

Dear Committee secretary,

Re: Inquiry into Early Childhood Engagement of CALD Communities

The Victorian Refugee Health Network welcomes the opportunity to provide a submission to Victoria's Legal and Social Issues Committee Inquiry into Early Childhood Engagement of Culturally and Linguistically Diverse (CALD) Communities.

The Victorian Refugee Health Network

The Victorian Refugee Health Network (the Network) was established in 2007. The Network facilitates coordination and collaboration amongst health and community services working with people of refugee backgrounds, including those seeking asylum. The aim of this collaboration is to improve service accessibility and responsiveness for people with refugee backgrounds. An executive group provides strategic direction and oversight over the Network's activities. The Network has provided expert advice to the sector and to successive State governments on refugee and asylum seeker health issues.

Language used in this submission

Refugee – is a person who has been forced to leave their country due to a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership of a particular social group, and who is unable to return to their country.¹

People seeking asylum – an 'asylum seeker' is a person who has applied for refugee status and is awaiting a decision on their application.

People from refugee backgrounds – this term is used to refer to people who arrived in Australia with, or who have subsequently been granted, permanent or temporary humanitarian visas; people seeking asylum; and people with refugee experience who arrive on another visa type. Where immigration status is significant (i.e. to service eligibility), this is noted.

¹ United Nations General Assembly. Convention relating to the status of refugees, 28 July 1951, United Nations Treaty Series, vol. 189

Approach to submission

Early childhood is a critical period of development, and a foundation for health, wellbeing and productivity across the lifespan². The early years influence life expectancy, and long-term health, social and educational outcomes³, and offer an opportunity to address inequities⁴. Early childhood services can play a crucial role in supporting child health and development, and children from disadvantaged or vulnerable backgrounds have the most to gain from high-quality service support.

The Network's submission focuses on early childhood engagement for children and families of refugee background. Attention to this cohort is important because:

- Children and families with refugee experience, particularly those who are newly arrived, have additional needs to other children with CALD backgrounds who have not experienced forced migration.
- Quality early childhood services must respond to these additional needs to assure high-quality service delivery, address equity issues and optimise health and wellbeing for all children in Victoria.

There are a range of programs and services supporting early childhood health and wellbeing in Victoria, including the Maternal and Child Health (MCH) program, playgroups, early childhood education, and programs supporting parents and families. This submission considers child health and development across the service spectrum, from primary health and early childhood education to secondary and tertiary services. This focus aligns with the expertise within the Network and is in recognition of health as a critical enabler to parent and family functioning and engagement with early childhood education and other services⁵.

² World Health Organisation, *Early Childhood Development*, <<https://www.who.int/topics/early-child-development/en/>>; World Health Organisation, *Nurturing Care for Early Childhood Development*, <<https://apps.who.int/iris/bitstream/handle/10665/272603/9789241514064-eng.pdf>>.

³ McDonald, M, Moore, T & Robinson, R 2014, *The future of early childhood education and care services in Australia*, Policy Brief No.26, Murdoch Children's Research Institute, <https://www.rch.org.au/uploadedFiles/Main/Content/ccch/140593%20METCALFE%20Policy%20Brief_web.pdf>

⁴ World Health Organisation, *Early Childhood Development*.

⁵ Victoria State Government 2016, *Victorian Early Years Learning and Development Framework*, Department of Education and Training (Victoria), viewed 4 October 2019, <<https://www.education.vic.gov.au/Documents/childhood/providers/edcare/VEYLDFAAppendix2.pdf>>

Refugee settlement in Victoria^{6,7}

<p>Victoria is a major humanitarian settlement state, for both people arriving as refugees and people seeking asylum.</p>	<p>There are significant numbers of refugee background children and families settling in Victoria.</p>	<p>Refugee background settlement is increasing in rural and regional Victoria.</p>
<ul style="list-style-type: none">• Over 51,000 people settled in Victoria under Australia's Refugee and Humanitarian Program between 2009 and 2019. This includes 4,338 people in the last financial year alone.• There are also significant numbers of people seeking asylum in Victoria.	<ul style="list-style-type: none">• In the last financial year, 13 percent of people arriving under the Refugee and Humanitarian program were aged 0-5 years old and 27 percent were aged 0-11 years old. Of the 6,634 people on BVEs in Victoria as of June 30 2019, 945 people were aged between 0-11. There are also significant numbers of the newly arrived community of reproductive age who might be expected to start families in Victoria.	<ul style="list-style-type: none">• 15 percent of humanitarian entrants over the past year have settled in rural and regional Victoria. The Commonwealth government has indicated plans to increase rural and regional settlement over the coming years. Incentives associated with Safe Haven Enterprise Visas (SHEVs) will also contribute to increased refugee settlement rural and regional Victoria

Further information on demographics is shown in Appendix 1.

Key Issues for refugee-background early childhood engagement

Maternal and Child Health services

The Universal Maternal Child Health (UMCH) program in Victoria is generally working well, although linkages and supports for new arrival children could be improved, especially for those aged 2-5 years. Key ages and stages visits are clustered in the 0-2 year period, and children arriving as refugees or seeking asylum after the age of 2 years may miss out on parenting support and primary care/community linkages provided through UMCH.

There are currently no publicly available data on participation rates for refugee background children and families in UMCH, however practitioners report that settlement stressors for refugee background families can compromise engagement with MCH. Understanding and monitoring engagement is important to inform inclusive policy implementation.

⁶ Australian Government, Department of Home Affairs, *Settlement database*, Settlement Data Team, Department of Home Affairs, accessed via email September 2019, settlement.data.request@homeaffairs.gov.au.

⁷ Australian Government, Department of Home Affairs 2019, IMA Legacy Caseload: Report on Processing Status and Outcomes, Department of Home Affairs, Canberra, viewed 7 October, <<https://www.homeaffairs.gov.au/research-and-stats/files/ima-legacy-caseload-june-2019.pdf>>

Enhanced Maternal and Child Health (EMCH)⁸ offers opportunities. Some EMCH programs routinely do a home visit for refugee background families who arrive in Victoria with young children, although the extent of this service delivery is unclear. Evidence indicates migrant and refugee women are at a higher risk of poor maternal and child health outcomes⁹ compared to Australian-born women. Considering refugee background children as a priority access group, and flexibility to extend the service beyond 3 years, where required, would facilitate care for vulnerable families.

Recommendations: Maternal and Child Health services

1. Explore options for developing and streamlining early parenting and childhood support for newly arrived families. These approaches should account for the mobile nature of the cohorts in early years of settlement, and for children who are not referred into MCH via hospital of birth.
2. Include refugee-background and asylum seeker families as a named priority access group for Enhanced Maternal and Child Health services and consider extending program delivery beyond 3 years where required.
3. Collect data on participation in MCH and EMCH by refugee-background children, and also interpreter assisted consultations to assist with program planning and evaluation.

Early childhood education - playgroups, childcare and kindergarten access

We commend the Victorian Government's decision to fund universal access to three-year-old kindergarten for children¹⁰ and also the Early Start Kindergarten (ESK)¹¹ program. Clinical experience within the Network suggests ESK has made an enormous difference to some of our most vulnerable refugee and asylum seeker children. Extending this program to a greater number of refugee-background families during implementation of the universal three-year-old kinder program would provide important interim support for vulnerable families.

⁸Victoria State Government 2018, *Enhanced Maternal and Child Health Program Guidelines*, Department of Education and Training, viewed 18 October 2019, <<https://www.education.vic.gov.au/Documents/childhood/professionals/health/enhancedmchproguidelines.pdf>>

⁹Multicultural Women's Health Australia (2016). *Sexual and Reproductive Health Data Report*, viewed on October 8, <http://www.mcwh.com.au/downloads/MCWH_SRH_Data_Report_July_2016.pdf>

¹⁰Victoria State Government, Department of Education and Training, *Kindergarten for three-year-old Children*, viewed October 16, <<https://www.education.vic.gov.au/about/programs/Pages/three-year-old-kinder.aspx>>

¹¹ Victoria State Government 2018, *Early start kindergarten information for early childhood education and care services*, Department of Education and Training (Victoria), viewed 18 October 2019, <<https://www.education.vic.gov.au/Documents/childhood/providers/funding/eskforservices.pdf>>.

Childcare and playgroups can be important resources for refugee background families. Supported playgroups and initiatives such as ‘smalltalk’¹² are not only valuable for children but also can also support parents and community connections after arrival¹³. We commend the Victorian Government’s recent expansion of supported playgroups for new arrivals¹⁴. While childcare is not always required, barriers to access should be considered for parents who work, who are pursuing English language classes, or who need respite, also noting childcare can be an important support for child development.

Four-year old kindergarten is a foundation for learning and school readiness for all children, including new arrivals. We commend the Victorian kindergarten fee subsidy program¹⁵ which has made an enormous difference to large number of refugee background and asylum seeker children. At the same time, there are no available data on four-year old kindergarten participation for refugee-background children, and kindergarten enrolment is not a key performance indicator (KPI) for the Humanitarian Settlement Program (the program of case management support for new Humanitarian program arrivals administered by Department of Home Affairs (DHA)). Clinical experience suggests a number of refugee children miss out on kindergarten and the associated benefits. There is a strong case to join up (federal-funded) settlement support with (state-funded) early childhood education, to ensure all new arrival children have access to four-year old kindergarten in a timely manner.

Immunisation status affects access to early childhood education. All refugee background children require catch-up vaccination after arrival in Australia, and available evidence shows substantial challenges to completing immunisation. The Commonwealth ‘No Jab, No Pay’ legislation¹⁶ and Victoria’s ‘No Jab No Play’ legislation¹⁷ both have implications for access to early childhood education for refugee background children and more generally for refugee-background families, predominantly through reduced childcare-related Centrelink benefits (‘No Jab, No Pay’). The Victorian Department of Health and Human Services (DHHS) funded a Refugee Immunisation Program over 2016-2020 to deliver immunisation in refugee

¹² Parenting Research Centre, *Smalltalk: Giving Your Kids a Great Start*, viewed 14 October 2019, <<https://www.smalltalk.net.au/>>.

¹³ Commerford, J, Robinson, E 2016, *Supported playgroups for parents and children: the evidence for their benefits*, Australian Institute of Family Studies, viewed 17 October 2019, <<https://aifs.gov.au/cfca/sites/default/files/publication-documents/cfca40-supported-playgroups.pdf>>.

¹⁴ Victoria State Government (updated 12 September 2019), *Supporting newly arrived families with playgroups*, Department of Education and Training (Victoria), viewed October 1 2019, <https://www.education.vic.gov.au/childhood/earlychildhoodupdate/Pages/ecupdate_playgroups.aspx>.

¹⁵ Victoria State Government (updated 10 September 2019), *How much kindergarten costs*, Department of Education and Training (Victoria), viewed October 1 2019, <<https://www.education.vic.gov.au/parents/child-care-kindergarten/Pages/howmuch-kindergarten-cost.aspx>>

¹⁶ Social Services Legislation Amendment (No Jab, No Pay) Act 2015, viewed 18 October 2019, <http://classic.austlii.edu.au/au/legis/cth/num_act/sslajnpa2015461/>

¹⁷ Public Health and Wellbeing Amendment (No Jab, No Play) Act 2015, viewed 18 October 2019, <http://classic.austlii.edu.au/au/legis/vic/num_act/phawajnpa201555o2015462/>

communities, with a focus on new Syrian and Iraqi arrivals. The program has addressed substantial challenges in catch-up vaccination and enrolled more than 6000 refugee-background Victorians.

Recommendations: early childhood education

1. Expand eligibility criteria for Early Start Kindergarten for refugee background and asylum seeker children.
2. Ongoing funding for supported playgroups, with attention to local government areas with high populations of refugee-background families (Hume, Melton, Whittlesea, Greater Dandenong, Casey).
3. Implement orientation for newly arrived refugee background families to kindergarten programs. This could include sessions where parents spend time in class to understand the structure, program and activities, to ensure they feel empowered and included in their child's learning.
4. Collect data on Early Start Kindergarten, and three- and four-year-old kindergarten participation by refugee background children, matched to settlement data to monitor participation.
5. Advocate with the Department of Home Affairs for kindergarten placement to be a key performance indicator for the Humanitarian Settlement Program.
6. Provide guidance on kindergarten/grade placement and school readiness (also see next section).
7. Support immunisation catch-up for refugee-background communities in Victoria to promote health, and ensure equitable access to family benefits and early childhood education.

The early school years - children aged 5-8 years

Early years policy development and service planning is frequently directed to the period of 0-6 years or 0-school entry - the Inquiry focus on 0-8 years is welcome. The early school years are an important period where children transition into formal education and families build connections to local community.

School readiness and grade placement are areas for attention. Year level placement in refugee-background students has important implications for education and development. While 2014 Department of Education and Training guidelines suggest newly arrived students should be placed in the year level appropriate for their age,¹⁸ it is important to note that within any grade, there will be students of different ages. Many students start school in

¹⁸Victoria State Government 2014, *No English Don't Panic, Department of Education and Early Childhood Development*, viewed October 18, <http://www.education.vic.gov.au/Documents/school/teachers/teachingresources/diversity/eal/no_english_dont_panic.pdf>.

Victoria aged 6 years, for example those born after 1st May, due to parent preference, or where children have completed a repeat year of kindergarten. Within any year level, there is usually an age range across two years. Grade placement in refugee-background children should consider age, prior education, overseas experience, development, settlement, psychological factors and parent preference. It is usually appropriate to consider placement with same age children in the younger grade level, and kindergarten should actively be considered as an option for children age 5 years.

There are challenges obtaining appropriate developmental assessments at the point of school entry. For new arrival children with developmental concerns or disability, it can be challenging to obtain assessments where these are needed for school entry. Strict Program for Students with Disability (PSD) categories and criteria for support funding mean most children with clinically apparent disability will require audiology, cognitive assessment, language assessment, +/- assessment for an autism-spectrum disorder. Whereas these assessments can be organised in a stepped fashion for Victorian-born children, long waiting lists, and a lack of clarity on processes mean this is very difficult for new-arrival refugee background children. They may enter school at a disadvantage, or, school entry may be delayed, sometimes for months. Specialist education services do not have straightforward access to obtaining these assessments, and the process is confusing - for providers, for schools, and for families. We suggest streamlining a process for comprehensive assessment, including a trauma informed paediatric assessment alongside any formalised testing, considering a general PSD category of severely interrupted schooling/critical education needs (to reduce to cost/burden of assessments) and supporting out of round PSD funding applications. While test validity issues are an active consideration, in practice the more frequent scenario is that children with significant developmental issues receive inadequate assessment and support.

English language school access can be difficult in terms of availability, and also location. New arrival children who meet eligibility criteria can attend English Language School (ELS) for 2-4 terms after arrival¹⁹. ELS and other schools with high refugee background populations are often trauma sensitive and attentive to the child's settlement journey at school. In practice there have been challenges with accessing ELS for refugee background students. An audit of 128 Syrian and Iraqi refugee children found 46% of school aged children attended ELS, and 30% of school aged children were still not enrolled in school 3 months after arrival²⁰. Information from the sector suggests that ELS need to be at capacity before they can apply

¹⁹ Victoria State Government (Revised 24 September 2019), English language schools and centres and regional English language programs, Department of Education and Training (Victoria), viewed October 18, <<https://www.education.vic.gov.au/school/teachers/support/diversity/eal/Pages/ealnewels.aspx>>

²⁰ Heenan, RC, Volkman, T, Stokes, S, Tosif, S, Graham, H, Smith, A, Tran, D & Paxton, G 2019, 'I think we've had a health screen': New offshore screening, new refugee health guidelines, new Syrian and Iraqi cohorts: Recommendations, reality, results and review.' *Journal of Paediatrics and Child Health*, vol. 55, no. 1, pp. 95-103., viewed 18 October 2019, <<https://www.ncbi.nlm.nih.gov/pubmed/30094942>>.

for funding for more classrooms, and ELS are not able to plan ahead for classrooms based on predicted settlement, resulting in delays and children on waitlists to access ELS. For children in the early years of school, the distance and travel-time to ELS are often barriers to attending, especially as families rely on public transport in the early stages of settlement. Outpost ELS arrangements are often more accessible for young primary age children.

Recommendations: The early school years

1. Provide guidance on grade placement - matching entry to the older children within a given year level and considering kindergarten placement for children who arrive aged 5 years.
2. Streamline a process for comprehensive developmental assessment where required, including a trauma informed paediatric assessment alongside any formalised testing;
3. Consider a general PSD category of severely interrupted schooling/critical education needs and support out of round PSD funding applications for new arrival refugee background students.
4. Ensure ELS are able to plan for predicted class sizes and settlement patterns and allocated funding accordingly.

Early intervention for refugee-background children with developmental delay or disability

We expect a proportion of all children to have developmental delays/disabilities, and newly-arrived refugee background children may have immediate support needs. Service systems, including early childhood intervention and the National Disability Insurance Scheme (NDIS) must consider migration and plan for an improved response to the needs of refugee background (and migrant) communities.

Increasing numbers of refugee background people in Victoria have a disability²¹. From 2012, the health requirements of the Migration Act have been waived for humanitarian entrants, meaning refugees with a disability are now able to settle in Australia. People from refugee backgrounds may be more likely to have a disability than other populations, due to experiences associated with forced migration, including conflict, displacement, inadequate health care, and torture²².

²¹ Exact numbers of refugees with a diagnosed disability upon arrival is unknown, as the reason for Health Waiver grants to humanitarian entrants are not readily available.

²² Refugee Council of Australia 2019, *Barriers and Exclusions: The support needs of newly arrived refugees with a disability*, viewed October 3 2019, <https://www.refugeecouncil.org.au/wpcontent/uploads/2019/02/Disability_report_WEB.pdf>

Evidence suggests refugee background children may be at higher risk of developing neurodevelopmental disorders or developmental delays^{23,24}. Many refugee background children have multiple pre-, peri- and post-natal risk factors for developmental delay and disability, including pregnancy and birth complications, malnutrition, communicable diseases, and vision/hearing impairment. Lack of access to healthcare and untreated conditions may compound functional impairment. Trauma experience has implications for neurobiological, cognitive, and emotional development,²⁵ and refugee background children have frequently experienced multiple traumatic events prior to resettlement. Parent trauma experience can also impact on the parent-child relationship, parents' ability to engage with supports and settlement tasks, and family functioning. Insecure visa status (people seeking asylum or people with temporary protection visas (TPVs) has implications for parental wellbeing and capacity²⁶.

There is complexity in developmental assessment for children of refugee backgrounds. The acquisition of English as an Additional Language (EAL) combined with the impacts of forced migration or asylum experience – including trauma, family separation and settlement – means development including language acquisition is challenging to assess. There are challenges with the validity of standardised tests (e.g. language assessments, cognitive testing, autism assessment tools) when they are conducted in languages other than English, and/or with an interpreter, although results may still be meaningful and useful. There is room for improving the level of understanding and responsiveness to these complexities across early intervention, NDIS, and the PSD systems. While there are concerns that refugee children are disproportionately being referred for cognitive assessment from English Language Schools,²⁷ other children with significant delays/disabilities are not being referred for support or intervention because difficulties are incorrectly attributed to trauma or English language acquisition.

The Victorian Government has supported paediatric workforce capacity in refugee health. DHHS funding has supported the Royal Children's Hospital Immigrant Health Service and the refugee fellow program, alongside other investments in refugee health. Due to these initiatives, there have now been 37 paediatricians who have trained/worked in child refugee health, with an ongoing training program in place, and a network of paediatric refugee

²³Abdullahi, H, Leonard, H, Cherian, S, Mutch, R, Glasson, EG, De Klerk, N & Downs H 2018, 'The Risk of Neurodevelopmental Disabilities in Children of Immigrant and Refugee Parents: Current Knowledge and Directions for Future Research'. *Review Journal of Autism and Development Disorders*, vol. 5, no.1, pp. 29–42.

²⁴ Geddes, JS 2012, 'Measuring Early Childhood Development in Refugee Children'. *Master of Public Health Thesis*.

²⁵ Ibid.

²⁶ Paxton, G, Smith, N, Ko Win, A, Mulholland, N & Hood, S 2011, *Refugee Status Report: A report how refugee children and young people in Victoria are faring*, Victorian Government, Department of Education and Early Childhood Development, Melbourne, viewed October 3 2019, <<https://www.education.vic.gov.au/Documents/about/research/refugeestatusreport.pdf>>

²⁷ Kaplan, I, Stolk, Y, Valibhoy, M, Tucker, A & Baker, J 2016, 'Cognitive assessment of refugee children: Effects of trauma and new language acquisition'. *Transcultural Psychiatry*, vol. 53, no.1, pp. 81–109.

services across metropolitan Melbourne and regional Victoria. DHHS contribution to long-term capacity and shaping the child health workforce warrants recognition.

Systemic barriers mean many refugee background children cannot access timely early intervention services in Victoria.

Access and engagement with primary care and early intervention is essential for optimising developmental outcomes. Early intervention services can significantly improve functioning, or delay or lessen decline in functioning²⁸. While Victorian-born children typically have a gradual evolution of diagnosis and service access, new arrivals may have immediate support needs, and may not have a clear diagnosis. Delays in assessment, diagnosis, services and equipment has a profound impact on settlement and community access²⁹, and can also negatively impact school entry. Layered exclusion criteria, based on diagnosis, postcode, residency and age, function as a barrier to health, and reduce the efficiency of the Victorian health system.

Diverse understandings of disability require an assertive, informed, and coordinated health system. People with refugee background may arrive in Australia with diverse cultural concepts for disability and may not have experience of accessing services and support to increase quality of life and function. Health promotion activities must focus on both increasing health and health system literacy in this cohort, as well as a more integrated responsive service system.

The NDIS is now administering Early Childhood Early Intervention (ECEI), and there are a range of associated complexities. ECEI is difficult for refugee background children to access, in terms of entry into the scheme, and obtaining ongoing services, and the implementation of NDIS appears to have resulted in a reduction of alternative pathways, including community health allied health services. The NDIS aims to increase choice and control for participants. However the consumer driven approach of the NDIS is reinforcing existing inequities driven by social determinants of health, such as English proficiency, health and health system literacy, education, household structure, household income and residential location.³⁰ At all stages of the NDIS - across access, planning and engaging with services; parents who are i) familiar with liaising with professionals and meetings, ii) able to navigate internet-based information and resources, iii) understand the health system and iv) are able to advocate for their child are at considerable advantage.³¹

²⁸ Early Childhood Intervention Australia, *About the NDIS*, viewed October 2 2019, <<https://www.ecia.org.au/NDIS-Info>>.

²⁹ Victorian Refugee Health Network 2018, *Service responses for people with disabilities from refugee backgrounds in northern Melbourne*, viewed September 26 2019, <http://refugeehealthnetwork.org.au/wpcontent/uploads/Report_2018_July_Service-responses-for-people-with-disabilities-from-refugee-backgroundsin-northern-Melbourne.pdf>

³⁰ Warr, D, Dickinson, H, Olney, S, et. al. 2017, *Choice, Control and the NDIS*, Melbourne, University of Melbourne.

³¹ Ibid.

The requirement for a diagnosis is a barrier to NDIS engagement. A diagnosis is required for NDIS participants aged 7-65 years, however it often takes months to years to achieve diagnostic clarity. Accessing diagnoses/assessments requires health system literacy and navigating lengthy waiting lists. Cost and the lack of interpreting for private allied health sector mean this pathway is not an option. These elements, combined with the challenges of settlement and recovery, delay access and engagement with early intervention - either through ECEI or the NDIS (age 7 years and older). Clinical experience suggests NDIS Early Intervention Partners are also frequently requesting diagnostic information for younger children, which is at odds with the guidelines on ECEI, and delaying intake and planning processes.

There are particular considerations for early intervention in rural and regionally settled communities. People in regional centers may have difficulty accessing timely primary care and specialist pediatric services. For specialist assessments, children are often required to travel to Melbourne. For families with limited income or health system literacy, this represents a significant additional barrier to access and engagement. There are limited public data on access to early childhood intervention services for CALD children in regional areas

The permanent residency requirement is a barrier to early intervention and the NDIS for children seeking asylum. There are challenges with access to early childhood intervention services for non-resident 0-6-year-olds in Victoria. This cohort includes children seeking asylum, and children on temporary protection visas, alongside other cohorts (children of temporary resident parents, many of whom will become permanent residents in the long term). The Victorian budget has allocated funding for ECEI for a small number of non-resident children; however the sustainability of these arrangements has not been confirmed, and information about eligibility and access pathways is difficult to find.

Recommendations: early intervention

1. Support initiatives to assist refugee background families navigate NDIS access and services. Promote systemic advocacy and change to improve efficiency, and reduce the resource-intensive, individual level advocacy by providers.
 - a. Develop pathways for early support for new arrivals with complex disability.
 - b. Ensure ECEI access is based on function rather than named diagnoses, in line with the principles of the NDIS.
 - c. Monitor participation of refugee-background children in ECEI and the NDIS.
2. Advocate with the National Disability Insurance Agency (NDIA) for more information on NDIS in community languages, including audio-visual formats, and for translated NDIS letters.
3. Plan for ongoing access to, and funding for ECEI, for children seeking asylum and children on TPVs, and ensure publicly available guidelines for these services.

4. 'No wrong door' approach: service coordination should mean that children and families requiring early intervention or disability services can access timely support from multiple service points.
 - a. Support ongoing provision of community health allied health services, and extend access to school age children.
 - b. Enable flexible service boundaries for early intervention and disability service providers given the mobility of these cohort during settlement.

Mental health services for refugee background children in Victoria

Refugee families and children are more likely to experience mental health issues due to their refugee experience and post-migration stressors, although research suggests mental illness is often under-recognised and untreated in these cohorts. Multiple barriers to engagement with mental health services are recognised for refugee-background populations.

We have not covered mental health in detail within this submission given the work of the Royal Commission into Victoria's Mental Health System³² and the Network's previous submission to the Commission.³³ We provide the following summary recommendations:

Recommendations: perinatal, infant and child mental health

1. Consider refugee background populations within reforms to Victoria's perinatal, infant, child and adolescent mental health systems.
2. Consider upstream approaches which address risk and protective factors early in life for children, and early in the course of mental illness for parents. A prevention-focused approach to refugee child health must address psychosocial influences on family and child wellbeing including settlement, community participation, social connections, economic inclusion, and accessing to secure housing.
3. Ensure initiatives to improve cultural sensitivity and responsiveness in mental health services are driven by meaningful community consultations and/or co-design.
4. Refugee background and asylum seeker children should be a named priority group for access to Child and Adolescent Mental Health Services (CAMHS). We support the Victorian Auditor-General's Office (VAGO) recommendation to expand targeted interventions for refugee background children.³⁴

³² Victoria State Government 2019, *Royal Commission into Victoria's Mental Health System*, viewed 16 October 2019, <<https://rcvmhs.vic.gov.au>>

³³ Victorian Refugee Health Network 2019, *Submission to the Royal Commission into Victoria's Mental Health System*, <<http://refugeehealthnetwork.org.au/wp-content/uploads/VRHN-Submission-Royal-Commission-into-Victorias-Mental-Health-System-July-2019.pdf>>

³⁴ Victorian Auditor-General's Office 2019, *Child and youth mental health*, Melbourne, viewed 17 October 2019, <https://www.audit.vic.gov.au/sites/default/files/2019-06/050619-Youth-Mental-Health_0.pdf>

Key elements to consider across all services and systems

Social determinants of health

Early childhood engagement must consider the social determinants of health, including forced migration experience, asylum experience, and uncertain migration status.

Housing stress and insecure tenancy is an ongoing, active issue in refugee background and asylum seeker populations. The experience of housing insecurity, homelessness, overcrowded housing (including living with sponsors for prolonged periods), or placement in insecure, inadequate housing, has severe impacts on child health, family functioning, and service access.

Poverty - refugee background children are more likely to live in poverty than their Victorian-born counterparts³⁵, and asylum seeker children are particularly vulnerable. While the labour force participation of humanitarian entrants converges to that of Australian-born populations with time³⁶, many families are dependent on welfare in the early years after settlement. Financial stress is common for those living on Centrelink payments in the current economic environment. Asylum seeker populations are even more vulnerable, with years of migration uncertainty, restricted work rights, and lack of access to English language classes, precluding employment. Recent changes to the (federal) Status Resolution Support Services (SRSS) program, now being implemented, for families with children mean there is imminent risk of destitution. We commend the Victorian Government's proactive funding supporting asylum seekers.

Uncertain migration status is a social determinant of health. People who arrived by boat seeking asylum have now been in Australia more than six years. More than 4000 asylum seekers in Victoria are still waiting for an initial decision on their protection application, and there are more than 5000 people who hold temporary protection visas.³⁷ There is also a cohort of individuals who have had negative decisions and are awaiting judicial review. Many of these people experienced prolonged detention, with large cohorts held for 18 months across 2013-14, and a smaller number of children and families that experienced more than 3 years detention, including time on Nauru. Ongoing uncertainty, detention experience,

³⁵ Paxton, G, Smith, N, Ko Win, A, Mulholland, N & Hood, S 2011, *Refugee Status Report: A report how refugee children and young people in Victoria are faring*, Victorian Government, Department of Education and Early Childhood Development, Melbourne, viewed October 3 2019, <<https://www.education.vic.gov.au/Documents/about/research/refugeestatusreport.pdf>>

³⁶ Hugo, G 2013, 'The Economic Contribution of Humanitarian Settlers in Australia'. *International Migration*, vol. 52. no. 2, viewed 18 October 2019, <https://www.kaldorcentre.unsw.edu.au/sites/default/files/the_economic_contribution_of_humanitarian_settlers_in_australia.pdf>

³⁷ Australian Government, Department of Home Affairs 2019, IMA Legacy Caseload: Report on Processing Status and Outcomes, Department of Home Affairs, Canberra, viewed 7 October, <<https://www.homeaffairs.gov.au/research-and-stats/files/ima-legacy-caseload-june-2019.pdf>>

intermittent/restricted work rights, separation from family, poverty, housing insecurity and marginalization combine to have profound negative impacts on health and wellbeing.

Rural and regional refugee settlement is increasing and should be considered in service development. In recent years, around 10% of humanitarian arrivals to Victoria settle in regional areas. Regional settlement is projected to increase to 15-19% of new arrivals, and the Safe Haven Enterprise Visa (SHEV) means these cohorts may also move to regional areas. Evidence suggests that people in rural and regional centers are more likely to experience poor health outcomes when compared with their metropolitan Melbourne counterparts,³⁸ due to a range of factors, including cost and distance from health care.

Trauma-informed care

Refugee background children and families are likely to have experienced a range of traumatic events prior to settlement in Victoria, including perilous journeys, separation from or loss of parents, family and friends, destruction of their homes, and witnessing violence³⁹. Asylum seeker children may have experience prolonged detention, with long-lasting negative impact on their mental health, development and family functioning. There is growing evidence on the impact of trauma on families and children, including effects on physical and mental health, relationships, and family functioning. Individuals may approach government programs and services with reluctance, experiencing mistrust and fear of authority figures.⁴⁰

⁴¹ This may function as a significant barrier to engagement with services.

Principles and practice of trauma-informed care should be embedded across the Victorian health, mental health and early years services systems to support engagement of this cohort. At the most basic level, trauma-informed care is an orientation for health services, based on how trauma impacts people's lives, and informs their service needs.

Recommendation: Trauma-informed care

1. That the Victorian Government continues to drive initiatives that embed the principles of trauma informed care across health, mental health and early years services.

³⁸ Victoria State Government 2011, *Victorian Health Priorities Framework 2012-2022: Rural and Regional Health Plan*, Department of Health (Victoria), viewed 3 October 2019, <<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/vhpf-2012-22-rural>>

³⁹ Kaplan, I, Stolk, Y, Valibhoy, M, Tucker, A & Baker, J 2016, 'Cognitive assessment of refugee children: Effects of trauma and new language acquisition'. *Transcultural Psychiatry*, vol. 53, no.1, pp. 81–109.

⁴⁰ Foundation House 2016, *The Early Childhood Access and Participation Project: Talking with Chin Families from Burma about Early Childhood Services*, Melbourne: Foundation House, <http://www.foundationhouse.org.au/wp-content/uploads/2016/07/ECAP_PROJECT_GUIDE_2016.pdf>

⁴¹ Whittlesea Community Advisors Group 2018/19; this group was facilitated by a partnership between Foundation House, Whittlesea Community Connections and City of Whittlesea Maternal & Child Health.

Communication, cultural diversity, coordination and collaborative relationships

Collaborative relationships and active communication between children, families and services are fundamental to quality engagement with health and development services.⁴²

Most humanitarian entrants have limited English proficiency when they arrive in Australia.⁴³ English language acquisition is an important part of settlement and inclusion, however, during the early years of settlement (and often beyond), most people with refugee backgrounds require access to interpreting for successful engagement with English-speaking health service providers. There is also a gendered dimension to language proficiency for refugees pre- and post-immigration⁴⁴, and a range of factors mean women often have a longer language learning journey⁴⁵. At the same time, women in many cultures hold primary care responsibilities for children, attending to their health and development. Health and adjacent services need to respond to this disparity. Despite strong Victorian government guidelines and funded language services across primary care and public health settings, health professionals do not always engage interpreting services appropriately, and Medicare Benefits Schedule (MBS) funded allied health services are not linked with language services.

Newly-arrived families experience competing settlement demands, including securing stable housing, finding employment, learning English, and accessing education and health care. Where services for more immediate needs are able to integrate with, or create strong working relationships with early childhood health services, opportunities for access and engagement increase. The Community Health Centre (CHC) model works well with co-location of a wide range of services, providing a one-stop-shop for GPs, allied health and social work, alongside orientation to legal services and also building local community. However, waitlists are long, and flexibility may be limited. Promoting coordination opportunities across the spectrum of care is important, including strengthening links between primary care and the broader system including hospitals.

Cultural understanding of healthcare and child health and development vary greatly, and developing collaborative relationships is essential for engagement. The Victorian government

⁴² Australian Children's Education and Care Quality Authority 2018, *Guide to the National Quality Framework*, viewed October 9 2019, <<https://www.acecqa.gov.au/sites/default/files/2019-07/Guide-to-the-NQF.pdf>>

⁴³ According to the Building a New Life in Australia study (2019, 23), over 80% of refugee respondents reported not speaking English well or at all upon arrival. Department of Social Services 2019, *Building a New Life in Australia (BNLA): The Longitudinal Study of Humanitarian Migrants - Wave 4 Update (Addendum to the Wave 3 Report)*, Canberra, viewed October 2 2019, <https://www.dss.gov.au/sites/default/files/documents/02_2019/bnla-wave-4-update.pdf>

⁴⁴ Watkins, P, Razee, H & Richters, J 2012, 'I'm Telling You ... The Language Barrier is the Most, the Biggest Challenge': Barriers to Education among Karen Refugee Women in Australia', *Australian Journal of Education*, vol. 56, no. 2.

⁴⁵ Ibid.

has demonstrated strong leadership on cultural responsiveness, through frameworks such as Delivering for Diversity⁴⁶.

Recommendations: Communication, cultural diversity and collaborative relationships

1. Ensure access to interpreting services for allied health - through adequate funding in community health services, and through advocacy to access language services alongside MBS funded allied health.
2. Ensure principles and guidelines around language services provision are implemented uniformly across health and early years services in Victoria.
 - a. Ensure standardised cross-cultural communication training for health and early years staff.
3. Ensure quality translated materials are available, across relevant languages, in combination with other accessible modes of communication.
4. Support interpreter workforce development and training to match settlement patterns.
5. Ensure culturally responsive practice is embedded across health and early childhood service systems.
6. Support programs demonstrating service integration and coordination across the spectrum of care, and ensure monitoring and reporting on these outcomes.

Supporting health literacy and health system literacy

Refugee background parents/carers in Victoria may not be aware of health or early childhood services, or know how to access these systems. The ability to understand and navigate the health system is a critical foundation for access and engagement with early childhood services. These cohorts may come from countries or settings (e.g. refugee camps) that do not have comparable health and human services infrastructure.

Limited and/or disrupted access to health care and education affects parent and carer health literacy. Health literacy is often understood as the individual's knowledge and skill in navigating health systems and making informed decisions about their health and wellbeing⁴⁷. Health literacy extends beyond the individual, and is influenced by communities, healthcare professionals, organisations and systems. An acknowledgement of the interaction between

⁴⁶ Victoria State Government 2016, *Delivering for diversity - Cultural diversity plan 2016-2019*, Department of Health and Human Services (Victoria), viewed October 15 2019, <<https://www.dhhs.vic.gov.au/publications/delivering-diversity-cultural-diversity-plan-2016-2019>>.

⁴⁷ Centre for Culture, Ethnicity and Health, *What is Health Literacy?*, viewed October 2 2019, <<https://www.ceh.org.au/resource-hub/what-is-health-literacy/>>

the individual and systems provides a foundation to consider strategic approaches to improving health literacy for communities⁴⁸.

Parent health literacy is correlated with health service engagement and positive family health outcomes. Health-promotion activities aimed at developing health literacy for the refugee background population are likely to be beneficial for child health, and may help address health inequities.

Recommendations: Health literacy and health system literacy

1. Support programs to embed culturally appropriate health literacy initiatives in health service delivery.

Data and measurement

There is inconsistent data collection across the health, development and early childhood services systems. Identifying people from refugee backgrounds (including people seeking asylum) in Victorian data sets is vital to understanding health outcomes and service usage patterns for these individuals and communities. Identification enables services providers, planners, and funders to measure the impact of service changes and assess the effectiveness of policy.

Recommendations: Data and measurement

1. Collect four minimum data items in all health datasets developed and/or administered by the Victorian Department of Health and Human Services:
 - a. Country of birth
 - b. Year of arrival
 - c. Need for interpreter
 - d. Preferred language

Consider a further data item 'refugee/asylum seeker on arrival in Australia' with pilot testing across settings.

2. Training to support data collection, entry, retrieval and analysis to improve data integrity and utilisation.⁴⁹

⁴⁸ Migrant and Refugee Women's Health Partnership, Harmony Alliance: Migrant and Refugee Women for Change 2018, *Roundtable: Enhancing health literacy strategies in the settlement of migrant and refugee women*, Outcomes document, viewed October 2 2019, <<https://culturaldiversityhealth.org.au/wp-content/uploads/2018/12/Outcomes-document-Health-literacy-roundtable-June-2018.pdf>>.

⁴⁹ For further information see Victorian Refugee Health Network 2014, *Identifying people from refugee backgrounds: health data collection, storage and access*, viewed October 17 2019, <https://refugeehealthnetwork.org.au/wpcontent/uploads/Brief_Identifying-people-from-refugee-backgrounds-Oct2014.pdf>.

3. Ensure service providers, planners, policy makers, funding bodies and consumers have access to data, and that data on refugee-background communities are included in Victorian Government reporting.

Thank-you for the opportunity to provide this submission, and we look forward to meeting with the Parliamentary Committee.

Appendix - demographics

1. Settlement by LGA

Top 15 Refugee Settlement Victorian Local Government Areas (LGAs) 2009-2019⁵⁰

LGA	Settled 2009-2019	% of total refugee settlement
Hume	11,137	21.8
Casey	5,867	11.5
Greater Dandenong	5,432	10.6
Wyndham	3,935	7.7
Brimbank	3,593	7
Melton	2,658	5.2
Whittlesea	2,512	4.9
Maroondah	2,230	4.3
Greater Geelong	1,878	3.7
Greater Shepparton	1,109	2.2
Moreland	1,019	2
Maribyrnong	996	1.9
Greater Bendigo	993	1.9
Yarra Ranges	828	1.6
Darebin	584	1.1

⁵⁰Australian Government, Department of Home Affairs, *Settlement database*, Settlement Data Team, Department of Home Affairs, accessed via email August 2019, settlement.data.request@homeaffairs.gov.au.