victorian refugee health network

19 June 2015

Submission to the Royal Commission into Family Violence

The Victorian Refugee Health Network is grateful for the opportunity to make a submission to the Royal Commission.

This submission is based on the work of the Victorian Refugee Health Network ('the Network') since it was established in 2007. The Network's work is overseen by a Reference Group with members from primary health care and specialist services, settlement and asylum seeker services, refugee background communities and the Victorian and Commonwealth government (see appendix 1). The Network aims to identify and address emerging health issues and build sector capacity to provide accessible and appropriate health care for people from refugee backgrounds, including asylum seekers.

The Network has provided expert advice to the sector and to successive State and Commonwealth governments on refugee/asylum seeker health and we value the collaborative relationships that have developed over many years. We have worked with the Department of Health and Human Services on policy and service development in the areas of primary health and specialist services, maternity care, sexual and reproductive health, oral health, asylum seeker access to healthcare, the Ebola virus disease response and catch-up immunisation.

In preparing this submission we have been privy to the submission of our auspicing agency the Victorian Foundation for Survivors of Torture (Foundation House) which we endorse and do not intend to duplicate.

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1. Background and context: Humanitarian settlement in Victoria

Victoria is rightly regarded as a national leader in refugee policy and settlement; nonetheless there are continuing challenges in delivering accessible and responsive services to people from refugee backgrounds.

Data is available from several Australian government sources that assist in understanding the number of people living in Victoria from refugee backgrounds:

- Around 4000 people arrive in Victoria each year through Humanitarian Settlement Program. Over the past five years 27,735 people who were provided visas under this program settled in Victoria.[1]
- A number of people who are asylum seekers live in the Victorian community as they await assessment for protection visas, these include:
    - Approximately 10,000 people who arrived by boat who have bridging visa E.[2]
    - 904 people living in community detention.[3]
    - 295 people living in immigration detention facilities.[3]
    - Nationally 9,646 people who arrived by plane with a valid visa (e.g.: tourist, student, business) subsequently lodged protection visa applications in 2013-14 financial year. No statistical breakdown is available for Victoria that shows the number of people waiting for outcomes of their application.[4]
- An unknown but growing number of people live on temporary visas in the Australian community after being found to be owed protection by the Australian government. Due to numerous legislative changes in the past two years a range of temporary visas exist including the Temporary Humanitarian Stay (subclass 449), Temporary Humanitarian Concern (subclass 786) and Temporary Protection Visa (subclass 785). The Safe Haven Enterprise Visa will be issued imminently.
- People from humanitarian source countries also enter Australia on other visas such as family visas. (see appendix 2)

People from refugee backgrounds come from many countries around the world, as noted by Foundation House: “[i]n the past year alone our clients came from more than 50 countries of origin and within some of those there were differences of ethnicity, language and faith.”

The Foundation House submission highlights the multiplicity of factors impacting on families from refugee backgrounds who are affected by family violence, which will not be covered again in this submission.

This submission will focus on overcoming some of the service system barriers that people from refugee backgrounds are known to face that may impact on their ability to access necessary services and other supports when required.

2. Positioning family violence as a health issue

While conceptualising family violence as a health issue has limitations, this approach is useful as it places a duty on the universal health service system to respond. This

approach also allows for exploration of health frameworks that seek to understand vulnerability and inform responses to family violence.

The Victorian Refugee Health Network ('the Network') works to understand service access patterns of people from refugee backgrounds living in the Victorian community. Underutilisation of services is identified and the perspectives of community, practitioners, policy makers and managers are utilised to problem solve and allocate collective resources appropriately. Identifying the 'social determinants of health' and grounding responses in a person's 'right to health' strongly underpin the work of the Network and these frameworks may also inform responses to family violence.

Common themes that emerge as barriers for people from refugee background in accessing services include, among others, service providers' poor uptake of language services, and community members' lack of service literacy or trust in services. There is also a general lack of available data to build understanding about service access patterns for people from refugee backgrounds.

These areas have clear relevance to early identification of family violence and access to support for people affected by violence, and are explored in further detail below.

2.1 Appropriate provision of language services

> *"We have never had interpreters because we never needed one (husband interpreted) and they also said that it was very expensive on the government as well so we never asked for on." (Female Participant)*[5]

> *"No I didn't need an interpreter …my husband would come with me for the appointments and would ask them about anything that he wanted to know." (Female Participant)*[5]

Effective communication between service providers and clients is essential to assess a person's needs, develop an understanding of their situation and how they understand their situation, provide information about options and establish plans to improve safety.

More than 90% of new arrival refugees have no or low English language proficiency with similar figures expect for asylum seekers.[6] Systemic, practice and skill barriers exist that prevent frontline workers from using interpreters in Victorian services.[6] Phillips and Travaglia found that GPs who have access to fee free interpreting services used this service "for patients with poor proficiency in English is less than 1 in 100 (0.97%) Medicare-funded consultations."[7]

Family members are often used to interpret. This may be well intentioned, i.e. to save the service money, to be more inclusive of family or to make a client feel more comfortable, however there are significant issues with this approach. Service providers that use family or friends to interpret:

- risk information not being communicated accurately,
- placing undue stress on family members or friends,
- in the case of using a child, impose unfair responsibility on them and perhaps expose them to traumatic or age inappropriate material, and
- make it impossible for a person to communicate about matters that the family member or friend does not want them to communicate.

Foundation House completed a comprehensive review of the barriers and facilitators to interpreter use in health services in 2013 with 31 recommendations that have implications for Commonwealth and State governments, peak bodies, education institutions, service providers and those responsible for the interpreter workforces.[6]

Recommendation 1:

All services should have capacity to work with people with low English proficiency through the provision of credentialed interpreters (onsite or phone). The following steps should be implemented by all Victorian services, including services that respond to family violence, and supported by governments:

(a) all services should have a language services policy that indicate when interpreters should be used, how to arrange interpreters, and specifying practices that are inappropriate such as the use of family members or friends,

(b) all services should be appropriately costed and funded for interpreter use, this should be foreseen as a core operating costs,

(c) all staff should receive training to improve competence and confidence in using interpreters, including methods to appropriately brief and debrief interpreters, to communicate effectively through an interpreter, how to manage an interpreter mediated conversation that a practitioner may have concerns about, how to negotiate concerns that clients may have about interpreter use,

(d) all services should have infrastructure required to use interpreters, such as speaker phones for phone interpreters (important in crisis context as onsite interpreters often requiring advance bookings), and

(e) all services should develop agreements with interpreting providers that allow for the provision of appropriate interpreters as required, such as if a client requests an interpreter of a certain gender, age, dialect. Furthermore agreements should allow for consistency of interpreter to assist in the development of trust.

2.2 Utilising universal services for early identification of family violence: Multiple entry points to support

> *"Care providers reported not having the time to ask about what is happening in women's lives, not knowing how to talk with women about their emotional wellbeing or issues such as family violence, and feeling that they lacked skills in responding to disclosure, and knowledge of local agencies for referral."*[5]

People who have low English proficiency, limited social and familial networks, and little knowledge of the geographical area struggle to find services, this is the case for many people from refugee backgrounds.

In order to seek a service a person needs to have a sense that their situation may be improved, they need to know that there is a response for the problem available, where to find the service and it must be logistically accessible.

Universal services such as General Practice and Maternal and Child Health play a vital role in identifying family violence and counselling people who are affected by violence and those who have been violent about their options. This role is even more pertinent for people from refugee background including asylum seekers who may be isolated and may have very limited opportunities to seek support. Recent research, however, has indicated reluctance or lack of confidence by health practitioners in discussing psychosocial concerns with new arrivals.[5]

Recommendation 2:

(a) Build the capacity of universal services, such as general practice, schools, maternal and child health, to be sites for entry into support services for people who are affected by violence and those who have been violent.

(b) Develop a coordinated service system that supports people who are affected by violence as they transition between services, including transitions between universal services and population specific or targeted services. (see example of approach in section 3.1)

(c) Build the capacity of universal services and services that respond to family violence to be culturally competent. Including the development of a cultural competence plans which considers all levels of the organisation including: governance, policy, workforce attitudes, skills and knowledge and infrastructure.

2.3 Data

Collection of data that enables the identification of people from refugee backgrounds is required to better understand service utilisation patterns and plan targetted responses to groups who are not accessing services as expected.

The Refugee Status Report published by the Department of Education and Early Childhood Development highlighted the significant gaps in data collection that rendered people from refugee backgrounds invisible in the family violence and child protection databases.[8]

Recommendation 3:

(a) Services should collect the minimum data items: (1) country of birth, (2) year of arrival, (3) need for interpreter, and (4) preferred language.

(b) Services should provide training to their workforce to support data collection, entry, retrieval and analysis to improve data integrity and to inform service delivery and planning.

(c) The Australian and Victorian governments should utilise standardised data dictionaries across program areas to enable analysis between datasets.

3. Good approaches to working with people from refugee backgrounds

The Network endorses the community engagement and development strategies that Foundation House described in its submission as methods of building understanding of

the Australian laws and connecting communities to support. The programs described were: Supporting Traditional African Mediators Project (STAMP)[9] and the Foundation House Family Strengthening Strategy.

Other programs that the Network would like draw the Royal Commission's attention to as examples of good approaches to working with people from refugee backgrounds are the community health based Refugee Health Program and the health literacy and social marketing work of the Centre for Culture, Ethnicity and Health.

3.1 Refugee Health Program (formally the Refugee Health Nurse program)

The Refugee Health Program is a targeted service delivered through community health services in Victoria. The Department of Health and Human Services funded program has grown steadily since its establishment in 2005. The target groups for the program are people who are newly arrived through the Australian Humanitarian Program and asylum seekers.

The Refugee Health Program has three aims:

- Increase refugee access to primary health services.
- Improve the response of health services to refugees' needs.
- Enable individuals, families and refugee communities to improve their health and wellbeing.

This program works with individuals and families delivering services as well as providing training and other capacity building activities to the broader primary health care system to build understanding of the unique needs of people from refugee backgrounds.

Significant features of this program include:

- Dedicated funding for language services.
- The role of the Statewide Refugee Health Program Coordinator who visits all programs around the state to provide technical assistance.
- Centralised training delivered through Foundation House in partnership with the Statewide Refugee Health Program Coordinator.
- State Government Policy that supports service access and delivery to people from refugee backgrounds, including naming people who are refugees and asylum seekers as one of the six priority access groups for community health services.
- State Government guidelines to support program development.[10]

The program's strengths and successes are widely accepted. The Victorian Auditor General's office in 2014 reviewed access to services for migrants, refuges and asylum seekers including timeliness of the services, service coordination and the ability of the service to respond to client's identified needs. The Refugee Health Program played a large part in the Auditor General's conclusion that "only the Department of Health can demonstrate at a strategic level that it understands the complex and multiple needs of migrants, refugees and asylum seekers."[11] (p. x)

3.2 Health Literacy and social marketing

The Department of Health and Human Services has funded the Centre for Culture, Ethnicity & Health for 2014-17 to re-develop the Victorian Health Translations Directory which aims to improve health literacy of individuals and populations through the development and dissemination of targeted, in-language and culturally relevant information resources for all Victorians. The funding has a focus on newly arriving communities from refugee background.[12]

The Centre for Culture, Ethnicity and Health has editorial guidelines drawn from its extensive work in the area of social marketing which involves community consultation and testing of resources.

This initiative has the potential to develop specific resources on family violence prevention, intervention, and service access and availability.

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Appendix 1: Victorian Refugee Health Network Reference Group

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Appendix 2: Migration streams by country of birth, top 10 humanitarian settlement program countries 2013-14 Victoria

	Humanitarian	Family	Skilled	Unknown	Total	% humanitarian stream	% humanitarian plus family
IRAQ	879	212	15	17	1,123	78%	97%
AFGHANISTAN	712	683	1	11	1,407	51%	99%
BURMA	687	73	8	11	779	88%	98%
IRAN	350	158	325	61	894	39%	
THAILAND	293	366	20	15	694	42%	
SYRIA	195	34	0	10	239	82%	96%
PAKISTAN	110	535	570	197	1,412	8%	
EGYPT ARAB REP OF	91	93	58	119	361	25%	
MALAYSIA	66	221	393	263	943	7%	
ETHIOPIA	55	264	9	1	329	18%	97%
SOMALIA	52	95	0	0	147	35%	100%

Source: Australian Government Department of Immigration and Border Protection. Settlement Reporting Facility. http://www.immi.gov.au/settlement/srf/. Accessed September 29, 2014. (Arrival date range 1/7/2013-31/6/2014)