2018

victorian refugee health network

Statewide meeting report

Date: Thursday 1 November 2018, 1.15 - 2.45pm
Venue: Training rooms, Foundation House, 4 Gardiner St, Brunswick
Co-chairs: Sheenagh McShane and Jacquie McBride

Contents

Report compiled by Samantha Furneaux and Philppa Duell-Piening
Contact: info@refugeehealthnetwork.org.au
Last updated: 4 December 2018

Summary

More than fifty five people attended the statewide meeting of the Victorian Refugee Health Network on 1 November 2018. Sheenagh McShane and Jacquie McBride have now been appointed as co-chairs of the Victorian Refugee Health Network and will serve a two year term in this position.

Participants at the statewide meeting were provided a series of updates relating to work being undertaken in the *Access to health services for people seeking asylum* working group and the *Disability Action Group* as well as the most recent settlement data and asylum seeking data, the current policy environment, current clinical issues and a snapshot of activity in local regional refugee health working groups in the outer north and the outer south east of Melbourne.

In response to the previous meeting, where mental health was identified as a priority area for action for the Network, a workshop was facilitated for participants to contribute their knowledge and experience to issues relating to mental health of particular sub-population groups within the refugee population. The Network executive will consider this data and appropriate approaches to address mental health service and policy gaps through the work of the Victorian Refugee Health Network.

The meeting dates for 2019 have been set and will be held at the auspicing agency of the Network, Foundation House, 4 Gardiner St, Brunswick on: 7 March, 6 June, and 28 November, 3.15-4.45pm

Language used in this report

People from refugee backgrounds

The term ‘people from refugee backgrounds’ is used throughout this report to refer to those who: have arrived in Australia with, or who have subsequently been granted, permanent or temporary humanitarian visas; people seeking asylum; and those who come from refugee backgrounds who have another visa type, including family migration and skilled migration. Where the immigration status a person currently has or had on entry to Australia is significant (i.e. to service eligibility), this will be noted.

Welcome

Sheenagh McShane and Jacquie McBride were welcomed as the new Victorian Refugee Health Network (the Network) co-chairs.

The co-chairs acknowledged it was great to see such a mix of people who were present at the Network meeting. This included many people in clinical roles, policy, service managers, people working directly with clients and a range of others. Meeting attendees are listed in appendix 1.

Headline updates

Working groups

Access to health services for people seeking asylum working group – Tracey Cabrié

This working group has co-chairs Tracey Cabrié (Centre Manager, Cabrini Asylum Seeker and Refugee Health Hub, and Sarah Christensen, Refugee Health Nurse Program Coordinator IPC Health) and diverse representation from health, and asylum seeker support agencies.

Pharmaceutical costs

A focus of the meeting was on pharmaceutical costs and pharmacy waiver programs. Some funding has been allocated from the Department of Health and Human Services (DHHS) to Asylum Seeker Resource Centre (ASRC), Monash Health & cohealth. Cabrini are also currently working with DHHS to arrange potential funding to increase their pharmacy program.

Ambulance waivers and Public Transport Victoria (PTV) concession cards

As access to Status Resolution Support Services (SRSS) for people seeking asylum is reduced, this is having an impact on the ability of people seeking asylum to access PTV concession cards and ambulance cost waivers. SRSS providers were specifically named as having the authority to signed off ambulance cost waivers and PTV concession cards. As SRSS casework is reduced, there are fewer people who are able to sign off such items. This working group is currently exploring which other services may be well placed to authorise access to these services in order to provide advice to the state government.

Data

Data collection was also discussed – the working group suggested a number of data items that could be collected to inform advocacy to state government. A survey will be conducted to determine the data items that are routinely collected by services and explore platforms to aggregate this data.

What does the group plan to do?

- Write a proposal about continued access to PTV concession cards and ambulance cost waivers.

- Survey working group members and others working with people seeking asylum to determine data items to include in a minimum dataset to monitor issues impacting people seeking asylum.

Contact: Philippa Duell-Piening, duell-pieningp@foundationhouse.org.au

AMES Disability Action Group - Natalie Henry

The AMES Disability Action Group (DAG) is co-chaired by Natalie Henry and Jacinta Bongiorno (Settlement Health Coordinators at IPC/AMES and DPV Health/AMES). The group has diverse representation including people from disabled persons organisations, disability support services, settlement, acute health services, community health, NDIS and government.

The DAG is currently focusing on the recommendations from the Victorian Refugee Health Network report *Service responses for people with disabilities from refugee backgrounds in northern Melbourne*: http://refugeehealthnetwork.org.au/service-responses-for-people-with-disabilities-from-refugee-backgrounds-in-northern-melbourne/

The group began looking at the recommendations and what work is already being done. This is being documented in an Excel Online spreadsheet which will be used to progress recommendations within the group. The group are wanting to be an *action* group.

In addition, the pro-bono network of allied health professionals has been established to assist with meeting the demand for services for people seeking asylum and people from refugee backgrounds on long waiting lists.

Contact: Natalie Henry, natalie.henry@dpvhealth.org.au

Data – Philippa Duell-Piening

Philippa Duell-Piening (Coordinator, Victorian Refugee Health Network) circulated a data bulletin with the meeting documents to all those who had RSVPed to the state-wide meeting. The data bulletin can be accessed here: http://refugeehealthnetwork.org.au/wp-content/uploads/Data-bulletin_2018_November_Victorian-Refugee-Health-Network-statewide-meeting.pdf. PowerPoint slides may be accessed in Appendix 2: http://refugeehealthnetwork.org.au/wp-content/uploads/PowerPoint_2018_November_statewide-meeting.pdf

Access to Settlement Data

This Refugee and Humanitarian Program data was extracted from the Department of Social Services Settlement Reporting Facility. While previously access was provided to the database and anyone could run data reports as needed, this web access has been decommissioned. As such, data requests can be made to the Settlement Data Team settlement.data.request@dss.gov.au. The Settlement Data Team provide a report usually within a couple of days. Philippa is happy to support people to engage with the Settlement Data Team at DSS.

Contact: Philippa Duell-Piening, duell-pieningp@foundationhouse.org.au

Data snapshot

The data bulletin indicated age on arrival – fairly typical spread, although increasingly greater numbers of older people are arriving.

Accurate and up to date data on people seeking asylum is difficult to get. This is increasingly problematic as people have long waits for their applications to be processed and reviewed. Accurate data would assist with service planning and advocacy.

There is a reported increase in the number of people arriving by plane entering Australia with a valid visa and later seeking asylum, however this data is difficult to obtain. Refugee Council of Australia (RCOA) typically access this information through Senate Estimates. In 2016/17 there were approximately 18,000 plane arrivals and in 2017/18 the seven months of data available indicated a trend that may reach 30,000 people.

Data for people who arrived by boat was last released in March by Department of Home Affairs.

The data bulletin included the numbers of TPVs and SHEVs granted, high grant rate of 72% of those who have visa outcomes to date. However, it is difficult to get LGA level data for this group.

Policy update – Sheenagh McShane

The PowerPoint slides may be accessed in Appendix 2:
http://refugeehealthnetwork.org.au/wp-content/uploads/PowerPoint_2018_November_statewide-meeting.pdf

- New minister for Home Affairs, David Coleman
- Ongoing impact of SRSS changes – letter sent to Premier Andrews from the Network
- Kids Off Nauru campaign – announcement that this will happen by Christmas, however there are concerns that this needs to happen sooner given the health issues experienced by many of these children.
- Royal Commission into aged care focusing on quality and safety
- Psychosocial stream of NDIS – working with Mental Health Australia to improve the pathways for people with psychosocial disability
- Extension of mandatory reporting requirements
- Upcoming state election in Victoria
- Minority Commonwealth government

Discussion:

Two service providers reported knowing of people seeking asylum who have been approved for NDIS despite informing the NDIA that these clients do not meet residency requirements for the NDIS. Concern that people may receive bills later down the track for services received.

Clinical services (universal, across the life span, and specialist) – Jacquie McBride

The PowerPoint slides may be accessed in Appendix 2: http://refugeehealthnetwork.org.au/wp-content/uploads/PowerPoint_2018_November_statewide-meeting.pdf

Current issues:

- Insecure housing, particularly for people seeking asylum
- Data does not catch secondary settlement, making accuracy and planning difficult
- Increase in children and adolescents arriving through the Humanitarian Settlement Program as well as those children arriving from Nauru.
- Evolving theme of mental health distress
- Missed health alerts
    - In the north, Settlement Health Coordinators are screening the health reports available in HAPlite prior to arrival. Critical alerts are typically picked up pre-arrival, however there are some health alerts that are missed relating to chronic disease that may be unstable etc. This information is being fed back to the Department of Home Affairs, however it is unclear what will be done with this information in the longer term.

Local refugee health working groups: Outer Northern Melbourne and South Eastern Melbourne

At each state-wide meeting two local refugee health working groups will be invited to present key work they are undertaking.

Outer Northern Refugee Health Network (ONRHN) – Mohammad Karimi

ONRHN was established in December 2015 to address health issues of new arrivals in the outer northern region. The ONRHN aims to improve health and wellbeing for new arrivals in the outer north by applying multi-sectoral strategies. See Appendix 3 for Mohammad's slides: http://refugeehealthnetwork.org.au/wp-content/uploads/PowerPoint_2018_November_ONRHN_Mohammad-Karimi.pdf

Strategic Plan

Development of the strategic plan has included the processes of literature review, data analysis, online consultation with community members from refugee and asylum seeker backgrounds and service providers in the north. This data and information has informed the final discussion with service providers at a workshop in which the strategic plan was finalised. In the workshop, five priorities areas were identified and each was supported by a range of actions, activities and expected outcomes.

Full strategic plan available here: http://www.hwpcp.org.au/wp-content/uploads/2018/08/Strategic-Plan-2018-2021-Final.pdf

ONRHN Service Directory

Currently looking to integrate this local service directory with the National Health Services Directory. Access the ONRHN Service Directory here: http://www.hwpcp.org.au/wp-content/uploads/2018/10/HWPCP008-Northern-Refugee-Service-Directory-FINAL-August-2018.pdf

Data bulletin

ONRHN recently launched a data bulletin to assist with service planning and delivery. Access the August 2018 data bulletin here: http://www.hwpcp.org.au/wp-content/uploads/2018/08/HWPCP_ONRHN_Data-Bulletin_-17-Aug-2018.pdf

Outer South East PSAAR Taskforce: Supporting people seeking asylum at risk of destitution – Rob Koch

The PSAAR taskforce identified the risk of destitution for people losing SRSS support but also for those with no income who are at the post review stage of the asylum application process.

City of Greater Dandenong created a Material Aid consortium and database, allowing services to see what reserves of material aid are available at each organisation and coordinate support to people seeking asylum at risk. This could be a model that works in other regions.

Asylum Seeker Resource Centre (ASRC) have bought a building in Dandenong to assist with meeting the demand in South East. This will be a partnership with other agencies co-located in a Hub model.

Welcome Dinner projects are ongoing, as well as community mobilisation info sessions.

As part of a strategy to mobilise mainstream Australia, a series of 'practitioner forums' will be held to upskill people in the community and groups who are often called upon to act as pseudo case managers.

For further details about the PSSAR taskforce contact Rob Koch Robert.Koch@monashhealth.org. See Appendix 4 for a copy of Rob's PowerPoint slides: http://refugeehealthnetwork.org.au/wp-content/uploads/PowerPoint_2018_November_PSAAR-Taskforce_Rob-Koch.pdf

Themed discussion: mental health

Mental health was identified in the August statewide meeting as the number one unmet need. The purpose of this themed discussion was to define this unmet need more fully and to decide on some strategic actions. Meeting attendees were asked to break into small groups with others who work with similar population groups: Children & Adolescents, People seeking asylum, >55 year olds, new humanitarian program arrivals, established communities. Groups were ideally 5-6 people to allow everyone to contribute to the discussion. The questions discussed included: 'How do we know that there is an unmet mental health need in this population?' 'Please describe the main issues, and prioritise three.' 'What do we need to do? Consider the sites of intervention.' Groups were then asked to select the top two interventions and feedback to the larger group.

The following table documents what groups identified as their top two interventions:

Summary of prioritised mental health interventions

Community	Services	Political	Other
New arrival communities			
• Health Literacy • Cultural attitudes • Establishing strong communities – hubs • Normalising mental health education • Engaging with communities to reduce barriers including formal and informal leaders	• Recognising need for outreach	• Fund services to provide outreach to new arrival communities	Nil
Established communities			
• Ask communities about unmet mental health needs • Identify where people congregate and provide education in these places	• Review demand on services • Resolve language barriers – promote the use of interpreters • Active screening • Staff training	• Strengthen, fund and enforce standards around interpreter use in mental health services	Nil

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	• Training of interpreters		
People seeking asylum			
• Health literacy • Priorities may not be mental health but housing	• Confidence amongst service providers • Bring together research about practice	• Translating research to policy – consider avenues • Funding for translated resources	
Children and adolescents			
• Health literacy	• Engaging with whole of family including in schools • Utilise schools as hubs including welfare staff • Early years – demand on services, i.e.: Maternal and Child Health waiting list due to birth rates • Lack of identification of families from refugee backgrounds in hospitals • Consider longer term programs		

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Population of focus: New arrivals (Group 1)

<table>
<tr><td colspan="2">How do we know that there is an unmet mental health need in this population?</td><td colspan="2">Please describe the main issues:</td></tr>
<tr><td colspan="2">• Research / data
• Case studies
• Anecdotal research</td><td colspan="2">• Lack of understanding around mental health/poor health literacy
• Cultural attitudes / beliefs
<u>Intervention</u>
• Establishing strong supports for families/individuals, particularly within the first 6 months (e.g. community hubs / religious organisations /schools / community groups)
• Decrease stigma - normalising</td></tr>
<tr><td colspan="4">What do we need to do? Sites of intervention</td></tr>
<tr><td>Community</td><td>Services</td><td>Political</td><td>Other</td></tr>
<tr><td>CHC
AMEP classes
Churches / synagogues / mosques
Community groups</td><td>Settlement services
GPs
Mental Health Services (e.g. FASSTT)</td><td>Grass roots activities – local govt, state, federal
Funding advocacy e.g. VRHN feeding into policy and planning</td><td></td></tr>
</table>

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Population of focus: New arrivals (Group 2)

How do we know that there is an unmet mental health need in this population?		**Please describe the main issues:**	
• People telling us • Opportunistic pick up e.g. behaviour during health assessments • Taboo and stigma – lack of engagement with services • Competing demands • Follow up & recall, continuity of care		• Social isolation • Comprehensive screening • Lack of familiarity w/ external service model • Language • Culture • Unemployment • Persisting symptoms • Appropriate housing / community support	
What do we need to do? Sites of intervention			
Community	**Services**	**Political**	**Other**
Education Health promotion Cultural safety Involving community leaders Advisory groups	Context of education Transport Outreach	Advisory boards	

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Population of focus: New arrivals >55 years

<table>
<tr><td colspan="2">How do we know that there is an unmet mental health need in this population?</td><td colspan="2">Please describe the main issues:</td></tr>
<tr><td colspan="2">• Barriers
  ○ “stigma”, taboo
  ○ Feedback from community
• Opportunistic pick up e.g. behaviour
• Difference in culture / accessing external mental health services
• Refugee health assessment screening and follow up, continuity of care
• Clients report themselves</td><td colspan="2">• Culture shock - English language, stress from Centrelink to get a job when may never have worked before in a formal job or studied (especially women aged 55-65 years)
• Social isolation
• Language</td></tr>
<tr><td colspan="4">What do we need to do? Sites of intervention</td></tr>
<tr><td>Community</td><td>Services</td><td>Political</td><td>Other</td></tr>
<tr><td>Opening up conversations – advisory boards
Education
Health promotion
Removing stigma</td><td>Health promotion
Offering refugee specific groups or ensuring service is not exclusive
Outreach / ensuring transport / ability to access public transport and knowledge of transport system</td><td></td><td>Getting religious people / churches involved</td></tr>
</table>

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Population of focus: Established communities (plus 12 months of arrival)*

How do we know that there is an unmet mental health need in this population?	**Please describe the main issues:**
• Little or no interpreter use • Community disengagement • Over-representation in corrections and disengagement in education, employment etc • Ageing populations reverting to primary language • Reluctance to engage with services • Little or no data collected • Lack of access into services	• Lack of knowledge in clinicians leading to needs being unmet • Supporting interpreters with right language for mental health (mental health glossary) • Missed diagnosis of chronic health issues i.e. auto-immune diseases

What do we need to do? Sites of intervention			
Community	**Services**	**Political**	**Other**

	• Promote interpreter use
	  ○ Standards for safety in health care
			• Support interpreters in mental health consultations
			  ○ Resources already out there
			• Tool to promote culturally responsive clinical practice working with people from refugee and migrant backgrounds. Source is Migrant and Refugee Women's Health Partnership www.culturaldiversityhealth.org.au

*Established communities post initial intensive 12 months of settlement support services do start to decline post 12 months so there is need to look at communities post 12 months and not necessarily post 5 years of arrival

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Population of focus: Established communities

How do we know that there is an unmet mental health need in this population?	**Please describe the main issues:**
• Through direct work with the community • Through clinical work and demand for services • Frequent presentations with some symptoms without obvious pathology (e.g. presenting with an ache but it's actually emotional anguish) • Inability to maintain a job • Missing appointments • Substance use • Poor educational outcomes in children – intergenerational trauma	• Language barrier • Lack of translated resources • Relying on family members (inappropriate for disclosing mental health issues) • Competing social priorities • Cultural taboos

What do we need to do? Sites of intervention			
Community	**Services**	**Political**	**Other**
Find out where clients congregate and provide information there (e.g. social group, church group etc.)	More actively screening for mental health Using interpreters – not family members Provide training to staff	More funding for translated resources	

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Population of focus: People seeking asylum (Group 1)

How do we know that there is an unmet mental health need in this population?	**Please describe the main issues:**
• Anxiety / distress caused by unstable housing → • Cannot treat ongoing mental health concerns due to current insecurities e.g. housing, visas • Not a priority for clients with multiple, competing demands • Reduced ability to afford ongoing medications • Waitlists inadequate in community health for mental health services • Committed staff with strong advocacy skills!! • Policy windows with elections looming!!	Compounding all issues

What do we need to do? Sites of intervention

Community	**Services**	**Political**	**Other**
Advocate through mainstream community Rotary Multi-faith representation / religious leaders	Medical professions of high social standing	Take advantage of the electoral cycle (elections!!)	The Wiggles Approach famous people w social cred

Really clear pathway for asylum seekers to access services →

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Population of focus: People seeking asylum (Group 2)

How do we know that there is an unmet mental health need in this population?	**Please describe the main issues:**
1. Increased demand for not for profit / charitable services / pro-bono 2. Increased referrals and presentations (to health and settlement services, anecdotal) 3. Increased wait times for specialist mental health services 4. Increased self harm and suicidal ideation – Nicholas Proctor, STARTTS, Monash Crossing Borders	Prolonged uncertainty / negative pathways Destitution and financial pressure Family separation Grief / retraumatisation Poor health literacy

What do we need to do? Sites of intervention			
Community	**Services**	**Political / Policy**	**Other**
Decreasing stigma / awareness raising Increasing mental health literacy	Clarity on pathways Increasing confidence in discussing mental health – STAR-MH Tool for caseworkers Data – monitoring demands & waitlists. Identifying gaps and strategic approach to filling these. Data on mental health impacts of current policy environment	Ease of accessibility to research State Government Royal Commission on mental health → VRHN submission Research and practice evidence	

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Population of focus: Children & adolescents (Group1)

How do we know that there is an unmet mental health need in this population?	**Please describe the main issues:**
• Melton – West Melb. Djerriwarrh ○ CHS – home visit, health assessment, linkage to services • Gap in ongoing therapy • Limited sessions • Funding short term • Lack early childhood services	• Parents struggling with behaviours • Changes in role – child's English • Conflict b/w child/adol & parent

What do we need to do? Sites of intervention

Community	**Services**	**Political**	**Other**
Build health literacy of clients & services Knowledge in services Modify services to meet client / population group needs Longer term funding for programs Making sure families are linked to universal services	Services need to identify refugees and asylum seekers Lack of services to refer children and adolescents Support for wellbeing teams in schools Outreach – going to clients – removing barriers of access to transport Confidentiality for young people Services requiring parental consent before engaging		

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Population of focus: Children & adolescents (Group 2)

How do we know that there is an unmet mental health need in this population?	**Please describe the main issues:**
Youth justice involvement Engagement with children showing challenging behaviours Children: relationships with children, managing institutions, schools providing trauma informed spaces Cognitive Ax / diagnosis	Engagement with young people Engagement with families Consent with >14 years old Intergenerational trauma Interpreters access Differentiating trauma v behaviour

What do we need to do? Sites of intervention			
Community	**Services**	**Political / Policy**	**Other**
Primary school hubs (networks of welfare staff) Mental health of parents improves when see children starting to thrive Improve access to sport clubs, address barriers such as $, uniforms, gender Working with community leaders (formal and informal)	Step out of the square – try different engagement methodology Educating whole of family (traumatised parents & ability to care) Communities of practice – training professionals Outreach in schools (cuts through potential stigma, opportunity for peer support, upskill teachers) Group partnership programs with clinicians and young people leaving schools.		

Wrap up and evaluation

What was the most useful aspect of today's meeting for your work?

Responses	Number of people
Networking	9
Updates	6
Themed discussion	4
Data overview	4
Arrival updates	2
The facilitation: The competent facilitation, the hosts are fabulous	2
Hear the participants talk about the difficulties client's/patients experience in different areas of work	1
New ideas for my region	1
Presentation by South Eastern Melbourne - interesting work to replicate in the North	1
New programs	1
The presence of multiple stakeholders, giving time to a couple of speakers for a more detailed presentation was also great.	1
Inspiration	1
Hearing about programs and initiatives	1
Meeting others working on this space. Information and tools available for me and my team	1
Understanding what other organizations do	1
Networking with fresh ideas	1
Comprehensive update on the sector	1
Updates about new arrivals, asylum seeker stats, informal networking, collecting resources, small table discussion	1
Hearing other things happening	1
Discussion about sites for intervention in MH	1
Policy updates	1
Hearing what's happening in other regions	1
This evaluation app	1
Hearing about new programs in the sector I had not heard of before	1
Network meeting	1
Hearing about the place-based work	1
Seeing the resources that are available	1
Meeting new people	1

What could be done differently to improve future statewide meetings?

Responses	Number of people
Longer meeting to allow for more discussion, add a half an hour.	7
More small group themed discussions	4
More time for themed discussions/workshop	2
Allow for question time after speakers	2
Global updates would be interesting	2
Happy with all aspects....	2
Allow time for informal networking	2
More updates	1
More forward planning/planning for interventions	1
It's a really long day maybe less meetings	1
Timing with other events is helpful	1
Targeting areas for discussion	1
Allow more interaction	1
Give speakers longer time to present	1
More opportunity to network/ know who is in the room	1
Having a list of attendees/ organisations attending in advance	1
Get relevant data from all the services that are seeing clients e.g. cohealth, Monash, each etc	1
Community advisors	1
Even more people from refugee backgrounds speaking	1
More community representation e.g. community leaders present	1
Already covered comprehensively. Probably would be better to discuss on major mental health issues and intervention against the identified issues.	1
Links to relevant research in the sector	1
External speakers like Kon Karapagnotidis	1
N/A - the facilitators were awesome! Adept at encouraging dialogue.	1
Issues should be brainstorming than prescribed	1
Data good but need a 12 month overview	1

Appendices

Appendix 1: Attendees

Name	Organisation
Agnieszka Kleparska	NWMPHN
Aisleen Glasby	DPV Health
Andrea Vancia	Brisbane South PHN
Belinda Tominc	DPV Health
Britt Haller	Asylum Seeker Resource Centre / Western Health
Chiedza Malunga	Monash Health
Chris Drummond	Cabrini Asylum Seeker and Refugee Health Hub
Cinzia Bonciani	Alfred Health
Dina Korkees	Foundation House
Donata Sackey	Mater Health
Dr Esther Belleli	Star Health
Farah Suleman	QPASTT
Georges Oteng	Melaleuca Darwin
Gillian Singleton	Cabrini Asylum Seeker and Refugee Health Hub
Herfina Nababan	ASRC
Jacquie McBride	Monash Health
Janan Allouche	Your Community Health
Jawid Sayed	Hepatitis Victoria
Jennifer Keyes	The Water Well Project
Kate McGannon	Brotherhood of St Laurence
Dr Kate Walker	cohealth
Kath Cooney	Foundation House
Kath Desmyth	cohealth
Laura Jobson	Monash University
Lauren Tyrrell	Victorian Refugee Health Network
Lester Mascarenhas	Your Community Health
Lindy Marlow	cohealth

Name	Organisation
Mardi Stow	Foundation House
Mariano Coello	STARTTS
Melanie Block	Cohealth – hand written but no indication of what she attended
Merilyn Spratling	EACH
Mohammad Daud Karimi	Hume Whittlesea Primary Care Partnership
Natalie Henry	DPV Health
Philippa Duell-Piening	Victorian Refugee Health Network
Prabha Shrestha	Djerriwarrh Health Services
Rachel Barter	cohealth
Rebecca Eckard	Refugee Council of Australia
Rebecca Fredrickson	Hume City Council
Rob Koch	Monash Health
Rose Dupleix	Foundation House
Russel Anbiah	EACH
Sadaf Ismail	AMES - SRSS
Samantha Furneaux	Victorian Refugee Health Network, Foundation House
Sandy Eagar	NSW Refugee Health Service
Sarah Christensen	IPC Health
Scott Andrews	Melaleuca Refugee Centre
Sheenagh McShane	Asylum Seeker Resource Centre
Shiva Vasi	Monash University
Siv Yoganathan	Life Without Barriers
Stefania Zen	Northern Health
Suman Shah	Djerriwarrh Health Services
Tracey Cabrie	Cabrini Asylum Seeker and Refugee Health Hub

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Appendix 3: Outer North Refugee Health Network PowerPoint slides pdf

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