victorian refugee health network

Submission to the Australian Government's Review into integration, employment and settlement outcomes for refugees and humanitarian entrants

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Prepared by Philippa Duell-Piening,[1] Coordinator of the Victorian Refugee Health Network
email: duell-pieningp@foundationhouse.org.au, phone: 03 9389 8909

About the Victorian Refugee Health Network

The Victorian Refugee Health Network (the Network) was established in June 2007 to facilitate greater coordination and collaboration amongst health and community services to provide more accessible and appropriate health services for people of refugee backgrounds. More information about the Network may be found on our website: www.refugeehealthnetwork.org.au

Introduction

The Australian Refugee and Humanitarian Program is, by world standards, a large and generous program of resettlement. Within the broader Australian migration program this stream's intent and purpose is to 'provide permanent resettlement to those most in need, who are in desperate situations overseas',[2] unlike the skilled migration program which has clear objectives to contribute to the Australian economy.[3] That said, people who arrive in Australia through the Refugee and Humanitarian Program want to work,[4,5] and bring a host of skills that may contribute to Australian society and economy. Work is indeed important to

[1] Acknowledging the contributions of Sam Furneaux, Sue Casey, Jo Szwarc, Susie Strehlow, Rose Dupleix, Jacinta Bongiorno, Natalie Henry, Rob Koch, and Kay Graves (see correspondence after case studies).
[2] Department of Home Affairs. (2018). *Discussion paper: Australia's Humanitarian Program 2018-19*. Retrieved from Department of Home Affairs website: https://www.homeaffairs.gov.au/reports-and-pubs/files/2018-19-discussion-paper.pdf, p.3.
[3] "In 1993, the Government separated the Humanitarian Program from the Migration Program to provide a better balance between Australia's international humanitarian objectives and the domestic, social and economic goals of the Migration Program." Department of Home Affairs, op. cit., p.10.
[4] Tyrrell, L., Duell-Piening, P., Morris, M., & Casey, S. (2016). *Talking about health and experiences of using health services with people from refugee* backgrounds. Retrieved from the Victorian Refugee Health Network website: http://refugeehealthnetwork.org.au/wp-content/uploads/Report_2016_September_Victorian-Refugee-Health-Network_Talking-About-Health_FINAL-WEB.pdf,p.32.
[5] Community advisory group. (2018). *Resettling in Victoria – advice from people from refugee backgrounds living with disabilities and their carers*. Retrieved from the Victorian Foundation for Survivors of Torture website: http://www.foundationhouse.org.au/wp-content/uploads/2019/01/FINAL_Submission_2018_Oct12_Disability-Advocacy-Futures.pdf.

an individual and their family's health, the ability to integrate, and supports positive settlement outcomes.

The timeframe for this Review has not enabled us to consult comprehensively with participants of our Network, instead we have drawn from existing data sources such as our reports.

Health(care), integration, employment and settlement outcomes

Health is a key indicator of integration but also 'serve[s] as potential means to support the achievement of integration'.[6] The Australian government recognises the importance of health to settlement and integration through funding the Medical Benefits Schedule (MBS) *Health assessment for refugees and other humanitarian entrants*, to be undertaken within twelve months of arrival (or visa grant for 866 visa holders).[7] At this stage it is unclear how many people have these assessments on arrival, as the MBS billing item number is the same item as a number of other assessment types (see **recommendation 1**).

Good health enables participation in a new society and is necessary to seek and maintain employment; in Ager and Strang's study 'good health was widely seen as an important resource for active engagement in a new society'.[8] The project advisory group of the Network's 2016 community consultation reflected that a person's ability to look for work and secure employment was dependent on their physical and mental wellbeing, English language competence, and confidence levels.[9]

Just as good health supports participation in employment, employment supports good health outcomes. Refugee background communities surveyed by the Network in 2016 identified employment and income as closely linked to health.[10] People described living on low incomes as negatively impacting health in a number of ways – through financial stress and worry, and by creating cost barriers to purchasing healthy food, accessing health services, and accessing exercise and sporting facilities.[11] This is supported by research that demonstrates income and employment are social determinants of health.[12]

Measuring health outcomes and health service access for people from refugee backgrounds is currently not possible, as most administrative health datasets do not identify people who have arrived in Australia through the Refugee and Humanitarian Program. If this cohort were able to be identified within these datasets, the de-identified and aggregated data may be utilised to understand service access and health outcomes. Ager and Strang propose that 'reliable access to health services marks effective engagement with a key state service',[13] and may be used as a measure of integration. Further to identification of people who arrived through the Refugee and Humanitarian Program in datasets, service usage patterns and measurement of integration indicators (including health) may be strengthened through

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[6] Ager, A., & Strang, A. (2008). 'Understanding Integration: A Conceptual Framework', *Journal of Refugee Studies* 21(2), pp. 166-191. Retrieved from https://academic.oup.com/jrs/article/21/2/166/1621262.
[7] http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_refugees
[8] Ager, A., & Strang, A., op cit.
[9] Tyrrell, L., Duell-Piening, P., Morris, M., & Casey, S., op. cit., p.32.
[10] ibid.
[11] ibid.
[12] Wilkinson, R., & Marmot, M. (2003). *Social Determinants of Health: the Solid Facts.* Geneva, p20-21.
[13] Ager, A., & Strang, A., op. cit.

linkage of the immigration database with health and other databases (see **recommendation 2**).

Recommendation 1: The Australian Government Department of Health to reintroduce a unique MBS item number for *Health assessment for refugees and other humanitarian entrants* to track the completion rate and to identify people from refugee backgrounds within the broader MBS data set.

Recommendation 2: The Australian Government, through Council of Australian Governments, lead a process of data linkage to understand access to health services and health outcomes for people who enter Australia through the Refugee and Humanitarian Program. This may be led by the Department of Social Services, Department of Health, and/or Department of Home Affairs, in consultation with the Australian Bureau of Statistics.

Accessing effective health care for people from refugee backgrounds

As discussed in the previous section, good health facilitates integration, and a person's ability to access health care is an indicator of integration. General practice and specialist refugee health providers both have a key role to play in the delivery of on-arrival and ongoing care to Refugee and Humanitarian Program entrants. Settlement services play an important role in supporting access to health services and coordinating follow up care. During the 2017 Humanitarian Settlement Program re-design the Refugee Health Network of Australia (RHeaNA) wrote to the Australian Government Department of Social Services to request an avenue to input into the new model, this was declined. This was regrettable, as health providers and settlement services are both key to supporting access to health services for new arrivals and working together are able to remedy access barriers more effectively (see **recommendation 3 & 4**, and **Settlement Health Coordinator** case study).

Barriers to accessing effective health care for people from refugee backgrounds are well documented in the literature.[14] In the Network's consultation with communities from refugee backgrounds and service providers,[15,16,17] the following barriers to accessing effective health care were identified:

- language concordance, including not being provided with an interpreter, (see *Promoting the engagement of interpreters in Victorian health services*[18] for a full discussion of the barriers to interpreter provision in health, **recommendation 5** of this submission addresses a barrier to interpreting that the Australian government may remedy)
- cost of health care,

[14] Milosevic, D., Cheng, I., & Smith, M. (2012) 'The NSW Refugee Health Service Improving refugee access to primary care'. *Australian Family Physician*. 41, pp 147-149; Russell G., Harris, M., Cheng I-H, et al. (2013). *Coordinated primary health care for refugees: a best practice framework for Australia*. Southern Academic Primary Care Research Unit: Melbourne; Cheng I-H., Drillich, A., Schattner P. (2015). 'Refugee experiences of general practice in countries of resettlement: a literature review'. *British Journal of General Practice*. 65(632) pp.171-6.

[15] Tyrrell, L., Duell-Piening, P., Morris, M., & Casey, S., op. cit.

[16] Victorian Refugee Health Network. (2018). *Service responses for people with disabilities form refugee backgrounds in northern Melbourne*. Retrieved from the Victorian Refugee Health Network website: http://refugeehealthnetwork.org.au/service-responses-for-people-with-disabilities-from-refugee-backgrounds-in-northern-melbourne/.

[17] Furneaux, S., Duell-Piening, P., Christensen, S., Jaraba, S., Loupetis, M., & Varenica, R. (2016). *Engaging and supporting general practice in refugee health: final report*. Retrieved from the Victorian Refugee Health Network website: http://refugeehealthnetwork.org.au/wp-content/uploads/Report_2016_August_Primary-Care-Report_FINAL-REPORT.pdf.

[18] The report may be retrieved from: http://refugeehealthnetwork.org.au/promoting-the-engagement-of-interpreters-in-victorian-health-services/

- distance to services,
- lack of transport options, not being confident or familiar with public transport,
- cost of transport to health care appointments,
- long wait times for appointments, especially to see a medical specialist,
- difficulty making appointments, especially over the phone,
- difficulty filling in forms in English,
- caring responsibilities and not having access to childcare or respite,
- inability to request female health practitioners,
- multiple appointments across many services for new arrivals, and
- low health and service literacy.

Conversely, enablers that assisted access to health care were identified as:[19,20]

- convenient location or proximity of the service to where a person lives,
- availability of public transport to get to the service,
- attending services that are co-located,
- attending services that employ bilingual GPs and/or other health professionals,
- drop-in clinics where appointments are not required,
- bi-cultural access workers,
- culturally competent health providers,
- translated appointment reminders, and
- welcoming front of house staff, including bilingual receptionists.

People with complex health problems and disabilities need to attend more appointments and may have specific access issues related to their condition or disability. In addition to those listed above, specific barriers identified for people with disabilities included: [21]

- long waiting times for aids and equipment,
- long waiting times for allied health and psychology assessments and treatment (most newly arrived Refugee and Humanitarian Program entrants have low English proficiency. This limits referral options for allied health services as MBS funded allied health services do not qualify for TIS fee-free interpreting, see **recommendation 5**), and
- long waiting times for specialist assessments, for diagnosis necessary to access support services.

Strategies and services that supported access to health services for people with complex health problems or disabilities included: [22]

- case management,
- sharing of information between the professionals providing care,
- good quality, comprehensive on arrival assessment with a general practitioner with appropriate and supported referrals, and
- referral of children for specialist care and assessment by paediatricians.

Further, general practitioners and other health providers require support to overcome a number of challenges they experience in working with people from refugee backgrounds, such as uncertainty of clinical knowledge, using interpreters, cross-cultural negotiation and

[19] Tyrrell, L., Duell-Piening, P., Morris, M., & Casey, S., op. cit., p.23.
[20] Victorian Refugee Health Network, op. cit.
[21] ibid.
[22] ibid.

health system barriers.[23] Making information resources available to health providers can have a positive impact on 'patient care'.[24] A number of resources have been developed and updated as once off projects such as the *Australian Refugee Health Practice Guide*[25] and the *Recommendations for comprehensive post-arrival health assessment for people from refugee-like backgrounds.*[26] To ensure that these resources continue to be relevant for practitioners they need to be maintained and updated frequently (see **recommendation 6**).[27]

There are a range of initiatives being undertaken by Commonwealth, State and Local governments, as well as by services, to try and address barriers experienced by people from refugee backgrounds in accessing appropriate health care. Following are some recommendations about how the Australian government may further contribute.

Recommendation 3: The Australian Government Department of Social Services to work with refugee health providers, through the Refugee Health Network of Australia, and settlement services to design services and indicators that support new arrivals to access appropriate health services and to troubleshoot access barriers that may arise.

Recommendation 4: The Australian Government Department of Social Services to fund secretariat for RHeaNA to convene health professionals, policy makers and administrators to share practice, discuss emerging issues, and provide advice to government on necessary system reforms (see **Victorian Refugee Health Network** case study).

Recommendation 5: The Australian Government Department of Social Services to extend TIS free interpreting services to Medical Benefits Schedule (MBS) funded allied health services and psychological services.

Recommendation 6: The Australian Government Department of Health provide funds to maintain evidence-based resources in refugee health to support practitioners.

The impact of precarious housing on health

This section draws on, among other references, the unpublished manuscript of Dr Kudzai Kanhutu. The full manuscript may be requested by emailing Kudzai.Kanhutu@mh.org.au

Housing is often identified as a priority by new arrival communities.[28] In our Network meetings and forums, health practitioners often identify housing related stress as an issue for people from refugee backgrounds, impacting on health. This is supported by research which demonstrates that precarious housing has a negative impact on health.[29]

Precarious housing is defined as: [30]

1. Unaffordable housing (high cost in proportion to income)
2. Unsuitable housing (overcrowded/poor condition/unsafe/poorly located)

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[23] Wittick, T., Walker, K., Furler, J.,& Lau, P. (2018) 'An online resource supporting refugee healthcare in Australian general practice: an exploratory study', *Australian Journal of General Practice*. 47(11) 802-806.
[24] ibid, p.805.
[25] The resource may be retrieved from: http://refugeehealthguide.org.au/
[26] The recommendations may be retrieved from: https://www.asid.net.au/documents/item/1225
[27] Wittick, T., Walker, K., Furler, J.,& Lau, P., op. cit., p.806.
[28] Victorian Refugee Health Network, op. cit., p.46.
[29] Kanhutu, K., Quintana, J., Gabriel, J. & Biggs, B-A. (2019) *Healthcare worker perspectives on the impact of refugee housing on health and health care provision in Melbourne, Australia; a qualitative study*. Untitled manuscript submitted for publication.
[30] ibid.

3. Insecure tenure

In 2011 it was found that a higher proportion of '[refugee and] humanitarian entrants pay rent compared with other streams [of migration]'.[31] Refugee and humanitarian entrants found it harder to pay rent, they were less satisfied with where they lived and struggled to find suitable rental accommodation for large families.[32] 40% of new arrivals reported it was difficult to find housing,[33] primarily because it was too expensive, appropriate accommodation was not available, and due to lack of employment or low income.[34] Also in 2011, approximately two thirds of refugee and humanitarian entrants living in Victoria resided in the most socially disadvantaged suburbs, often in the outer fringes of Melbourne (see **recommendation 7**).[35]

Having secure housing tenure, a fixed address, is important for continuity of health care. People rarely update their address with services when they move, and as such, they are at risk of missing the often essential appointments they have been waiting for e.g. public hospital outpatient appointments, public housing,[36] as correspondence regarding waiting lists are often sent out by post. When people move they lose links with services and their community. Secondary movement of Refugee and Humanitarian Program entrants is not uncommon, and may be for reasons other than security of tenure, including a desire to be closer to family and ethnic communities, to find jobs, and to move to more suitable accommodation.[37] For people who move regularly, a health record that may be shared among health providers supports continuity of health care, the Australian Government's My Health Record may be one such mechanism (see **recommendation 8**).

Precarious housing experienced by Refugee and Humanitarian Program entrants is compounded when people experience complex health conditions and disabilities.[38]

> *'Disability is a big need and the housing isn't appropriate anywhere…this person is crawling along the ground because the house isn't appropriate for a wheelchair or they can't have a shower' Quote from nurse*[39]

For settlement services, timely sourcing of suitable accommodation is dependent on advanced notice (prior to a person arriving) of the specific mobility or access needs of the individual or family. Recent changes to the health information systems by the Australian Government Departments of Social Services and Home Affairs has resulted in poor information flow of assessments completed prior to immigration to settlement services.[40] Settlement services are often reliant on health services notifying them of access requirements noted on the Health Assessment Portal which is not accessible by settlement services (see **recommendation 9**). Even with notice, arranging home modifications in private rentals involves negotiations with landlords and may be time consuming. When

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[31] Australian Survey Research. (2011). *Settlement outcomes for new arrivals*. Australian Survey Research Group Pty Ltd for the Department of Immigration and Citizenship. p. 36-41.
[32] ibid.
[33] Kanhutu, K., Quintana, J., Gabriel, J. & Biggs, B-A., op cit.
[34] Australian Survey Research, op. cit.
[35] Davern, M., Warr, D., Block, K., La Brooy, C., Taylor, E. & Hosseini, A. (2016) *Humanitarian Arrivals in Melbourne: A spatial analysis of population distribution and health service needs. Extended Report*. Retrieved from the University of Melbourne website https://minerva-access.unimelb.edu.au/handle/11343/208049 on 14 January 2019.
[36] Kanhutu, K., Quintana, J., Gabriel, J. & Biggs, B-A., op cit.
[37] Victorian Refugee Health Network, op. cit., p.47.
[38] Kanhutu, K., Quintana, J., Gabriel, J. & Biggs, B-A., op cit.
[39] ibid.
[40] Victorian Refugee Health Network, op. cit., p.46-7.

permanent accessible housing becomes available, it may meet some needs, but it may also create dislocation in care, loss of connections and health records.[41]

Recommendation 7: The Australian Government through the Council of Australian Governments' National Housing and Homelessness Agreement provide specific recognition of access to affordable and social housing for Refugee and Humanitarian Program entrants, with a requirement for regular reporting against key precarious housing indicators.

Recommendation 8: The Australian Digital Health Agency, Australian Government Department of Social Services, settlement services, Refugee Health Programs and Primary Health Networks provide accessible information to new arrival communities regarding My Health Record.

Recommendation 9: The Australian Government Departments of Home Affairs and Social Services provide early notification to the Humanitarian Settlement Program of mobility restrictions experienced by Refugee and Humanitarian Program entrants to assist with sourcing appropriate housing.

Pathways to employment for health professionals who arrive in Australia through the Refugee and Humanitarian Program

Health professionals who speak additional languages to English and have an understanding of cultural and health beliefs of communities from refugee backgrounds can assist with access to health services for those communities.[42] People who enter Australia with refugee or humanitarian visas have diverse life experiences, yet within these communities there are always people who have had a role in providing health care to their community prior to their arrival in Australia, whether it be as a medic who worked in camp hospitals on the Thai Burma border or as a qualified surgeon who worked in world class hospitals in Syria. The employment and training pathway for these health professionals will be different – but both have experience, skills and vocational interests that may be translated to an Australian context.

The Victorian Foundation for Survivors of Torture (Foundation House) consulted with a group of health professionals from Syria and Iraq in early 2018. Within this group there were people who had significant professional experience in their home country including as health professionals.[43] During the meetings it emerged that people who have worked as health professionals in their home country faced many barriers to finding work in their profession in Australia.

For health professionals who had equivalent qualifications and experience to those required in Australia, the barriers broadly related to two areas: the exams, and local experience. With regards to the exams, they are very expensive for most of the group. Further, the exams are also very difficult and required extensive studying. Many applicants, including Australian trained applicants, need to repeat the exams adding to the expense. Finding time to study for the exams was also difficult as Job Networks do not recognise study for professional exams as a job search activity, therefore a person studying loses their income from Centrelink if they do not apply for the minimum required number of jobs per week.

[41] Victorian Refugee Health Network, op. cit., p. 47.
[42] Tyrrell, L., Duell-Piening, P., Morris, M., & Casey, S., op. cit., p.23.
[43] 5 pharmacists, 4 veterinary scientists, 7 dentists, 12 doctors who had been in Australia less than two years, source minutes from meetings 26 February 2018 and 6 March 2018

Some people within the group had already passed some of the exams, and therefore had permission to work in Australia under supervision. To progress in their professional registration they were required to gain Australian experience, however most people in the group had arrived in the previous two years and did not have networks to draw upon to identify work opportunities. Work placements were difficult to secure, even when people had a willingness to work voluntarily to gain experience and people felt anxious about long breaks from working in their profession as this also reflected poorly throughout their professional registration.

Health professionals who were older and those whose qualifications were significantly different to those required in Australia were considering alternate pathways, including interpreting in health settings, or re-training in similar fields (see **Refugee Health Volunteer Program in Dandenong** case study).

Supporting health professionals who arrive through the Refugee and Humanitarian Program is not straight forward as people have varying qualifications, are at different stages of the registration process and/or in different professions. Discerning an individual's professional needs and understanding the systems they need to engage with is time consuming and impenetrable to new arrivals. By comparison, Foundation House has also identified a group of engineers within the Syrian and Iraqi arrivals. For this group of professionals, having their qualifications recognised seemed more straight forward and support from industry was much more forthcoming.

Recommendation 10: The Australian Government Departments of Education and Training, and Health explore methods to support experienced health professionals from refugee backgrounds on pathways to employment.

Case Study: Settlement Health Coordinators

This case study primarily relates to (tick any that apply):

- ☑ Integration
- ❒ Employment
- ☑ Settlement

1. Description of case study (maximum 250 words)

The settlement health coordinator (SHC) is a senior refugee health nurse who provides advice, secondary consultation and training to settlement case managers, health providers, and newly arrived people from refugee backgrounds. The SHC is employed by a community health service in an area of high settlement, and are located at the local settlement service.

SHCs are involved in triaging and prioritising referrals to health services and identifying local referral pathways. SHCs access pre-arrival health information (through Department of Home Affairs' Health Assessment Portal), liaise with case managers regarding any necessary follow-up, and coordinate care for 'critical' and 'potential' medical health issues for new arrivals. SHCs provides capacity building and partnership development with local general practices, hospitals and other health services to improve access to, and the delivery of, appropriate, high quality health services to newly arrived people from refugee backgrounds.

SHCs builds the capacity of settlement case managers to understand the health system and the most appropriate local referral pathways, delivering health and human service information during orientation of new staff and provide an ongoing point of contact for settlement case managers. For people from refugee backgrounds who arrive with complex health needs and/or present in crisis, SHCs works in partnership with case managers undertaking clinical assessments to determine immediate health needs and facilitate referral pathways.

SHCs works with health providers, settlement services and the Refugee Health Program Statewide Facilitator to respond to emerging issues and continually improve practice in the delivery of health services to newly arrived people from refugee backgrounds.

2. What are the key elements that demonstrate success? (maximum 75 words)

A 2018 interim evaluation of the SHC pilot project in Victoria found that co-location of SHCs with refugee settlement services is "a high impact intervention, which has resulted in changes in practice within settlement services; and improved quality of refugee referrals to health centres".[44(p1)]

Key elements include the partnership approach between community health services, refugee health programs and settlement services. This has resulted in a co-designed service model that addresses needs and maximises local health and settlement service resources. In addition, flexibility in the role has allowed the ability to support and upskill case managers as required, and the development and improvement of local referral pathways.

3. What structures, programs, policy or leadership supported this success? (maximum 100 words)

[44] McFeeter, J. and Marlow, L. (2017). *Settlement Health Coordinator pilot project: evaluation interim report*. Victorian Government Department of Health and Human Services: Melbourne.

The 2016-17 State Budget provided funding over four years to co-locate experienced refugee health nurses, otherwise known as SHCs, with settlement services. SHC are employed by community health and co-located with the settlement service. This assists with clinical governance issues related to the delivery of healthcare but also builds a closer relationship between the community health service and settlement services.

The three SHC roles in Victoria are four year funded pilot positions and are part of the broader state funded refugee health program. A working group has been established to oversee the development, implementation and evaluation of the SHC role. The SHC Memorandum of Understanding outlines the agreement between the community health service and the settlement services.

4. How would you frame a strategic response to the key areas being considered by the review? (optional: 250 words)

Access to timely health care is recommended within one month of arrival for Refugee and Humanitarian Program entrants,[45] many of whom arrive with complex or previously unmanaged health needs as a result of their experiences pre, during and post-migration. The links between health, settlement and integration of people from refugee backgrounds are well established, with health acting as both an enabler and indicator of integration.[46]

Co-location of SHC with settlement services should occur in all settlement service agencies. In Victoria, this approach has been shown to maximise the existing investment of resources in the refugee health program.[1] Evaluation evidence from the Victorian SHC pilot project demonstrates that a SHC role:

- "addresses a documented gap in health knowledge and capacity of settlement services
- quickly improves settlement case managers' awareness of the health system and their capacity for better informed triage practice and more comprehensive referrals of new arrivals for refugee health assessments
- provides greater certainty that refugees are accessing primary health care in a timely manner, avoiding escalation to acute care and reducing potential clinical risk
- addresses the heavy demand on time and resources in community health centres and in settlement services to follow up incomplete referrals
- provides efficiencies in time management because settlement case managers are trained and use the e-referral tool used by health centres
- provides consistency in referrals and access to primary care across a community health service catchment area rather than previous, variable approaches which can result in
    - clients missing out on available services
    - existing services not being used to full potential

[45] Chaves, N.J., Paxton, G., Biggs, B.A., Thambiran, A., Smith, M., Williams, J., Gardiner J., Davis, J.S.; on behalf of the Australiasian Society of Infectious Diseases and Refugee Health Network of Australia Guidelines writing group. (2016). *Recommendations for comprehensive post-arrival health assessment for people from refugee-like backgrounds*.
[46] Ager, A. and Strang, A., op. cit.

- provides systematic mechanisms for capacity building within the broader health services (including GP practices) in areas of high refugee re-settlement to better manage refugee health assessments".[1(p1)]

5. Is there any research that you have undertaken that the panel should consider? (please attach links or PDF)

An interim evaluation of the Settlement Health Coordinator pilot project was conducted by McFeeter and Marlow in 2017 and has been cited in this case study. The full report is available on request.

Case Study 2: Victorian Refugee Health Network

This case study primarily relates to (*tick any that apply*):

☑ Integration

❒ Employment

☑ Settlement

1. Description of case study *(maximum 250 words)*

The Victorian Refugee Health Network (the Network) was established in June 2007 to facilitate greater coordination and collaboration amongst health and community services to provide more accessible and appropriate health services for people of refugee backgrounds, including people seeking asylum.

Mission: Collaborating to reduce health disparities experienced by people from refugee backgrounds, including people seeking asylum.

Vision: Victorians from refugee backgrounds, including those seeking asylum, have timely access to appropriate services and other resources required to build and maintain health and wellbeing.

The Network is underpinned by the following values:

- Collaboration
- Accountability
- Responsiveness
- Political neutrality

The work of the Network is overseen by an executive group, and by detailed work plans developed by Network working groups. The Network provides support to the health, settlement and community sector by convening working groups, developing resources, hosting forums, completing reviews of available literature, providing specialist advice and participating in practice-related research projects.

The Network has also undertaken time limited projects on a range of health and wellbeing issues including, on-arrival refugee health assessment, general practice engagement and support, access to services for people with disabilities, community consultation, immunisation, oral health, maternity, maternal and child health, and language services.[47] In addition, the Network regularly contributes to or participates in advisory groups, research, training delivery, submissions and other relevant networks including the Refugee Health Network of Australia (RHeaNA).

Network participants include healthcare providers from a range of disciplines, including those working in primary and tertiary settings, settlement service providers, asylum seeker support agencies, community services, government departments, and other local relevant networks.

2. What are the key elements that demonstrate success? *(maximum 75 words)*

The Victorian Refugee Health Network is a trusted source of information for local networks, collecting knowledge on behalf of local networks and at times representing the views of the sector in state-wide meetings and national forums. The Network is also a trusted source of

[47] More information about the projects of the Victorian Refugee Health Network may be accessed here: http://refugeehealthnetwork.org.au/engage/refugee-health-network/

information for government departments, policy makers and service planners working to improve policy and practice relating to the health and wellbeing of people from refugee backgrounds and people seeking asylum in Victoria.

3. **What structures, programs, policy or leadership supported this success?** *(maximum 100 words)*

The Network is funded by state government, providing strong secretariat support, with additional funding sources allowing for time limited and focused projects.

The Network is overseen by an executive group who bring a range of skills, expertise and perspectives. Drawing on input from the Network's participants, the Network executive group refines, endorse and monitor the Network's strategic plan and work plan; provides strategic direction and oversight of the Network's activities and resources.[48]

Victoria has thriving local refugee health networks which undertake a wide range of activities including targeted community health literacy programs, development of local refugee health directories and referral pathways, facilitating capacity building and networking of local services, co-designing services with local communities, and the developing programs to meet local needs. Participants from local networks engage with the Victorian Network in various ways, attending Victorian Network meetings and associated working groups, others receive information and contribute to the Victorian Network through their local refugee health network chair.[49]

In addition, the Network have developed and maintained strong relationships with state government and government departments and an extensive range of health, settlement and community service providers.

4. **How would you frame a strategic response to the key areas being considered by the review?** *(optional: 250 words)*

Good health is an important resource for active engagement in a new society, and is both an indicator and an enabler of integration.[50]

While the benefits of the 'mainstreaming' health provision to people from refugee backgrounds is recognised, health professionals also recognise the specific health needs of people from refugee backgrounds as a result of their experiences pre, during and post migration.[1]

The strength of the Victorian Refugee Health Network comes from its extensive and multidisciplinary participation, strong relationships with government and the broader sector, and its active secretariat to progress actions and issues raised by the broader network. While statewide networks of health professionals working with people from refugee backgrounds exist in a number of states and territories, strengthening the national network (RHeaNA) would allow greater collaboration, sharing of emerging issues and development of national resources that support good practice in refugee health. In addition, a resourced national network would provide a point of contact for the Australian government for advice relating to health and settlement of people from refugee backgrounds. For example, in 2018,

[48] Read more about the Executive Group here: http://refugeehealthnetwork.org.au/about/executive-group/
[49] Read more about local refugee health networks in Victoria here: http://refugeehealthnetwork.org.au/engage/refugee-health-network/
[50] Ager, A. and Strang, A., op. cit.

a better-resourced national point of contact for refugee health would have benefited the Australian Government Departments of Home Affairs and Social Services, as well as the refugee health sectors, to support communication and implementation of a system change impacting on the transfer of health information from offshore to Australian health services.

Support for a national network with diverse participation and a holistic approach to health and wellbeing, with funding for a national network coordinator, would provide opportunities to improve policy and practice at a national level relating to health and settlement outcomes for people from refugee backgrounds.

5. **Is there any research that you have undertaken that the panel should consider?** *(please attach links or PDF)*

The Victorian Refugee Health Network have produced a number of publications, including project reports, community consultation findings, submissions and other publications: http://refugeehealthnetwork.org.au/library/publications/

Case Study 3: Monash Health – Refugee Health Volunteer Program in Dandenong

This case study primarily relates to (*tick any that apply*):

- ☑ Integration
- ☑ Employment
- ☑ Settlement

1. Description of case study *(maximum 250 words)*

The current Refugee Health Volunteer Team is comprised of 80 men and women from 20 countries, speaking 32 languages. The majority are awaiting determination of their asylum claims, and some have no income or work rights. However, through their dedication and enthusiasm to volunteer, they have demonstrated their eagerness to contribute to Australian society.

Volunteers perform a 'Concierge' role within the complex community health site. They greet and guide clients, visitors and patients to their appointments. They conduct surveys, assist clients to complete forms, engage with reception staff, call taxis and assist incapacitated clients.

Several volunteers serve as 'Dialysis Patient Visitors' supporting patients who attend three days a week. They assist staff serving tea, and interact with patients. With further training and oversight some massage feet, and others assist patients with exercises. Several help staff with administrative tasks or run social inclusion programs.

Increasingly the focus has been employment readiness. Most of the 128 'graduates' since 2014 are now in employment due to the skills and confidence they received from volunteering. 21 are now employed at Monash Health. Scholarships into entry level health professions have been created, with a guaranteed placement at Monash Health and a staff member assigned as a mentor. Other initiatives include involving graduates in work experience with Monash Health, traineeships and internships.

2. What are the key elements that demonstrate success? *(maximum 75 words)*

In addition to the measurable employment outcomes, comprehensive evaluation of the program has identified enhanced social capital and sense of belonging, expanded social networks, improved English competency, increased confidence and mental health, and development of workplace competency and skills. Volunteers typically attribute their success both personally and professionally, to their volunteer experience at Monash Health. Impacts also identified on the broader workforce particularly in regards to cultural understanding.

3. What structures, programs, policy or leadership supported this success? *(maximum 100 words)*

- Rigorous recruitment and training processes, work directions, job descriptions etc.;
- Peer mentoring and a high level of investment and support from coordinator, manager and other staff;
- Qualitative and quantitative research and evaluation drives program improvement and resulted in recognition through various internal and external awards;
- A visual record has helped to promote and celebrate successes and develop community;

- Developing a flexible and positive environment that encourages initiative has produced outstanding contributions;
- Continual expansion of the service provides fresh opportunities for involvement, and creates a catalyst for other teams and departments to utilize volunteers;
- Staff treating volunteers as colleagues and friends rather than clients has been instrumental;
- The genuine belief of staff in the value of having refugees working in the service, and showing appreciation and recognition informally and formally has been key.

Correspondence to the Victorian Refugee Health Network regarding the Review from Kaye Graves, Team Manager Cultural Diversity and Relationships, Bendigo Community Health Services, email: kayegraves@bchs.com.au

1. Barriers to accessing healthcare

A concerted and strategic effort is required to ensure health and welfare agencies have regular updates on understanding the refugee journey; pre and post settlement experiences for the main ethnic groups. It is evident in Bendigo we have been settling intensely for 10 years. We have an estimated 2,500 Karen 250 Afghan and 100 South Sudanese who have settled via the humanitarian program. We also have many arriving via secondary migration because Bendigo offers affordable housing a large suit of settlement programs, a proactive local council etc.

However, the service providers do not understand the refugee journey, lived experience and impacts of a life of deprivation and trauma. The impacts this has on health, learning and literacy is profound. The Karen community have lived in camps for decades hence many are not literate in their first language and find learning English difficult. The service providers also do not understand the various new faiths and cultures and health beliefs of our new arrivals.

Funding is required to build knowledge and capacity of providers. Policy development is required to ensure government funding is linked to agencies increasing and maintaining their knowledge of the refugee background impacts on settlement and access to service and culture and faith. Currently we provide capacity building sessions to service providers. This is largely unfunded.

New arrivals have poor health literacy, no concept of prevention mental health or disability. Increased focus is required in settlement programs to build health and service literacy. Currently funding model is not adequate.

Assessment requires a stronger focus regarding the refugee health check in the areas of dental and mental health. Currently these questions are subjective and between the client and GP. They often have oral health issues but do not indicate. An oral health check should be mandatory. The mental health questions need some thought and different approach. As the new arrival is required to have a health check within 1 months of arrivals (or we don't get paid for that activity) the mental health assessment is often looked over due to competing other health assessment activities tests etc. A full mental health assessment should be compulsory at the exit time from the HSP program. We will be trialling such an approach at BCHS.

2. Consideration needs to be given to the various differences in abilities lived experiences literacy etc. Currently both the SETS and HSP settlement programs provide the same service across the justifications. For instance, some Syrians come with English and qualifications. The Karen come with neither.

3. Barriers to employment.

The Job Active model is highly problematic. During settlement the staff are required to attend the first session with a Jobactive provider. Jobactive providers are paid on outcomes, which does not provide the motivation to understand the overt and covert barriers to employment.

At initial assessment by Centrelink using a Job Seeker Classification Instrument (JSCI) is not accurate. These inaccuracies have a high impact. This instrument classifies new arrivals as being least and most employable. i.e. Stream A most employable, Stream C least

employable. Due to inexperience feeling nervous of authority, fear of failure, poor health literacy, not understanding what is being asked of them, with many new arrivals often do not answering honestly- there is questionable authenticity in results.

The team at BCHS believe all new arrivals should be streamed C Streams C's are afforded more time and brokerage funds to enhance employability. Also hidden are the health impacts of a life of deprivation. Musculoskeletal issues, mental health issues with grief and a sense of loss not obvious but compounding the ability to learn and remain motivated.

We strongly suggest a review of this tool and the Jobactive model.

We also suggest integrating employment into settlement programs as it is the settlement provider staff who the new arrivals know and trust. The settlement staff also have greater insight into the new arrivals capabilities, health, career and job aspirations etc. Currently we often find suitable meaningful jobs, training and career pathways during the settlement activities which is often outside our contract scope. However this is very successful with sustained employment and training outcomes because of the pre-existing trust and relationship with the settlement team and greater insight into the client. The current model is counterproductive.

Letters are often set in English outlining Centrelink obligations. This is a difficult situation as even letters translated may not be understood.

4. Integration

Embed an integration activity/position into settlement. At about 6 months settlement staff can work to integrate families into sports, groups etc. It's our observation those that thrive are linked with locals of non-refugee background via sports clubs etc.

The good news is the latest report Regional Futures Economic and Social Impact of the Karen Resettlement in Bendigo evidences the sustained attractiveness of Bendigo as a settlement destination. It also highlights the settlement work BCHS has undertaken over the last 10 years when we have consistently and successfully applied for primary and secondary settlement grants, refugee health nurse program, Torture and Trauma Counselling and various other DPC funded Community harmony and Community Resilience projects and our efforts at building the city's capacity to enhance cultural competence and a welcoming city. In net present value terms (NPV) over a 10year period the total economic impact from the region resettlement of the Karen population on the Bendigo economy is estimated to have been $67.1 million.

The other good news and strong suggestion is that every regional area and metro area have refugee settlement networks with a focus on health education employment English and youth, to bring the players together to identify unmet needs, enhance service coordination and identify professional development needs of staff working in this area Integrating into mainstream services we have found has been enhanced due to this activity BCHS has lead the Local Bendigo Settlement network for the past 5 years.