative Evaluation. Melbourne, Centre for Health Policy, Programs and Economics.

Social Inclusion Board (2010). Social Inclusion: How is Australia fairing? Canberra, Department of the Prime Minister and Cabinet.

VFST (2007). Promoting refugee health: A guide for doctors and other health care providers caring for people of refugee backgrounds. Melbourne, Victorian Foundation for Survivors of Torture Inc.

Attachment

Attachment 1: Country of Birth

Over the last 10 years Victoria has accepted people via the humanitarian program from the following countries (only top 20 intake countries listed):

SUDAN	7804
IRAQ	5675
AFGHANISTAN	4928
BURMA	3819
FORMER YUGOSLAVIA	1660
ETHIOPIA	1569
THAILAND (children born to parents of minority groups from Burma in protracted refugee situation)	1277
IRAN (some children of Afghan parent's in transit)	1153
SRI LANKA	907
EGYPT ARAB REP OF (children born to Sudanese parents in protracted refugee situation)	764
SOMALIA	655
KENYA (children born to parents from neighbouring countries in protracted refugee situations)	587
LIBERIA	539
CROATIA	477
BOSNIA-HERZEGOVINA	468
AUSTRALIA (children born to parents on Temporary Protection Visas or Asylum Seekers)	443
CHINA PEOPLES REP	428
ERITREA	426
INDONESIA (children born to parents in transit country)	374
PAKISTAN (children born to Afghan parents in protracted refugee situation)	335

Total Top 20 Arrivals	**34288**
Total Other Arrivals	**3445**
Total Invalid/Unknown	**215**

Total Arrivals for Report Period	**37948**

Data extracted from the DIAC data base 9 March 2011 for the period 1 July 2000 to 31 June 2010.

Attachment 2: LGA of residence

Pattern of settlement over the past 10 years in Victorian LGAs (only top 10 listed).

LGA	Arrivals
Greater Dandenong (C)	7513
Brimbank (C)	4234
Hume (C)	3969
Casey (C)	3113
Wyndham (C)	2082
Maribyrnong (C)	1654
Maroondah (C)	1205
Whittlesea (C)	1175
Darebin (C)	1098
Moreland (C)	1016

Total	Arrivals
Total Top 10 Arrivals	**27059**
Total Other Arrivals	**10332**
Total Invalid/Unknown	**557**

Total	Arrivals
Total Arrivals for Report Period	**37948**

Data extracted from the DIAC data base 30 March 2011 for the period 1 July 2000 to 31 June 2010.